Medicare Part D: 5 Tier Closed Performance Formulary 2025

Por favor haga clic aquí.

Para Medicare Part D: Criterios de autorización previa

Por favor haga clic aquí.

Para Medicare Part D: Criterios de terapia escalonada

Por favor haga clic aquí.

Para obtener información más reciente o hacer otras preguntas, comuníquese con:

Servicio de farmacia Freedom Blue PPO (DE) al 1-844-576-1246
Servicio de farmacia Freedom Blue PPO (PA) al 1-800-550-8722
Servicio de farmacia Freedom Blue PPO (WV) al 1-888-459-4020
Servicio de farmacia Security Blue HMO-POS al 1-800-935-2583
Servicio de farmacia Community Blue Medicare HMO al 1-888-234-5397
Servicio de farmacia Community Blue Medicare PPO al 1-888-757-2946
Servicio de farmacia Community Blue Medicare Plus PPO al 1-888-757-2946
Servicio de farmacia Complete Blue PPO al 1-833-227-9375
Servicio de farmacia Together Blue Medicare HMO al 1-888-328-5704

Los usuarios de TTY deben llamar al 711, los siete días de la semana, de 8 a. m. a 8 p. m., o visitar **medicare.highmark.com/formulary**.

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Nota a los miembros actuales: Este formulario ha cambiado desde el año pasado. Revise este documento para asegurarse de que aún contenga los medicamentos que toma.

Cuando esta Lista de medicamentos (Formulario) se refiere a “nosotros” o “nuestro”, significa Highmark Senior Health Company, Highmark Choice Company, Highmark Senior Solutions Company, Highmark BCBSD Inc., o Highmark Health Insurance Company.

Cuando se refiere a “plan” o “nuestro plan”, significa Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO o Together Blue Medicare HMO.

Este documento incluye una Lista de medicamentos (formulario) para nuestro plan, en vigor a partir del 1 de enero de 2025. Para obtener una Lista de medicamentos (formulario) actualizada, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización de la lista de medicamentos cubiertos, aparece en la portada y en la contracubierta.

Generalmente, debe utilizar las farmacias de la red para recibir el beneficio de los medicamentos con receta. Los beneficios, el formulario, la red de farmacias o los copagos/coseguros pueden cambiar el 1 de enero de 2026 y ocasionalmente durante el año.

¿Qué es el formulario de Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO y Together Blue Medicare HMO?

En este documento, usamos los términos Lista de medicamentos y formulario para referirnos a lo mismo: una lista de medicamentos cubiertos que selecciona nuestro plan junto con un equipo de proveedores de atención médica, que representa a las terapias recetadas que se consideran parte necesaria de un programa de tratamiento de calidad. Nuestro plan generalmente cubrirá los medicamentos mencionados en nuestra lista de medicamentos cubiertos (formulario) siempre que el medicamento sea médicamente necesario, la receta se surta en una de las farmacias de la red de nuestro plan y se sigan otras reglas del plan. Para obtener más información sobre cómo surtir sus recetas, consulte su Evidencia de cobertura.

¿Puede cambiar el formulario?

La mayoría de los cambios en la cobertura de medicamentos ocurre el 1 de enero, pero es posible que agreguemos o eliminemos medicamentos del formulario durante el año, que los movamos a diferentes niveles de costo compartido o que agreguemos nuevas restricciones. Debemos seguir las reglas de Medicare al hacer estos cambios. Las actualizaciones del formulario se publican mensualmente en nuestro sitio web aquí: **medicare.highmark.com/formulary**.

Cambios que pueden afectarlo este año: En los casos que se mencionan abajo, los cambios de cobertura lo afectarán durante el año:

- **Sustituciones inmediatas de ciertas nuevas versiones de medicamentos de marca y productos biológicos originales.** Podemos eliminar inmediatamente un medicamento de nuestro formulario si vamos a reemplazarlo con una nueva versión de ese medicamento que aparecerá en el mismo o en un nivel de costo compartido más bajo y con las mismas o menos restricciones. Cuando agregamos una nueva versión de un medicamento a nuestro formulario, podemos decidir mantener el medicamento de marca o el producto biológico original en nuestro formulario, pero moverlo inmediatamente a un nivel diferente de costo compartido o agregar nuevas restricciones.

  Solo podemos hacer estos cambios inmediatos si vamos a agregar una nueva versión genérica de un medicamento de marca, o ciertas nuevas versiones biosimilares de un producto biológico original que ya estaba en el formulario (por ejemplo, si se agrega un biosimilar intercambiable que puede sustituir un producto biológico original en una farmacia sin una nueva receta).

  Si actualmente está tomando el medicamento de marca o el producto biológico original, es posible que no le avisemos por adelantado antes de hacer un cambio inmediato, pero después le daremos información sobre el cambio específico que hicimos.

  Si hacemos dicho cambio, usted o su médico pueden solicitarnos una excepción para que continuemos cubriendo el medicamento que se va a cambiar. Para obtener más información, consulte la sección de abajo titulada “¿Cómo solicito una excepción al formulario de Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO o Together Blue Medicare HMO?”

  Algunos de estos tipos de medicamentos pueden ser nuevos para usted. Para obtener más información, consulte la sección debajo titulada “¿Qué son los productos biológicos originales y cómo están relacionados con los biosimilares?”

- **Medicamentos sacados del mercado.** Si un fabricante retira un medicamento de la venta o la Administración de Alimentos y Medicamentos (FDA) determina que se debe retirar por razones de seguridad o efectividad, podemos eliminar inmediatamente el medicamento de nuestro formulario y posteriormente informar a los miembros que lo están tomando.

- **Otros cambios.** Es posible que hagamos otros cambios que afecten a los miembros que actualmente toman un medicamento. Por ejemplo, podemos retirar un medicamento de marca de nuestro formulario al agregar un equivalente genérico o eliminar un producto biológico original al agregar un biosimilar. También podemos aplicar nuevas restricciones al medicamento de marca o al producto biológico original, moverlo a un nivel de costo compartido diferente, o las dos cosas. Estos cambios pueden hacerse de acuerdo con nuevas directrices clínicas. Si eliminamos medicamentos de nuestro formulario, agregamos autorización previa, límites de cantidad o restricciones de terapia escalonada a un medicamento, o movemos un medicamento a un nivel de costo compartido más alto, debemos informar a los miembros afectados sobre el cambio al menos 31 días antes de que el cambio entre en vigor. Alternativamente, cuando un miembro solicita un resurtido del medicamento, puede recibir un suministro de 31 días del medicamento junto con el aviso del cambio.

Si hacemos estos otros cambios, usted o su médico pueden solicitarnos una excepción para que continuemos cubriendo el medicamento que toma. El aviso que le enviemos también incluirá información sobre cómo solicitar una excepción, y también puede encontrar esta información en la sección de abajo titulada "¿Cómo solicito una excepción al formulario de Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO o Together Blue Medicare HMO?"

Cambios que no lo afectarán si actualmente está tomando el medicamento. Por lo general, si está tomando un medicamento de nuestra lista de medicamentos cubiertos de 2025 que estaba cubierto al inicio del año, no descontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura del 2025, excepto como se describe arriba. Esto significa que estos medicamentos seguirán disponibles con el mismo costo compartido y sin nuevas restricciones para los miembros que los estén tomando durante el resto del año de cobertura. No recibirá un aviso directo este año sobre los cambios que no lo afecten. Pero, el 1 de enero del próximo año, dichos cambios lo afectarán y es importante consultar el formulario para el nuevo año de beneficios para conocer si hay cambios en los medicamentos.

La lista de medicamentos cubiertos adjunta está actualizada al 01 de agosto 2025.
Para recibir información actualizada sobre los medicamentos que cubre nuestro plan, comuníquese con nosotros. Nuestra información de contacto está en la portada y en la contracubierta. Si hay cambios a medio año en la lista de medicamentos cubiertos, que no sean cambios de mantenimiento, se les avisará por correo a los miembros y los miembros potenciales recibirán una actualización de esta lista de medicamentos cubiertos. El formulario más actualizado está disponible en nuestro sitio web: **medicare.highmark.com/formulary**.

¿Cómo uso el formulario?

Hay dos formas de buscar su medicamento en el formulario:

Condición médica

El formulario comienza en la página 9. Los medicamentos de este formulario están agrupados en categorías según el tipo de condiciones para los que se usan. Por ejemplo, los medicamentos que se usan para tratar una condición cardíaca se mencionan en la categoría "Cardiovascular, hipertensión y lípidos". Si sabe para qué se usa su medicamento, busque el nombre de la categoría en la lista que comienza en la página 9. Luego, busque su medicamento debajo del nombre de la categoría.

Lista en orden alfabético

Si no está seguro en qué categoría buscar, debe buscar su medicamento en el Índice que comienza en la página 9. El índice incluye una lista en orden alfabético de todos los medicamentos incluidos en este documento. Los medicamentos de marca y los genéricos se mencionan en el Índice. Consulte el índice y busque su medicamento. Junto a su medicamento, verá el número de página donde puede encontrar información de la cobertura. Vaya a la página incluida en el Índice y busque el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Nuestro plan cubre medicamentos de marca y medicamentos genéricos. La FDA aprueba un medicamento genérico siempre que tenga el mismo ingrediente activo que el medicamento de marca. Generalmente, los medicamentos genéricos funcionan tan bien como los productos de marca y pueden costar menos. Hay medicamentos genéricos sustitutos disponibles para muchos medicamentos de marca. Los medicamentos genéricos generalmente pueden sustituirse por el medicamento de marca en la farmacia sin necesidad de una nueva receta, según las leyes estatales.

¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?

En el formulario, cuando nos referimos a medicamentos, esto puede significar un medicamento o un producto biológico. Los productos biológicos son medicamentos que son más complejos que los medicamentos habituales. Debido a que los productos biológicos son más complejos que los medicamentos normales, en vez de tener una forma genérica, tienen alternativas llamadas biosimilares. En general, los biosimilares funcionan tan bien como el producto biológico original y pueden costar menos. Existen alternativas biosimilares para algunos productos biológicos originales. Algunos biosimilares son biosimilares intercambiables y, según las leyes estatales, pueden sustituir el producto biológico original en la farmacia sin necesidad de una nueva receta, al igual que los medicamentos genéricos pueden sustituir los medicamentos de marca.

- Para obtener información sobre los tipos de medicamentos, consulte la Evidencia de cobertura, Capítulo 5, Sección 3.1, “La ‘Lista de medicamentos’ menciona qué medicamentos de la Parte D están cubiertos”.

¿Hay alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener otros requisitos o límites de cobertura. Estos requisitos y límites pueden incluir:

- **Autorización previa:** Nuestro plan exige que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que necesitará la aprobación de nuestro plan antes de que se le surtan sus recetas médicas. Si no obtiene la aprobación, es posible que nuestro plan no cubra el medicamento.
- **Límites de cantidad:** Para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que cubriremos. Por ejemplo, nuestro plan da 31 tabletas, cada 31 días, por receta de Losartan 100 mg. Esto puede ser además del suministro estándar para uno o tres meses.
- **Terapia escalonada:** En algunos casos, nuestro plan exige que primero pruebe con ciertos medicamentos para tratar su condición antes de cubrir otro medicamento para dicha condición. Por ejemplo, si el Medicamento A y el Medicamento B están recomendados para su condición, es posible que nuestro plan no cubra el Medicamento B, a menos que pruebe primero el Medicamento A. Si el Medicamento A no funciona para usted, entonces nuestro plan cubrirá el Medicamento B.

Puede averiguar si su medicamento tiene más requisitos o límites consultando la lista de medicamentos cubiertos que comienza en la página 9. También puede obtener más información sobre las restricciones aplicadas a medicamentos cubiertos específicos visitando nuestro sitio web. Publicamos documentos en línea que explican nuestra autorización previa y las restricciones de la terapia escalonada. También puede pedirnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización de la lista de medicamentos cubiertos, aparece en la portada y en la contracubierta.

Puede pedir a nuestro plan que hagamos una excepción a estas restricciones o límites, o para una lista de otros medicamentos similares que podrían servir para tratar su condición médica. Consulte la sección, "¿Cómo solicito una excepción al Formulario de Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO o Together Blue Medicare HMO?" en la página 6 para obtener información sobre cómo solicitar una excepción.

¿Qué pasa si mi medicamento no está en el Formulario?

Si su medicamento no está incluido en esta Lista de medicamentos cubiertos (Formulario), primero debe comunicarse con Servicios de Farmacia y preguntar si su medicamento está cubierto.

Si usted se entera que de nuestro plan no cubre su medicamento, tiene dos opciones:

- Puede pedir a Servicios de Farmacia una lista de medicamentos similares que estén cubiertos por nuestro plan. Cuando reciba la lista, preséntesela al médico y pídale que le recete algún medicamento similar que cubra nuestro plan.
- Puede solicitar a nuestro plan que haga una excepción y cubra su medicamento. Consulte más abajo para obtener información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción al Formulario de Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO o Together Blue Medicare HMO?

Puede solicitar a nuestro plan que haga una excepción a nuestras reglas de cobertura. Hay varios tipos de excepciones que puede pedirnos.

- Puede pedirnos que cubramos un medicamento aunque no esté en nuestro formulario. Si se aprueba, este medicamento estará cubierto a un nivel de costo compartido predeterminado, y no podrá pedirnos que le demos el medicamento a un nivel de costo compartido más bajo.

- Puede solicitarnos que eliminemos una restricción de cobertura, incluyendo la autorización previa, la terapia escalonada o un límite de cantidad del medicamento. Por ejemplo, para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede pedirnos que no apliquemos el límite y cubramos una cantidad mayor.
- Puede pedirnos que cubramos un medicamento del formulario a un menor nivel de costo compartido, a menos que el medicamento esté en el nivel de especialidad. Si se aprueba, esto reduciría la cantidad que debe pagar por el medicamento.

Generalmente, nuestro plan solo aprobará su solicitud de excepción si los medicamentos alternativos incluidos en el formulario del plan, el medicamento de menor costo compartido, o la aplicación de la restricción no serían tan efectivos para usted o le causarían efectos adversos.

Usted o su médico deben comunicarse con nosotros para solicitar una excepción de nivel o del formulario, incluyendo una excepción a una restricción de cobertura. **Cuando solicite una excepción, su médico deberá explicar las razones médicas por las que necesita la excepción.** Por lo general, debemos tomar nuestra decisión en un plazo de 72 horas después de recibir la declaración de respaldo de la persona que receta. Puede solicitar una decisión expedita (rápida) si cree, y estamos de acuerdo, que su salud podría verse gravemente afectada al esperar hasta 72 horas para una decisión. Si estamos de acuerdo, o si su médico solicita una decisión rápida, debemos tomar una decisión a más tardar 24 horas después de recibir la declaración de apoyo de su médico.

¿Qué puedo hacer si mi medicamento no está en el formulario o tiene una restricción?

Como miembro nuevo o actual de nuestro plan, es posible que esté tomando medicamentos que no se encuentran en nuestra lista de medicamentos cubiertos. O puede que esté tomando un medicamento que está en nuestro formulario pero que tiene una restricción de cobertura, como la autorización previa. Debe hablar con su médico sobre solicitar una decisión de cobertura para demostrar que cumple los criterios de aprobación, cambiar a un medicamento alternativo que cubrimos o solicitar una excepción al formulario para que cubramos el medicamento que toma. Mientras usted y su médico determinan el mejor curso de acción para usted, podemos cubrir su medicamento en ciertos casos durante los primeros 90 días en que sea miembro de nuestro plan.

Para cada uno de sus medicamentos que no esté en nuestro formulario o tenga una restricción de cobertura, cubriremos un suministro temporal de 31 días. Si su receta es para menos días, permitiremos resurtidos para que tenga un suministro máximo de medicamentos para 31 días. Si la cobertura no se aprueba después de su primer suministro de 31 días, no pagaremos por estos medicamentos, incluso si fue miembro del plan durante menos de 90 días.

Si usted es residente de un centro de atención a largo plazo y necesita un medicamento que no está en nuestra lista de medicamentos cubiertos o si su capacidad para obtener sus medicamentos es limitada, pero ya cumplió los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia para 31 días de ese medicamento mientras pida una excepción a la lista de medicamentos cubiertos.

El proceso de transición de arriba se implementará como una adaptación para usted si necesita inmediatamente un medicamento que no está en el formulario o un medicamento que necesite autorización previa debido a un cambio en su nivel de atención mientras espera que se procese una solicitud de excepción.

Para obtener más información

Para obtener más información detallada sobre la cobertura de medicamentos con receta de su plan, revise su Evidencia de cobertura y otro material del plan.

Si tiene alguna pregunta sobre su plan, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización de la lista de medicamentos cubiertos, aparece en la portada y en la contracubierta.

Si tiene preguntas generales sobre la cobertura de medicamentos con receta de Medicare, llame a Medicare al 1-800-MEDICARE (1-800-633-4227) las 24 horas del día, los siete días de la semana. Los usuarios de TTY deberán llamar al 1-877-486-2048.
O visite **http://www.medicare.gov**.

Formulario de Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO o Together Blue Medicare HMO

El formulario que empieza en la siguiente página da información de cobertura sobre los medicamentos cubiertos por su plan. Si tiene problemas para encontrar su medicamento en la lista, consulte el índice en la página 9.

La primera columna de la tabla muestra el nombre del medicamento. Los medicamentos de marca están en mayúsculas (por ejemplo, ABELCET) y los medicamentos genéricos están en cursiva minúscula (por ejemplo, *abacavir*).

La información en la columna Requisitos/Límites le dice si su plan tiene algún requisito especial de cobertura de su medicamento.

El siguiente es solo un ejemplo del formato del formulario:

Nombre del medicamento	Nivel del medicamento	Requisitos/Límites
Antiinfecciosos		
MEDICAMENTO XYZ	NF	QL-28

Tabla de contenido

	Nivel de medicamento **T1** = El Nivel 1 de costo compartido incluye medicamentos genéricos preferidos. Este es el nivel de costo compartido más bajo. **T2** = El Nivel 2 de costo compartido incluye medicamentos genéricos. **T3** = El Nivel 3 de costo compartido incluye medicamentos de marca preferidos y puede incluir algunos medicamentos de fuente única (aquellos medicamentos genéricos fabricados por un solo fabricante). **T4** = El Nivel 4 de costo compartido incluye medicamentos de marca no preferidos y puede incluir algunos medicamentos genéricos de una sola fuente (aquellos medicamentos genéricos fabricados por un solo fabricante). **T5** = El Nivel 5 de costo compartido incluye medicamentos especializados. Este es el nivel de costo compartido más alto.	**Requisitos/Límites** **LA** = Acceso limitado **PA** = Se requiere autorización previa **PA-BvD** = Este medicamento puede estar cubierto por la parte B o D de Medicare según las circunstancias. Es posible que sea necesario enviar información que describa el uso y la establecimiento del medicamento para tomar la determinación. **PA-NC** = Se requiere autorización previa solo para nuevos inicios **QL** = Se aplica límite de cantidad. El límite de cantidad se anota para cada medicamento. Por ejemplo, si el límite de cantidad es LC (90 c/u por 180 días), el límite de cantidad sería 90 unidades por suministro de 180 días. **ST** = Se aplica la terapia escalonada **ST-NC** = La terapia escalonada se aplica únicamente a los nuevos comienzos.
lowercase italics = Generic drugs **UPPERCASE BOLD** = Brand name drugs		

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
Anti-Infecciosos		
abacavir	T4	
abacavir-lamivudine	T4	
acyclovir oral capsule	T2	
acyclovir oral suspension 200 mg/5 ml	T4	
acyclovir oral tablet	T2	
acyclovir sodium intravenous solution	T4	PA-BvD
adefovir	T4	
albendazole	T4	
amantadine hcl oral capsule	T3	QL (124 EA per 31 days)
amantadine hcl oral solution	T3	
amantadine hcl oral tablet	T3	
amikacin injection solution 500 mg/2 ml	T4	
amoxicillin oral capsule	T1	
amoxicillin oral suspension for reconstitution	T1	
amoxicillin oral tablet	T2	
amoxicillin oral tablet,chewable 125 mg, 250 mg	T1	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
amoxicillin-pot clavulanate oral suspension for reconstitution	T2	
amoxicillin-pot clavulanate oral tablet	T2	
amphotericin b	T4	PA-BvD
amphotericin b liposome	T5	PA-BvD
ampicillin oral capsule 500 mg	T2	
ampicillin sodium injection recon soln 1 gram, 10 gram	T4	
ampicillin-sulbactam injection	T4	
APTIVUS	T5	
ARIKAYCE	T5	PA
atazanavir	T4	
atovaquone	T4	
atovaquone-proguanil	T3	
azithromycin intravenous	T2	
azithromycin oral tablet	T2	
aztreonam injection recon soln 1 gram	T4	
aztreonam injection recon soln 2 gram	T5	
BICILLIN C-R	T3	
BICILLIN L-A INTRAMUSCULAR SYRINGE 600,000 UNIT/ML	T3	
BIKTARVY	T5	QL (31 EA per 31 days)
caspofungin	T4	
CAYSTON	T5	PA
cefaclor oral capsule 500 mg	T2	
cefadroxil oral capsule	T2	
cefadroxil oral suspension for reconstitution 250 mg/5 ml	T2	
cefadroxil oral suspension for reconstitution 500 mg/5 ml	T4	
cefadroxil oral tablet	T3	
cefazolin injection recon soln 1 gram, 500 mg	T2	
cefazolin injection recon soln 10 gram	T4	
cefdinir oral capsule	T2	
cefepime injection	T4	
cefixime oral capsule	T2	
cefoxitin	T4	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
cefpodoxime oral suspension for reconstitution 100 mg/5 ml	T4	
cefpodoxime oral suspension for reconstitution 50 mg/5 ml	T3	
cefpodoxime oral tablet	T3	
cefprozil	T2	
ceftazidime	T4	
ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg	T2	
cefuroxime axetil oral tablet	T2	
cefuroxime sodium injection recon soln 750 mg	T3	
cefuroxime sodium intravenous recon soln 1.5 gram	T3	
cephalexin oral capsule 250 mg, 500 mg	T2	
cephalexin oral suspension for reconstitution	T2	
chloroquine phosphate oral tablet 250 mg	T3	QL (50 EA per 30 days)
chloroquine phosphate oral tablet 500 mg	T3	QL (25 EA per 30 days)
CIMDUO	T5	QL (31 EA per 31 days)
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	T1	
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	T2	
clarithromycin oral suspension for reconstitution	T4	
clarithromycin oral tablet	T2	
clarithromycin oral tablet extended release 24 hr	T2	
clindamycin hcl	T2	
clindamycin in 5 % dextrose	T2	
CLINDAMYCIN PEDIATRIC	T4	
clindamycin phosphate injection	T2	
clotrimazole mucous membrane	T2	
COARTEM	T4	
colistin (colistimethate na)	T4	
COMPLERA	T5	
dapsone oral	T3	
daptomycin	T4	
darunavir	T5	
DELSTRIGO	T5	QL (31 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
DESCOVY	T5	QL (31 EA per 31 days)
dicloxacillin	T2	
DIFICID ORAL TABLET	T5	QL (20 EA per 10 days)
DOVATO	T5	QL (31 EA per 31 days)
DOXY-100	T4	
doxycycline hyclate intravenous	T4	
doxycycline hyclate oral capsule	T2	
doxycycline hyclate oral tablet 100 mg, 20 mg	T2	
doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg	T4	
doxycycline monohydrate oral capsule 100 mg, 50 mg	T2	
doxycycline monohydrate oral tablet 100 mg, 50 mg	T2	
E.E.S. 400 ORAL TABLET	T4	
EDURANT	T5	
efavirenz oral tablet	T4	
efavirenz-emtricitabin-tenofov	T5	
efavirenz-lamivu-tenofov disop	T5	QL (31 EA per 31 days)
emtricitabine	T4	
emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg	T5	
emtricitabine-tenofovir (tdf) oral tablet 200-300 mg	T4	
EMTRIVA ORAL SOLUTION	T3	
EMVERM	T5	
entecavir	T4	
ertapenem	T4	
erythromycin ethylsuccinate oral tablet	T4	
erythromycin oral tablet	T2	
ethambutol	T2	
etravirine	T5	
EVOTAZ	T5	
famciclovir	T3	
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml	T3	
fluconazole oral suspension for reconstitution	T3	
fluconazole oral tablet	T2	
flucytosine oral capsule 250 mg	T4	
flucytosine oral capsule 500 mg	T5	
fosamprenavir	T5	
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml	T2	
gentamicin injection	T4	
GENVOYA	T5	
griseofulvin microsize	T4	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	T4	
hydroxychloroquine oral tablet 200 mg	T2	QL (93 EA per 31 days)
imipenem-cilastatin	T4	
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	
isoniazid oral solution	T2	
isoniazid oral tablet	T1	
itraconazole oral capsule	T4	PA
ivermectin oral tablet 3 mg	T3	PA
JULUCA	T5	
KALETRA ORAL SOLUTION	T5	
ketoconazole oral	T2	
LAGEVRIO (EUA)	T3	QL (360 EA per 365 days)
lamivudine	T2	
lamivudine-zidovudine	T2	
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
levofloxacin oral solution	T4	
levofloxacin oral tablet	T2	
linezolid in dextrose 5%	T4	
linezolid oral tablet	T4	
LIVTENCITY	T5	PA; QL (372 EA per 31 days)
lopinavir-ritonavir oral tablet	T4	
maraviroc oral tablet 150 mg	T5	
maraviroc oral tablet 300 mg	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)
mefloquine	T2	
meropenem intravenous recon soln 1 gram, 500 mg	T3	
methenamine hippurate	T4	
metronidazole in nacl (iso-os)	T2	
metronidazole oral tablet 250 mg, 500 mg	T2	
micafungin	T4	
minocycline oral capsule	T2	
minocycline oral tablet	T2	
moxifloxacin oral	T3	
moxifloxacin-sod.chloride(iso)	T4	
nafcillin injection	T4	
neomycin	T2	
nevirapine oral suspension	T2	
nevirapine oral tablet	T2	
nevirapine oral tablet extended release 24 hr 400 mg	T4	
nitazoxanide	T5	
nitrofurantoin macrocrystal oral capsule 100 mg	T2	QL (90 EA per 365 days)
nitrofurantoin macrocrystal oral capsule 50 mg	T2	QL (180 EA per 365 days)
nitrofurantoin monohyd/m-cryst	T2	QL (90 EA per 365 days)
NORVIR ORAL POWDER IN PACKET	T4	
nystatin oral	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
ofloxacin oral tablet 300 mg	T4	
ofloxacin oral tablet 400 mg	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
oseltamivir oral capsule 30 mg	T2	QL (170 EA per 365 days)
oseltamivir oral capsule 45 mg, 75 mg	T2	QL (90 EA per 365 days)
oseltamivir oral suspension for reconstitution	T3	QL (1080 ML per 365 days)
oxacillin injection recon soln 1 gram	T2	
oxacillin injection recon soln 2 gram	T5	
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (10)- 100 MG (10)	T3	QL (180 EA per 365 days)
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (6)- 100 MG (5)	T3	QL (99 EA per 365 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	T3	QL (270 EA per 365 days)
penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml	T4	
penicillin g potassium injection recon soln 20 million unit	T4	
penicillin v potassium oral tablet	T1	
pentamidine inhalation	T4	PA-BvD
pentamidine injection	T4	
PIFELTRO	T5	QL (62 EA per 31 days)
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram	T4	
posaconazole oral tablet,delayed release (dr/ec)	T5	PA
praziquantel	T4	
PREVYMIS ORAL PELLETS IN PACKET	T5	PA; QL (124 EA per 31 days)
PREVYMIS ORAL TABLET	T5	QL (31 EA per 31 days)
PREZCOBIX	T5	
PREZISTA ORAL SUSPENSION	T5	
PREZISTA ORAL TABLET 150 MG, 75 MG	T5	
PRIFTIN	T4	
primaquine	T3	
pyrazinamide	T4	
pyrimethamine	T5	PA
quinine sulfate	T4	PA; QL (42 EA per 28 days)
RELENZA DISKHALER	T3	
REYATAZ ORAL POWDER IN PACKET	T5	
ribavirin oral capsule	T3	
ribavirin oral tablet 200 mg	T3	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
rifabutin	T4	
rifampin intravenous	T5	
rifampin oral	T4	
rimantadine	T4	
ritonavir	T3	
RUKOBIA	T5	QL (62 EA per 31 days)
SELZENTRY ORAL SOLUTION	T5	
SIRTURO	T5	PA
sofosbuvir-velpatasvir	T5	PA; QL (28 EA per 28 days)
streptomycin	T5	
STRIBILD	T5	
sulfadiazine	T4	
sulfamethoxazole-trimethoprim oral suspension	T2	
sulfamethoxazole-trimethoprim oral tablet	T1	
SUNLENCA ORAL	T5	
SYMTUZA	T5	QL (31 EA per 31 days)
TEFLARO	T5	
tenofovir disoproxil fumarate	T3	
terbinafine hcl oral	T1	QL (90 EA per 180 days)
tetracycline oral capsule	T4	
tigecycline	T5	
tinidazole	T2	
TIVICAY ORAL TABLET 50 MG	T5	
TIVICAY PD	T5	
TOBI PODHALER	T5	PA; QL (224 EA per 56 days)
tobramycin in 0.225 % nacl	T5	PA
tobramycin inhalation	T5	PA
tobramycin sulfate injection solution	T4	
TRECATOR	T4	
trimethoprim	T2	
TRIUMEQ	T5	
TRIUMEQ PD	T4	QL (186 EA per 31 days)
TYBOST	T3	
valacyclovir	T2	
valganciclovir oral recon soln	T4	
valganciclovir oral tablet	T3	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg	T4	
vancomycin oral capsule 125 mg	T4	PA; QL (124 EA per 31 days)
vancomycin oral capsule 250 mg	T4	PA; QL (248 EA per 31 days)
vancomycin oral recon soln 50 mg/ml	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)
voriconazole intravenous	T5	PA
voriconazole oral	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)
zidovudine	T2	
Cardiovascular, Hipertensión / Lípidos		
acebutolol	T2	
aliskiren	T4	
amiloride	T2	
amiloride-hydrochlorothiazide	T2	
amiodarone oral	T2	
amlodipine	T1	
amlodipine-benazepril	T1	
amlodipine-olmesartan	T3	QL (31 EA per 31 days)
amlodipine-valsartan	T2	
aspirin-dipyridamole	T4	
atenolol	T1	
atenolol-chlorthalidone	T2	
atorvastatin	T1	
benazepril	T1	
benazepril-hydrochlorothiazide	T1	
bisoprolol fumarate oral tablet 10 mg, 5 mg	T2	
bisoprolol-hydrochlorothiazide	T1	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
bumetanide oral	T2	
CABLIVI INJECTION KIT	T5	PA; QL (31 EA per 31 days)
CAMZYOS	T5	PA; QL (31 EA per 31 days)
candesartan	T1	
candesartan-hydrochlorothiazid	T1	
captopril	T1	
CARTIA XT	T2	
carvedilol	T1	
carvedilol phosphate	T4	
chlorthalidone oral tablet 25 mg, 50 mg	T1	
cholestyramine (with sugar) oral powder in packet	T2	
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET	T2	
cilostazol	T2	
clonidine	T4	
clonidine hcl oral tablet	T1	
clopidogrel oral tablet 75 mg	T1	
colesevelam	T4	
colestipol oral packet	T4	
colestipol oral tablet	T3	
CORLANOR ORAL SOLUTION	T4	PA; QL (420 ML per 28 days)
digoxin oral solution	T3	QL (155 ML per 31 days)
digoxin oral tablet 125 mcg (0.125 mg)	T1	QL (62 EA per 31 days)
digoxin oral tablet 250 mcg (0.25 mg)	T2	QL (31 EA per 31 days)
diltiazem hcl oral capsule,extended release 12 hr	T2	
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	T2	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	T2	
diltiazem hcl oral tablet	T2	
diltiazem hcl oral tablet extended release 24 hr	T2	
DILT-XR	T2	
dofetilide	T4	
DOPTELET (10 TAB PACK)	T5	PA
DOPTELET (15 TAB PACK)	T5	PA
DOPTELET (30 TAB PACK)	T5	PA

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
doxazosin	T2	
ELIQUIS DVT-PE TREAT 30D START	T3	QL (74 EA per 30 days)
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)
enalapril maleate oral tablet	T1	
enalapril-hydrochlorothiazide	T1	
enoxaparin subcutaneous syringe	T4	
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)
eplerenone	T4	
ethacrynic acid	T4	
ezetimibe	T2	
ezetimibe-simvastatin	T3	QL (31 EA per 31 days)
felodipine	T2	
fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg	T2	
fenofibrate nanocrystallized	T2	
fenofibrate oral tablet 160 mg, 54 mg	T2	
flecainide	T2	
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 7.5 mg/0.6 ml	T5	
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml, 5 mg/0.4 ml	T4	
fosinopril	T1	
fosinopril-hydrochlorothiazide	T1	
FUROSCIX	T5	PA; QL (8 EA per 30 days)
furosemide injection solution	T2	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	T2	
furosemide oral tablet	T1	
gemfibrozil	T1	
heparin (porcine) injection solution	T3	PA-BvD
hydralazine oral	T1	
hydrochlorothiazide	T1	
icosapent ethyl oral capsule 0.5 gram	T4	QL (248 EA per 31 days)
icosapent ethyl oral capsule 1 gram	T4	QL (124 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
indapamide	T1	
irbesartan	T1	QL (31 EA per 31 days)
irbesartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	T2	
isosorbide mononitrate	T2	
isradipine	T4	
ivabradine oral tablet 5 mg	T4	PA; QL (93 EA per 31 days)
ivabradine oral tablet 7.5 mg	T4	PA; QL (62 EA per 31 days)
JANTOVEN	T1	
KERENDIA ORAL TABLET 10 MG, 20 MG	T4	PA; QL (31 EA per 31 days)
labetalol oral tablet 100 mg, 200 mg, 300 mg	T2	
lisinopril	T1	
lisinopril-hydrochlorothiazide	T1	
losartan oral tablet 100 mg	T1	QL (31 EA per 31 days)
losartan oral tablet 25 mg	T1	QL (93 EA per 31 days)
losartan oral tablet 50 mg	T1	QL (62 EA per 31 days)
losartan-hydrochlorothiazide	T1	
lovastatin	T1	
metolazone	T2	
metoprolol succinate	T2	
metoprolol ta-hydrochlorothiaz	T2	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	T1	
metoprolol tartrate oral tablet 37.5 mg, 75 mg	T2	
metyrosine	T5	PA
mexiletine	T3	
minoxidil oral	T2	
moexipril	T1	
MULPLETA	T5	PA
MULTAQ	T4	
nadolol	T4	
nebivolol oral tablet 10 mg, 2.5 mg	T2	QL (93 EA per 31 days)
nebivolol oral tablet 20 mg	T2	QL (62 EA per 31 days)
nebivolol oral tablet 5 mg	T2	QL (217 EA per 31 days)
NEXLETOL	T4	PA; QL (31 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
NEXLIZET	T4	PA; QL (31 EA per 31 days)
niacin oral tablet extended release 24 hr 1,000 mg, 750 mg	T4	
niacin oral tablet extended release 24 hr 500 mg	T4	QL (31 EA per 31 days)
nicardipine oral capsule 20 mg	T4	
nicardipine oral capsule 30 mg	T5	
nifedipine oral tablet extended release	T2	
nifedipine oral tablet extended release 24hr	T2	
nimodipine oral capsule	T4	
NITRO-BID	T2	
nitroglycerin sublingual	T2	
nitroglycerin transdermal patch 24 hour	T2	
nitroglycerin translingual	T4	
olmesartan oral tablet 20 mg, 40 mg	T2	QL (31 EA per 31 days)
olmesartan oral tablet 5 mg	T2	QL (93 EA per 31 days)
olmesartan-amlodipin-hcthiazid	T3	
olmesartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
omega-3 acid ethyl esters	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)
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	
pentoxifylline	T2	
perindopril erbumine	T2	
pindolol	T4	
pitavastatin calcium	T3	
prasugrel hcl	T3	
pravastatin	T1	
prazosin	T2	
PREVALITE ORAL POWDER IN PACKET	T4	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
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)
propafenone oral capsule,extended release 12 hr	T4	
propafenone oral tablet	T2	
propranolol oral capsule,extended release 24 hr	T2	
propranolol oral tablet	T2	
quinapril	T1	
quinapril-hydrochlorothiazide	T1	
quinidine sulfate oral tablet	T2	
ramipril	T1	
ranolazine	T4	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)
rosuvastatin	T1	
simvastatin	T1	
SOTALOL AF	T2	
sotalol oral	T2	
spironolactone oral tablet	T1	
spironolacton-hydrochlorothiaz	T2	
telmisartan	T2	
telmisartan-amlodipine	T4	
telmisartan-hydrochlorothiazid	T2	
terazosin	T1	
TIADYLT ER	T2	
ticagrelor	T2	
timolol maleate oral	T3	
torsemide oral	T1	
trandolapril	T1	
triamterene-hydrochlorothiazid	T1	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
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)
valsartan oral tablet 160 mg, 40 mg, 80 mg	T1	QL (62 EA per 31 days)
valsartan oral tablet 320 mg	T1	QL (31 EA per 31 days)
valsartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
verapamil oral capsule, 24 hr er pellet ct	T4	
verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg	T2	
verapamil oral capsule,ext rel. pellets 24 hr 360 mg	T4	
verapamil oral tablet	T2	
verapamil oral tablet extended release	T2	
VERQUVO	T4	PA; QL (31 EA per 31 days)
VYNDAQEL	T5	PA; QL (124 EA per 31 days)
warfarin	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)
Dermatológicos/Terapia Tópica		
ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG	T4	
acitretin	T4	PA
acyclovir topical ointment	T3	QL (30 GM per 30 days)
ADBRY	T5	PA; QL (4 ML per 28 days)
ALA-CORT TOPICAL CREAM 1 %	T1	
alclometasone	T3	
ammonium lactate	T2	
AMNESTEEM	T4	
betamethasone dipropionate topical cream	T2	
betamethasone dipropionate topical lotion	T2	
betamethasone valerate topical cream	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
betamethasone valerate topical lotion	T3	
betamethasone valerate topical ointment	T2	
betamethasone, augmented topical cream	T2	
betamethasone, augmented topical gel	T4	
betamethasone, augmented topical lotion	T4	
betamethasone, augmented topical ointment	T3	
calcipotriene scalp	T3	QL (60 ML per 28 days)
calcipotriene topical cream	T4	QL (60 GM per 28 days)
calcipotriene topical ointment	T3	QL (60 GM per 28 days)
CIBINQO	T5	PA; QL (31 EA per 31 days)
ciclopirox topical cream	T2	QL (90 GM per 28 days)
ciclopirox topical gel	T3	QL (45 GM per 28 days)
ciclopirox topical shampoo	T3	QL (120 ML per 28 days)
ciclopirox topical solution	T2	
ciclopirox topical suspension	T3	QL (60 ML per 28 days)
CLARAVIS	T4	
clindamycin phosphate topical gel	T2	QL (60 GM per 28 days)
clindamycin phosphate topical lotion	T2	QL (60 ML per 28 days)
clindamycin phosphate topical solution	T2	QL (60 ML per 28 days)
clindamycin phosphate topical swab	T2	
clotrimazole topical cream	T2	QL (45 GM per 28 days)
clotrimazole topical solution	T3	QL (30 ML per 28 days)
clotrimazole-betamethasone topical cream	T2	QL (45 GM per 28 days)
clotrimazole-betamethasone topical lotion	T3	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)
desoximetasone topical cream	T4	QL (100 GM per 28 days)
desoximetasone topical gel	T4	QL (60 GM per 28 days)
diclofenac sodium topical gel 3 %	T4	PA; QL (100 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)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
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)
ERY PADS	T3	
erythromycin with ethanol topical gel	T2	QL (60 GM per 28 days)
erythromycin with ethanol topical solution	T2	QL (60 ML per 28 days)
erythromycin-benzoyl peroxide	T4	
FILSUVEZ	T5	PA
fluocinolone and shower cap	T4	QL (118.28 ML per 28 days)
fluocinolone topical cream 0.01 %	T3	QL (60 GM per 28 days)
fluocinolone topical cream 0.025 %	T3	QL (120 GM per 28 days)
fluocinolone topical ointment	T3	QL (120 GM per 28 days)
fluocinolone topical solution	T3	QL (90 ML per 28 days)
fluocinonide topical cream 0.05 %	T2	QL (60 GM per 28 days)
fluocinonide topical gel	T3	QL (60 GM per 28 days)
fluocinonide topical ointment	T2	QL (60 GM per 28 days)
fluocinonide topical solution	T2	QL (60 ML per 28 days)
fluocinonide-emollient	T4	QL (60 GM per 28 days)
fluorouracil topical cream 5 %	T3	
fluorouracil topical solution 2 %	T2	
fluorouracil topical solution 5 %	T3	
fluticasone propionate topical cream	T2	
gentamicin topical	T3	QL (60 GM per 28 days)
halobetasol propionate topical cream	T4	QL (50 GM per 28 days)
halobetasol propionate topical ointment	T4	QL (50 GM per 28 days)
hydrocortisone butyrate topical lotion	T4	QL (118 ML per 28 days)
hydrocortisone topical cream 1 %	T1	
hydrocortisone topical lotion 2.5 %	T2	QL (118 ML per 28 days)
hydrocortisone topical ointment 1 %, 2.5 %	T1	
imiquimod topical cream in packet 5 %	T2	
ketoconazole topical cream	T2	QL (60 GM per 28 days)
ketoconazole topical shampoo	T2	QL (120 ML per 28 days)
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	T2	PA; QL (50 ML per 28 days)
lidocaine topical adhesive patch,medicated 5 %	T4	PA; QL (93 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
lidocaine topical ointment	T4	PA; QL (50 GM per 28 days)
LIDOCAINE VISCOUS	T2	
lidocaine-prilocaine topical cream	T2	PA; QL (30 GM per 28 days)
malathion	T4	
metronidazole topical cream	T3	
metronidazole topical gel 0.75 %	T3	
metronidazole topical gel 1 %	T4	
metronidazole topical lotion	T4	
mometasone topical	T2	
mupirocin	T2	
NYAMYC	T2	QL (60 GM per 28 days)
nystatin topical cream	T2	QL (30 GM per 28 days)
nystatin topical ointment	T2	QL (30 GM per 28 days)
nystatin topical powder	T2	QL (60 GM per 28 days)
NYSTOP	T2	QL (60 GM per 28 days)
PANRETIN	T5	PA-NC
penciclovir	T4	QL (5 GM per 28 days)
permethrin	T2	
podofilox topical solution	T4	
REGRANEX	T5	PA
selenium sulfide topical lotion	T1	
SILIQ	T5	PA; QL (6 ML per 28 days)
silver sulfadiazine	T1	
SKYRIZI SUBCUTANEOUS PEN INJECTOR	T5	PA; QL (1 ML per 84 days)
SKYRIZI SUBCUTANEOUS SYRINGE	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)
sulfacetamide sodium (acne)	T2	
SULFAMYLON TOPICAL CREAM	T3	
tacrolimus topical	T4	QL (100 GM per 28 days)
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML	T5	PA; QL (0.25 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 40 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML	T5	PA; QL (1 ML per 28 days)
tazarotene topical cream	T4	PA; QL (60 GM per 28 days)
tretinoin topical cream	T2	PA; QL (45 GM per 28 days)
tretinoin topical gel 0.01 %, 0.025 %	T4	PA; QL (45 GM per 28 days)
triamcinolone acetonide topical cream	T2	
triamcinolone acetonide topical lotion	T2	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	T2	
triamcinolone acetonide topical ointment 0.05 %	T4	
TRIDERM TOPICAL CREAM 0.5 %	T4	
VALCHLOR	T5	PA-NC
Diagnósticos / Agentes Varios		
acamprosate	T4	
anagrelide	T4	
bupropion hcl (smoking deter)	T2	QL (62 EA per 31 days)
carglumic acid	T5	PA
cevimeline	T4	
CHEMET	T4	
CLINIMIX 4.25%/D5W SULFIT FREE	T4	PA-BvD
d10 %-0.45 % sodium chloride	T2	
d2.5 %-0.45 % sodium chloride	T2	
d5 % and 0.9 % sodium chloride	T2	
d5 %-0.45 % sodium chloride	T2	
deferasirox oral tablet, dispersible 125 mg	T3	PA
deferasirox oral tablet, dispersible 250 mg, 500 mg	T5	PA
deferiprone	T5	PA
dextrose 10 % in water (d10w)	T2	
dextrose 5 % in water (d5w) intravenous parenteral solution	T2	
disulfiram	T3	
droxidopa oral capsule 100 mg	T5	PA; QL (465 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
droxidopa oral capsule 200 mg, 300 mg	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)
INCRELEX	T5	PA
JOENJA	T5	PA; QL (60 EA per 30 days)
KIONEX (WITH SORBITOL)	T2	
levocarnitine (with sugar)	T4	PA-BvD
levocarnitine oral tablet	T4	PA-BvD
LITFULO	T5	PA; QL (28 EA per 28 days)
LOKELMA	T3	PA; QL (93 EA per 31 days)
midodrine	T2	
NICOTROL NS	T4	
nitisinone	T5	PA
PHEBURANE	T5	PA; QL (620 GM per 31 days)
pilocarpine hcl oral	T3	
PROLASTIN-C INTRAVENOUS SOLUTION	T5	PA
RAVICTI	T5	PA
REZDIFFRA	T5	PA; QL (31 EA per 31 days)
riluzole	T4	
risedronate oral tablet 30 mg	T4	
sodium chloride 0.9 % intravenous parenteral solution	T2	
sodium chloride irrigation	T2	
sodium phenylbutyrate	T5	PA
sodium polystyrene sulfonate oral powder	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	
trientine oral capsule 250 mg	T5	QL (248 EA per 31 days)
varenicline tartrate oral tablet	T4	QL (60 EA per 30 days)
varenicline tartrate oral tablets,dose pack	T4	QL (106 EA per 365 days)
Endocrino/Diabetes		
acarbose	T2	QL (93 EA per 31 days)
ALCOHOL PADS	T2	PA
BAQSIMI	T3	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
BASAGLAR KWIKPEN U-100 INSULIN	T4	
BASAGLAR TEMPO PEN(U-100)INSLN	T4	
cabergoline	T3	
calcitonin (salmon) nasal	T3	PA-BvD
calcitriol oral capsule	T2	PA-BvD
calcitriol oral solution	T4	PA-BvD
CERDELGA	T5	PA; QL (62 EA per 31 days)
cinacalcet oral tablet 30 mg, 60 mg	T4	PA-BvD; QL (62 EA per 31 days)
cinacalcet oral tablet 90 mg	T4	PA-BvD; QL (124 EA per 31 days)
danazol	T4	
desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)	T4	
desmopressin oral	T2	
dexamethasone oral solution	T2	
dexamethasone oral tablet	T1	
diazoxide	T5	
doxercalciferol oral	T4	PA-BvD
FARXIGA	T3	QL (31 EA per 31 days)
FIASP FLEXTOUCH U-100 INSULIN	T3	
FIASP PENFILL U-100 INSULIN	T3	
FIASP U-100 INSULIN	T3	
fludrocortisone	T2	
glimepiride oral tablet 1 mg, 2 mg, 4 mg	T1	
glipizide oral tablet 10 mg, 5 mg	T1	
glipizide oral tablet extended release 24hr	T1	
glipizide-metformin	T1	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
glyburide	T2	
glyburide micronized	T2	
glyburide-metformin	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	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
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	
hydrocortisone oral	T1	
insulin asp prt-insulin aspart	T3	
insulin aspart u-100	T3	
insulin lispro	T3	
insulin lispro protamin-lispro	T3	
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)
LANTUS SOLOSTAR U-100 INSULIN	T3	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
LANTUS U-100 INSULIN	T3	
levothyroxine oral tablet	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	
liothyronine oral	T2	
metformin oral tablet 1,000 mg, 500 mg, 850 mg	T1	
metformin oral tablet extended release 24 hr	T1	
metformin oral tablet extended release 24hr	NF	
metformin oral tablet,er gast.retention 24 hr	NF	
methimazole oral tablet 10 mg, 5 mg	T2	
methylprednisolone	T2	
mifepristone oral tablet 300 mg	T5	PA; QL (124 EA per 31 days)
miglustat	T5	PA; QL (93 EA per 31 days)
MOUNJARO	T3	PA; QL (2 ML per 28 days)
nateglinide	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	
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)
paricalcitol oral	T4	PA-BvD
pioglitazone	T1	QL (31 EA per 31 days)
pioglitazone-metformin	T2	QL (93 EA per 31 days)
prednisolone oral solution	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	T2	
prednisone oral solution	T3	
prednisone oral tablet	T1	
prednisone oral tablets,dose pack	T2	
propylthiouracil	T2	
RECORLEV	T5	PA; QL (248 EA per 31 days)
repaglinide oral tablet 0.5 mg, 1 mg	T2	QL (124 EA per 31 days)
repaglinide oral tablet 2 mg	T2	QL (248 EA per 31 days)
RYBELSUS	T3	PA; QL (31 EA per 31 days)
sapropterin	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	
testosterone cypionate	T2	PA
testosterone enanthate	T3	PA
testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)	T3	PA
testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)	T3	PA
tolvaptan	T5	PA
TOUJEO MAX U-300 SOLOSTAR	T3	
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	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
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	
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)
YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML	T5	PA; QL (1.12 ML per 28 days)
YORVIPATH SUBCUTANEOUS PEN INJECTOR 294 MCG/0.98 ML	T5	PA; QL (1.96 ML per 28 days)
YORVIPATH SUBCUTANEOUS PEN INJECTOR 420 MCG/1.4 ML	T5	PA; QL (2.8 ML per 28 days)
ZEGALOGUE AUTOINJECTOR	T3	
ZEGALOGUE SYRINGE	T3	
Gastroenterología		
alosetron oral tablet 0.5 mg	T4	PA; QL (93 EA per 31 days)
alosetron oral tablet 1 mg	T5	PA; QL (62 EA per 31 days)
aprepitant oral capsule 125 mg	T5	PA-BvD
aprepitant oral capsule 40 mg, 80 mg	T4	PA-BvD
aprepitant oral capsule,dose pack	T4	PA-BvD
balsalazide	T4	
betaine	T5	
budesonide oral capsule,delayed,extend.release	T4	
budesonide oral tablet,delayed and ext.release	T5	
CIMZIA POWDER FOR RECONST	T5	PA; QL (2 EA per 28 days)
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	T5	PA; QL (2 EA per 28 days)
COMPRO	T4	
CONSTULOSE	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
CREON	T3	
cromolyn oral	T4	
dicyclomine oral capsule	T2	
dicyclomine oral solution	T2	
dicyclomine oral tablet	T2	
diphenoxylate-atropine oral liquid	T4	
diphenoxylate-atropine oral tablet	T2	
dronabinol	T4	PA-BvD
ENULOSE	T2	
esomeprazole magnesium oral capsule,delayed release(dr/ec)	T2	QL (31 EA per 31 days)
famotidine oral suspension for reconstitution	T2	
famotidine oral tablet 20 mg, 40 mg	T1	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T1	
GAVILYTE-G	T1	
GAVILYTE-N	T1	
GENERLAC	T2	
glycopyrrolate oral tablet 1 mg, 2 mg	T2	
granisetron hcl oral	T4	PA-BvD
hydrocortisone rectal	T4	
hydrocortisone topical cream with perineal applicator 2.5 %	T1	
hydrocortisone-pramoxine rectal cream 1-1 %	T4	
IBSRELA	T5	PA; QL (62 EA per 31 days)
lactulose oral solution	T2	
LINZESS	T3	QL (31 EA per 31 days)
loperamide oral capsule	T2	
lubiprostone	T3	QL (62 EA per 31 days)
meclizine oral tablet 12.5 mg, 25 mg	T2	
mesalamine oral capsule (with del rel tablets)	T4	QL (186 EA per 31 days)
mesalamine oral capsule,extended release 24hr	T4	QL (124 EA per 31 days)
mesalamine oral tablet,delayed release (dr/ec) 1.2 gram	T4	QL (124 EA per 31 days)
mesalamine rectal enema	T4	QL (1860 ML per 31 days)
metoclopramide hcl oral solution	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
metoclopramide hcl oral tablet	T2	
misoprostol	T2	
MOVANTIK	T3	QL (31 EA per 31 days)
nitroglycerin rectal	T4	
OCALIVA	T5	PA; QL (31 EA per 31 days)
omeprazole oral capsule,delayed release(dr/ec)	T1	
ondansetron hcl oral solution	T3	PA-BvD
ondansetron hcl oral tablet 4 mg, 8 mg	T2	PA-BvD
ondansetron oral tablet,disintegrating 4 mg, 8 mg	T2	PA-BvD
pantoprazole oral tablet,delayed release (dr/ec)	T1	
peg 3350-electrolytes	T1	
peg3350-sod sul-nacl-kcl-asb-c	T4	
peg-electrolyte soln	T1	
prochlorperazine	T4	
prochlorperazine maleate	T2	
PROCTOSOL HC TOPICAL	T2	
PROCTOZONE-HC	T2	
rabeprazole oral tablet,delayed release (dr/ec)	T2	QL (62 EA per 31 days)
scopolamine base	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)
sodium,potassium,mag sulfates	T4	
sucralfate	T2	
sulfasalazine	T2	
ursodiol oral capsule 300 mg	T4	
ursodiol oral tablet	T3	
VIBERZI	T5	PA; QL (62 EA per 31 days)
VOWST	T5	PA; QL (12 EA per 14 days)
Inmunología, Vacunas / Biotecnología		
ABRYSVO (PF)	T3	QL (1 EA per 365 days)
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
AREXVY (PF)	T3	QL (1 EA per 365 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	PA; QL (1 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	PA; QL (1 EA per 28 days)
bcg vaccine, live (pf)	T4	
BESREMI	T5	PA-NC; 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	
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	
HAVRIX (PF)	T3	
HEPLISAV-B (PF)	T3	PA-BvD
HIBERIX (PF)	T3	
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
MENQUADFI (PF)	T4	
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	T3	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
M-M-R II (PF)	T3	
MRESVIA (PF)	T3	QL (1 ML per 365 days)
NEULASTA	T5	
NIVESTYM	T5	
NORDITROPIN FLEXPRO	T5	PA
OCTAGAM	T5	PA
PANZYGA	T5	PA
PEDIARIX (PF)	T3	
PEDVAX HIB (PF)	T3	
PEGASYS	T5	PA
PENBRAYA (PF)	T3	
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-20MCG-5LF- 62 DU/0.5 ML	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)
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	
QUADRACEL (PF)	T3	
RABAVERT (PF)	T3	PA-BvD
RECOMBIVAX HB (PF)	T3	PA-BvD
RETACRIT	T3	PA-BvD
ROTARIX ORAL SUSPENSION	T3	
ROTATEQ VACCINE	T3	
SHINGRIX (PF)	T3	QL (2 EA per 999 days)
TENIVAC (PF)	T3	
TICOVAC	T3	
TRUMENBA	T3	
TWINRIX (PF)	T3	
TYPHIM VI	T3	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
VAQTA (PF)	T3	
VARIVAX (PF)	T3	
VAXCHORA VACCINE	T3	QL (200 ML per 365 days)
VIMKUNYA	T3	
VIVOTIF	T3	
XOLREMDI	T5	PA; QL (124 EA per 31 days)
YF-VAX (PF)	T3	
ZARXIO	T5	
ZIEXTENZO	T5	
Medicamentos Antineoplásicos E Inmunosupresores		
abiraterone oral tablet 250 mg	T5	PA-NC; QL (124 EA per 31 days)
abiraterone oral tablet 500 mg	T5	PA-NC; QL (62 EA per 31 days)
ABIRTEGA	T3	PA-NC; QL (124 EA per 31 days)
AKEEGA	T5	PA-NC; QL (62 EA per 31 days)
ALECENSA	T5	PA-NC; QL (248 EA per 31 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	T5	PA-NC; QL (31 EA per 31 days)
ALUNBRIG ORAL TABLET 30 MG	T5	PA-NC; QL (186 EA per 31 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	T5	PA-NC; QL (60 EA per 365 days)
anastrozole	T2	
AUGTYRO ORAL CAPSULE 160 MG	T5	PA-NC; QL (62 EA per 31 days)
AUGTYRO ORAL CAPSULE 40 MG	T5	PA-NC; QL (248 EA per 31 days)
AYVAKIT	T5	PA-NC; QL (31 EA per 31 days)
azathioprine oral tablet 50 mg	T2	PA-BvD
BALVERSA	T5	PA-NC
bexarotene oral	T5	PA-NC
bexarotene topical	T5	PA-NC; QL (60 GM per 28 days)
bicalutamide	T2	
BOSULIF ORAL CAPSULE 100 MG	T5	PA-NC; QL (186 EA per 31 days)
BOSULIF ORAL CAPSULE 50 MG	T5	PA-NC; QL (341 EA per 31 days)
BOSULIF ORAL TABLET 100 MG	T5	PA-NC; QL (93 EA per 31 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	T5	PA-NC; QL (31 EA per 31 days)
BRAFTOVI	T5	PA-NC; QL (186 EA per 31 days)
BRUKINSA	T5	PA-NC; QL (124 EA per 31 days)
CABOMETYX	T5	PA-NC; QL (31 EA per 31 days)
CALQUENCE	T5	PA-NC; QL (62 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
CALQUENCE (ACALABRUTINIB MAL)	T5	PA-NC; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 100 MG	T5	PA-NC; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 300 MG	T5	PA-NC; QL (31 EA per 31 days)
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	T5	PA-NC; QL (56 EA per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	T5	PA-NC; QL (112 EA per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	T5	PA-NC; QL (84 EA per 28 days)
COPIKTRA	T5	PA-NC; QL (62 EA per 31 days)
COTELLIC	T5	PA-NC; LA; QL (63 EA per 28 days)
cyclophosphamide oral	T3	PA-BvD
cyclosporine modified oral capsule	T2	PA-BvD
cyclosporine modified oral solution	T4	PA-BvD
cyclosporine oral capsule	T2	PA-BvD
DANZITEN	T5	PA-NC; QL (124 EA per 31 days)
dasatinib	T5	PA-NC; QL (31 EA per 31 days)
DAURISMO ORAL TABLET 100 MG	T5	PA-NC; QL (31 EA per 31 days)
DAURISMO ORAL TABLET 25 MG	T5	PA-NC; QL (62 EA per 31 days)
ELIGARD	T4	ST-NC; QL (1 EA per 30 days)
ELIGARD (3 MONTH)	T4	ST-NC; QL (1 EA per 90 days)
ELIGARD (4 MONTH)	T4	ST-NC; QL (1 EA per 120 days)
ELIGARD (6 MONTH)	T4	ST-NC; QL (1 EA per 180 days)
ENVARSUS XR	T4	PA-BvD
ERIVEDGE	T5	PA-NC; QL (31 EA per 31 days)
ERLEADA ORAL TABLET 240 MG	T5	PA-NC; QL (31 EA per 31 days)
ERLEADA ORAL TABLET 60 MG	T5	PA-NC; QL (93 EA per 31 days)
erlotinib	T5	PA-NC; QL (31 EA per 31 days)
EULEXIN	T4	
everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 7.5 mg	T5	PA-NC; QL (31 EA per 31 days)
everolimus (antineoplastic) oral tablet 5 mg	T5	PA-NC; QL (62 EA per 31 days)
everolimus (antineoplastic) oral tablet for suspension 2 mg, 5 mg	T5	PA-NC; QL (62 EA per 31 days)
everolimus (antineoplastic) oral tablet for suspension 3 mg	T5	PA-NC; QL (93 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
everolimus (immunosuppressive)	T5	PA-BvD
exemestane	T4	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	T5	PA-NC
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	T4	PA-NC
FOTIVDA	T5	PA-NC; QL (21 EA per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	T5	PA-NC; QL (84 EA per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	T5	PA-NC; QL (21 EA per 28 days)
GAVRETO	T5	PA-NC; QL (124 EA per 31 days)
gefitinib	T5	PA-NC; QL (31 EA per 31 days)
GENGRAF ORAL CAPSULE	T2	PA-BvD
GILOTRIF	T5	PA-NC; QL (31 EA per 31 days)
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG	T5	PA-NC
GLEOSTINE ORAL CAPSULE 40 MG	T4	PA-NC
GOMEKLI ORAL CAPSULE 1 MG	T5	PA-NC; QL (126 EA per 28 days)
GOMEKLI ORAL CAPSULE 2 MG	T5	PA-NC; QL (84 EA per 28 days)
GOMEKLI ORAL TABLET FOR SUSPENSION	T5	PA-NC; QL (168 EA per 28 days)
hydroxyurea	T2	
IBRANCE	T5	PA-NC; QL (21 EA per 28 days)
ICLUSIG	T5	PA-NC; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 100 MG	T5	PA-NC; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 50 MG	T5	PA-NC; QL (62 EA per 31 days)
imatinib oral tablet 100 mg	T5	PA-NC; QL (93 EA per 31 days)
imatinib oral tablet 400 mg	T5	PA-NC; QL (62 EA per 31 days)
IMBRUVICA ORAL CAPSULE 140 MG	T5	PA-NC; QL (124 EA per 31 days)
IMBRUVICA ORAL CAPSULE 70 MG	T5	PA-NC; QL (31 EA per 31 days)
IMBRUVICA ORAL SUSPENSION	T5	PA-NC; QL (216 ML per 25 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	T5	PA-NC; QL (31 EA per 31 days)
IMKELDI	T5	PA-NC; QL (280 ML per 28 days)
INLYTA	T5	PA-NC; QL (124 EA per 31 days)
INQOVI	T5	PA-NC; QL (5 EA per 28 days)
INREBIC	T5	PA-NC; QL (124 EA per 31 days)
ITOVEBI ORAL TABLET 3 MG	T5	PA-NC; QL (62 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
ITOVEBI ORAL TABLET 9 MG	T5	PA-NC; QL (31 EA per 31 days)
IWILFIN	T5	PA-NC; QL (248 EA per 31 days)
JAKAFI	T5	PA-NC; QL (62 EA per 31 days)
JAYPIRCA ORAL TABLET 100 MG	T5	PA-NC; QL (62 EA per 31 days)
JAYPIRCA ORAL TABLET 50 MG	T5	PA-NC; QL (31 EA per 31 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	T5	PA-NC; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	T5	PA-NC; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NC; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NC; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NC; QL (63 EA per 28 days)
KLISYRI (250 MG)	T5	PA
KOSELUGO ORAL CAPSULE 10 MG	T5	PA-NC; QL (279 EA per 31 days)
KOSELUGO ORAL CAPSULE 25 MG	T5	PA-NC; QL (124 EA per 31 days)
KRAZATI	T5	PA-NC; QL (186 EA per 31 days)
lapatinib	T5	PA-NC; QL (186 EA per 31 days)
LAZCLUZE ORAL TABLET 240 MG	T5	PA-NC; QL (30 EA per 30 days)
LAZCLUZE ORAL TABLET 80 MG	T5	PA-NC; QL (60 EA per 30 days)
lenalidomide	T5	PA-NC; QL (21 EA per 28 days)
LENVIMA	T5	PA-NC
letrozole	T2	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg	T3	
leucovorin calcium oral tablet 5 mg	T2	
LEUKERAN	T5	
leuprolide (3 month)	T4	QL (1 EA per 84 days)
leuprolide subcutaneous kit	T3	QL (2 EA per 28 days)
LONSURF	T5	PA-NC
LORBRENA ORAL TABLET 100 MG	T5	PA-NC; QL (31 EA per 31 days)
LORBRENA ORAL TABLET 25 MG	T5	PA-NC; QL (93 EA per 31 days)
LUMAKRAS ORAL TABLET 120 MG	T5	PA-NC; QL (124 EA per 31 days)
LUMAKRAS ORAL TABLET 240 MG	T5	PA-NC; QL (62 EA per 31 days)
LUMAKRAS ORAL TABLET 320 MG	T5	PA-NC; QL (93 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	T5	QL (1 EA per 90 days)
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 22.5 MG	T5	QL (1 EA per 84 days)
LUPRON DEPOT (4 MONTH)	T5	QL (1 EA per 112 days)
LUPRON DEPOT (6 MONTH)	T5	QL (1 EA per 168 days)
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	T5	QL (1 EA per 30 days)
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG	T5	QL (1 EA per 28 days)
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	T5	PA; QL (1 EA per 90 days)
LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)	T5	PA; QL (1 EA per 30 days)
LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT	T5	PA; QL (1 EA per 168 days)
LYNPARZA	T5	PA-NC; QL (124 EA per 31 days)
LYSODREN	T5	
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)	T5	PA-NC; QL (93 EA per 31 days)
LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)	T5	PA-NC; QL (124 EA per 31 days)
LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)	T5	PA-NC; QL (155 EA per 31 days)
MATULANE	T5	
megestrol oral suspension 400 mg/10 ml (40 mg/ml)	T2	PA
megestrol oral suspension 625 mg/5 ml (125 mg/ml)	T4	PA
megestrol oral tablet	T2	PA-NC
MEKINIST ORAL RECON SOLN	T5	PA-NC; QL (1260 ML per 31 days)
MEKINIST ORAL TABLET 0.5 MG	T5	PA-NC; QL (93 EA per 31 days)
MEKINIST ORAL TABLET 2 MG	T5	PA-NC; QL (31 EA per 31 days)
MEKTOVI	T5	PA-NC; QL (186 EA per 31 days)
mercaptopurine oral suspension	T5	
mercaptopurine oral tablet	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
mesna oral	T4	
methotrexate sodium	T2	PA-BvD
methotrexate sodium (pf) injection solution	T2	PA-BvD
mycophenolate mofetil oral capsule	T2	PA-BvD
mycophenolate mofetil oral suspension for reconstitution	T4	PA-BvD
mycophenolate mofetil oral tablet	T2	PA-BvD
mycophenolate sodium	T4	PA-BvD
NEMLUVIO	T5	PA; QL (2 EA per 28 days)
NERLYNX	T5	PA-NC; QL (186 EA per 31 days)
nilutamide	T5	
NINLARO	T5	PA-NC; QL (3 EA per 28 days)
NUBEQA	T5	PA-NC; QL (124 EA per 31 days)
octreotide acetate injection solution	T4	PA
ODOMZO	T5	PA-NC; LA; QL (31 EA per 31 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG	T5	PA-NC; QL (62 EA per 31 days)
OGSIVEO ORAL TABLET 50 MG	T5	PA-NC; QL (186 EA per 31 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	T5	PA-NC; QL (96 ML per 28 days)
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)	T5	PA-NC; QL (16 EA per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	T5	PA-NC; QL (20 EA per 28 days)
OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)	T5	PA-NC; QL (24 EA per 28 days)
OJJAARA	T5	PA-NC; QL (31 EA per 31 days)
ONUREG	T5	PA-NC; QL (14 EA per 28 days)
ORGOVYX	T5	PA-NC; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 345 MG	T5	PA-NC; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 86 MG	T5	PA-NC; QL (93 EA per 31 days)
pazopanib	T5	PA-NC; QL (124 EA per 31 days)
PEMAZYRE	T5	PA-NC; QL (14 EA per 21 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NC; 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-NC; QL (56 EA per 28 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
POMALYST	T5	PA-NC; QL (21 EA per 28 days)
PROGRAF ORAL GRANULES IN PACKET	T4	PA-BvD
QINLOCK	T5	PA-NC; QL (93 EA per 31 days)
RETEVMO ORAL CAPSULE 40 MG	T5	PA-NC; QL (186 EA per 31 days)
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	T5	PA-NC; QL (62 EA per 31 days)
RETEVMO ORAL TABLET 40 MG	T5	PA-NC; QL (93 EA per 31 days)
REVUFORJ ORAL TABLET 110 MG	T5	PA-NC; QL (124 EA per 31 days)
REVUFORJ ORAL TABLET 160 MG	T5	PA-NC; QL (62 EA per 31 days)
REVUFORJ ORAL TABLET 25 MG	T5	PA-NC; QL (248 EA per 31 days)
REZLIDHIA	T5	PA-NC; QL (62 EA per 31 days)
ROMVIMZA	T5	PA-NC; QL (8 EA per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	T5	PA-NC; QL (155 EA per 31 days)
ROZLYTREK ORAL CAPSULE 200 MG	T5	PA-NC; QL (93 EA per 31 days)
ROZLYTREK ORAL PELLETS IN PACKET	T5	PA-NC; QL (372 EA per 31 days)
RUBRACA	T5	PA-NC; QL (124 EA per 31 days)
RYDAPT	T5	PA-NC; QL (248 EA per 31 days)
SCEMBLIX ORAL TABLET 100 MG	T5	PA-NC; QL (124 EA per 31 days)
SCEMBLIX ORAL TABLET 20 MG	T5	PA-NC; QL (62 EA per 31 days)
SCEMBLIX ORAL TABLET 40 MG	T5	PA-NC; QL (310 EA per 31 days)
SIGNIFOR	T5	PA
sirolimus oral solution	T5	PA-BvD
sirolimus oral tablet	T4	PA-BvD
SOLTAMOX	T4	
sorafenib	T5	PA-NC; QL (124 EA per 31 days)
STIVARGA	T5	PA-NC; QL (84 EA per 28 days)
sunitinib malate	T5	PA-NC; QL (31 EA per 31 days)
TABLOID	T4	
TABRECTA	T5	PA-NC; QL (124 EA per 31 days)
tacrolimus oral capsule 0.5 mg, 1 mg	T2	PA-BvD
tacrolimus oral capsule 5 mg	T4	PA-BvD
TAFINLAR ORAL CAPSULE	T5	PA-NC; QL (124 EA per 31 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	T5	PA-NC; QL (930 EA per 31 days)
TAGRISSO	T5	PA-NC; LA; QL (31 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
TALZENNA	T5	PA-NC; QL (31 EA per 31 days)
tamoxifen	T1	
TASIGNA	T5	PA-NC; QL (124 EA per 31 days)
TAZVERIK	T5	PA-NC; QL (248 EA per 31 days)
TEPMETKO	T5	PA-NC; QL (62 EA per 31 days)
THALOMID ORAL CAPSULE 100 MG, 50 MG	T5	PA-NC; QL (28 EA per 28 days)
TIBSOVO	T5	PA-NC; QL (62 EA per 31 days)
toremifene	T4	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG	T4	ST-NC; QL (1 EA per 84 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 22.5 MG	T4	ST-NC; QL (1 EA per 168 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG	T4	ST-NC; QL (1 EA per 28 days)
tretinoin (antineoplastic)	T5	
TRUQAP	T5	PA-NC; QL (64 EA per 28 days)
TUKYSA ORAL TABLET 150 MG	T5	PA-NC; QL (124 EA per 31 days)
TUKYSA ORAL TABLET 50 MG	T5	PA-NC; QL (248 EA per 31 days)
TURALIO ORAL CAPSULE 125 MG	T5	PA-NC; QL (124 EA per 31 days)
VANFLYTA	T5	PA-NC; QL (62 EA per 31 days)
VENCLEXTA ORAL TABLET 10 MG	T3	PA-NC; QL (62 EA per 31 days)
VENCLEXTA ORAL TABLET 100 MG	T5	PA-NC; QL (186 EA per 31 days)
VENCLEXTA ORAL TABLET 50 MG	T5	PA-NC; QL (31 EA per 31 days)
VENCLEXTA STARTING PACK	T5	PA-NC; QL (84 EA per 365 days)
VERZENIO	T5	PA-NC; QL (62 EA per 31 days)
VIJOICE ORAL GRANULES IN PACKET	T5	PA-NC; QL (31 EA per 31 days)
VIJOICE ORAL TABLET 125 MG, 50 MG	T5	PA-NC; QL (28 EA per 28 days)
VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)	T5	PA-NC; QL (56 EA per 28 days)
VITRAKVI ORAL CAPSULE 100 MG	T5	PA-NC; QL (62 EA per 31 days)
VITRAKVI ORAL CAPSULE 25 MG	T5	PA-NC; QL (186 EA per 31 days)
VITRAKVI ORAL SOLUTION	T5	PA-NC; QL (310 ML per 31 days)
VIZIMPRO	T5	PA-NC; QL (31 EA per 31 days)
VONJO	T5	PA-NC; QL (124 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
VORANIGO ORAL TABLET 10 MG	T5	PA-NC; QL (62 EA per 31 days)
VORANIGO ORAL TABLET 40 MG	T5	PA-NC; QL (31 EA per 31 days)
WELIREG	T5	PA-NC; QL (93 EA per 31 days)
XALKORI ORAL CAPSULE	T5	PA-NC; QL (124 EA per 31 days)
XALKORI ORAL PELLET 150 MG	T5	PA-NC; QL (186 EA per 31 days)
XALKORI ORAL PELLET 20 MG, 50 MG	T5	PA-NC; QL (124 EA per 31 days)
XATMEP	T4	PA-BvD
XERMELO	T5	PA; QL (93 EA per 31 days)
XGEVA	T5	PA-NC
XOSPATA	T5	PA-NC; QL (124 EA per 31 days)
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-NC; QL (8 EA per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (10 MG X 4)	T5	PA-NC; QL (16 EA per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1)	T5	PA-NC; QL (4 EA per 28 days)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)	T5	PA-NC; QL (24 EA per 28 days)
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	T5	PA-NC; QL (32 EA per 28 days)
XTANDI ORAL CAPSULE	T5	PA-NC; QL (124 EA per 31 days)
XTANDI ORAL TABLET 40 MG	T5	PA-NC; QL (124 EA per 31 days)
XTANDI ORAL TABLET 80 MG	T5	PA-NC; QL (62 EA per 31 days)
YONSA	T5	PA-NC; QL (124 EA per 31 days)
ZEJULA ORAL TABLET	T5	PA-NC; QL (31 EA per 31 days)
ZELBORAF	T5	PA-NC; QL (248 EA per 31 days)
ZOLINZA	T5	PA-NC
ZYDELIG	T5	PA-NC; QL (62 EA per 31 days)
ZYKADIA	T5	PA-NC; QL (93 EA per 31 days)
Medicamentos Autonómicos/Snc, Neurología/Psico		
ABILIFY MAINTENA	T5	QL (1 EA per 28 days)
acetaminophen-codeine oral solution 120-12 mg/5 ml	T2	PA; QL (5167 ML per 31 days)
acetaminophen-codeine oral tablet	T2	PA; QL (403 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
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)
alprazolam oral tablet 0.25 mg, 0.5 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet 1 mg, 2 mg	T2	PA; QL (155 EA per 31 days)
amitriptyline	T2	PA-NC
amoxapine	T2	
apomorphine	T5	PA; QL (60 ML per 30 days)
aripiprazole oral solution	T4	PA-NC
aripiprazole oral tablet	T3	
aripiprazole oral tablet,disintegrating	T5	PA-NC
armodafinil	T4	PA; QL (31 EA per 31 days)
asenapine maleate	T4	PA-NC; QL (62 EA per 31 days)
atomoxetine oral capsule 10 mg, 25 mg, 40 mg	T4	QL (62 EA per 31 days)
atomoxetine oral capsule 100 mg, 60 mg, 80 mg	T4	QL (31 EA per 31 days)
atomoxetine oral capsule 18 mg	T4	QL (124 EA per 31 days)
AUSTEDO ORAL TABLET 12 MG, 6 MG	T5	PA; QL (124 EA per 31 days)
AUSTEDO ORAL TABLET 9 MG	T5	PA; QL (155 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG	T5	PA; QL (93 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 18 MG, 30 MG, 36 MG, 42 MG, 48 MG	T5	PA; QL (31 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 24 MG	T5	PA; QL (62 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 6 MG	T5	PA; QL (217 EA per 31 days)
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG	T5	PA; QL (56 EA per 365 days)
AUVELITY	T5	PA-NC; QL (62 EA per 31 days)
baclofen oral tablet 10 mg, 20 mg	T2	
BAFIERTAM	T5	PA; QL (124 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
benztropine oral	T2	PA
BRIVIACT ORAL SOLUTION	T5	QL (620 ML per 31 days)
BRIVIACT ORAL TABLET	T5	QL (62 EA per 31 days)
bromocriptine	T4	
buprenorphine	T4	PA; QL (4 EA per 28 days)
buprenorphine hcl sublingual tablet 2 mg	T3	QL (93 EA per 31 days)
buprenorphine hcl sublingual tablet 8 mg	T3	QL (62 EA per 31 days)
buprenorphine-naloxone sublingual film 12-3 mg, 4-1 mg, 8-2 mg	T2	QL (62 EA per 31 days)
buprenorphine-naloxone sublingual film 2-0.5 mg	T2	QL (93 EA per 31 days)
buprenorphine-naloxone sublingual tablet	T4	QL (93 EA per 31 days)
bupropion hcl oral tablet	T2	
bupropion hcl oral tablet extended release 24 hr 150 mg	T2	QL (93 EA per 31 days)
bupropion hcl oral tablet extended release 24 hr 300 mg	T2	QL (31 EA per 31 days)
bupropion hcl oral tablet sustained-release 12 hr	T2	QL (62 EA per 31 days)
buspirone	T2	
butorphanol nasal	T4	QL (5 ML per 28 days)
CAPLYTA	T5	PA-NC; QL (31 EA per 31 days)
carbamazepine oral capsule, er multiphase 12 hr	T3	
carbamazepine oral suspension 100 mg/5 ml	T2	
carbamazepine oral tablet	T2	
carbamazepine oral tablet extended release 12 hr	T3	
carbamazepine oral tablet,chewable 100 mg	T2	
carbidopa-levodopa	T2	
carbidopa-levodopa-entacapone	T4	
celecoxib oral capsule 100 mg, 200 mg, 50 mg	T2	QL (62 EA per 31 days)
celecoxib oral capsule 400 mg	T3	QL (62 EA per 31 days)
chlorpromazine oral	T4	
citalopram oral solution	T3	
citalopram oral tablet	T1	
clobazam oral suspension	T4	PA-NC; QL (496 ML per 31 days)
clobazam oral tablet	T3	PA-NC; QL (62 EA per 31 days)
clomipramine	T4	PA-NC
clonazepam oral tablet 0.5 mg	T2	PA-NC; QL (93 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
clonazepam oral tablet 1 mg	T2	PA-NC; QL (124 EA per 31 days)
clonazepam oral tablet 2 mg	T2	PA-NC; QL (310 EA per 31 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg	T2	PA-NC; QL (93 EA per 31 days)
clonazepam oral tablet,disintegrating 1 mg	T2	PA-NC; QL (124 EA per 31 days)
clonazepam oral tablet,disintegrating 2 mg	T2	PA-NC; QL (310 EA per 31 days)
clorazepate dipotassium oral tablet 15 mg	T3	PA-NC; QL (186 EA per 31 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	T3	PA-NC; QL (93 EA per 31 days)
clozapine oral tablet 100 mg	T3	QL (279 EA per 31 days)
clozapine oral tablet 200 mg	T3	QL (124 EA per 31 days)
clozapine oral tablet 25 mg	T2	QL (279 EA per 31 days)
clozapine oral tablet 50 mg	T2	QL (93 EA per 31 days)
clozapine oral tablet,disintegrating 100 mg, 25 mg	T4	QL (279 EA per 31 days)
clozapine oral tablet,disintegrating 12.5 mg	T4	QL (93 EA per 31 days)
clozapine oral tablet,disintegrating 150 mg	T4	QL (186 EA per 31 days)
clozapine oral tablet,disintegrating 200 mg	T4	QL (124 EA per 31 days)
COBENFY	T5	PA-NC; QL (62 EA per 31 days)
COBENFY STARTER PACK	T5	PA-NC; QL (112 EA per 365 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)
cyclobenzaprine oral tablet 10 mg	T2	QL (93 EA per 31 days)
cyclobenzaprine oral tablet 5 mg	T2	QL (155 EA per 31 days)
dalfampridine	T5	PA; QL (62 EA per 31 days)
dantrolene oral	T4	
DAYBUE	T5	PA; QL (3600 ML per 30 days)
desipramine oral tablet 10 mg, 25 mg	T3	
desipramine oral tablet 100 mg, 150 mg, 50 mg, 75 mg	T4	
desvenlafaxine succinate	T3	QL (31 EA per 31 days)
dexmethylphenidate oral capsule,er biphasic 50-50	T2	QL (31 EA per 31 days)
dexmethylphenidate oral tablet 10 mg	T2	QL (62 EA per 31 days)
dexmethylphenidate oral tablet 2.5 mg, 5 mg	T2	QL (93 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
dextroamphetamine-amphetamine oral capsule,extended release 24hr	T4	QL (31 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	T2	QL (62 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 20 mg	T2	QL (93 EA per 31 days)
DIACOMIT ORAL CAPSULE 250 MG	T5	PA-NC; QL (341 EA per 31 days)
DIACOMIT ORAL CAPSULE 500 MG	T5	PA-NC; QL (186 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 250 MG	T5	PA-NC; QL (341 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 500 MG	T5	PA-NC; QL (186 EA per 31 days)
DIAZEPAM INTENSOL	T2	PA-NC; QL (248 ML per 31 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	T2	PA-NC; QL (1500 ML per 31 days)
diazepam oral tablet	T2	PA-NC; QL (124 EA per 31 days)
diazepam rectal	T4	
diclofenac epolamine	T4	PA; QL (62 EA per 31 days)
diclofenac potassium oral tablet 50 mg	T2	
diclofenac sodium oral	T2	
diclofenac sodium topical drops	T2	QL (450 ML per 28 days)
diflunisal	T2	
dihydroergotamine nasal	T5	PA; QL (8 ML per 28 days)
DILANTIN	T4	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)	T5	PA; QL (120 EA per 365 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 240 mg	T5	PA; QL (62 EA per 31 days)
divalproex oral capsule, delayed rel sprinkle	T2	
divalproex oral tablet extended release 24 hr 250 mg	T2	
divalproex oral tablet extended release 24 hr 500 mg	T3	
divalproex oral tablet,delayed release (dr/ec)	T2	
donepezil oral tablet 10 mg, 5 mg	T1	
donepezil oral tablet 23 mg	T3	QL (31 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
donepezil oral tablet,disintegrating	T2	
doxepin oral capsule	T2	PA-NC
doxepin oral concentrate	T2	PA-NC
doxepin oral tablet	T3	PA
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG	T4	PA-NC; QL (93 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 30 MG, 60 MG	T4	PA-NC; QL (62 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	T4	PA-NC; QL (31 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 60 mg	T2	QL (62 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 30 mg	T2	QL (31 EA per 31 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	T3	PA; QL (372 EA per 31 days)
entacapone	T3	
EPIDIOLEX	T5	PA-NC
EPITOL	T2	
EPRONTIA	T4	PA-NC; QL (496 ML per 31 days)
ergotamine-caffeine	T3	PA
escitalopram oxalate oral solution	T4	QL (620 ML per 31 days)
escitalopram oxalate oral tablet 10 mg	T2	QL (45 EA per 30 days)
escitalopram oxalate oral tablet 20 mg, 5 mg	T2	QL (30 EA per 30 days)
eslicarbazepine oral tablet 200 mg	T4	QL (186 EA per 31 days)
eslicarbazepine oral tablet 400 mg	T5	QL (93 EA per 31 days)
eslicarbazepine oral tablet 600 mg, 800 mg	T5	QL (62 EA per 31 days)
ethosuximide oral capsule	T3	
ethosuximide oral solution	T4	
etodolac oral capsule	T3	
etodolac oral tablet	T2	
etodolac oral tablet extended release 24 hr 400 mg, 500 mg	T3	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
etodolac oral tablet extended release 24 hr 600 mg	T4	
EVRYSDI ORAL RECON SOLN	T5	PA; QL (240 ML per 31 days)
EVRYSDI ORAL TABLET	T5	PA; QL (31 EA per 31 days)
FANAPT ORAL TABLET 1 MG	T4	PA-NC; QL (62 EA per 31 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	T5	PA-NC; QL (62 EA per 31 days)
FANAPT TITRATION PACK A	T4	PA-NC; QL (16 EA per 365 days)
felbamate	T4	
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 75 mcg/hr	T4	PA; QL (10 EA per 30 days)
fentanyl transdermal patch 72 hour 25 mcg/hr, 50 mcg/hr	T2	PA; QL (10 EA per 30 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	T4	PA-NC; QL (56 EA per 365 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG	T4	PA-NC; QL (31 EA per 31 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	T4	PA-NC; QL (93 EA per 31 days)
fingolimod	T5	PA; QL (31 EA per 31 days)
FINTEPLA	T5	PA-NC; QL (360 ML per 30 days)
FIRDAPSE	T5	PA; QL (248 EA per 31 days)
FLECTOR	T4	PA; QL (62 EA per 31 days)
fluoxetine (pmdd)	T2	
fluoxetine oral capsule	T1	
fluoxetine oral solution	T3	
fluoxetine oral tablet 10 mg, 20 mg	T2	
fluphenazine decanoate	T3	
fluphenazine hcl injection	T4	
fluphenazine hcl oral concentrate	T4	
fluphenazine hcl oral tablet	T2	
flurbiprofen oral tablet 100 mg	T2	
fluvoxamine oral tablet	T2	
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)
gabapentin oral capsule 100 mg, 400 mg	T2	PA-NC; QL (270 EA per 30 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
gabapentin oral capsule 300 mg	T2	PA-NC; QL (360 EA per 30 days)
gabapentin oral solution 250 mg/5 ml	T4	PA-NC; QL (2160 ML per 30 days)
gabapentin oral tablet 600 mg	T2	PA-NC; QL (180 EA per 30 days)
gabapentin oral tablet 800 mg	T2	PA-NC; QL (120 EA per 30 days)
galantamine oral capsule,ext rel. pellets 24 hr	T3	
galantamine oral solution	T4	
galantamine oral tablet	T3	
glatiramer subcutaneous syringe 20 mg/ml	T5	PA; QL (31 ML per 31 days)
glatiramer subcutaneous syringe 40 mg/ml	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)
guanfacine oral tablet extended release 24 hr	T2	PA
haloperidol	T2	
haloperidol decanoate	T2	
haloperidol lactate injection	T1	
haloperidol lactate oral	T2	
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
hydromorphone oral liquid	T4	PA; QL (1240 ML per 31 days)
hydromorphone oral tablet 2 mg, 4 mg	T2	PA; QL (186 EA per 31 days)
hydromorphone oral tablet 8 mg	T3	PA; QL (155 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	T1	
imipramine hcl	T2	PA-NC
indomethacin oral capsule	T2	
indomethacin oral capsule, extended release	T2	
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)
INGREZZA SPRINKLE	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)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
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)
KLOXXADO	T3	
lacosamide oral	T4	
lamotrigine oral tablet	T2	
lamotrigine oral tablet extended release 24hr	T4	
lamotrigine oral tablet, chewable dispersible	T2	
levetiracetam oral solution 100 mg/ml	T2	
levetiracetam oral tablet	T2	
levetiracetam oral tablet extended release 24 hr	T2	
lithium carbonate oral capsule	T1	
lithium carbonate oral tablet	T1	
lithium carbonate oral tablet extended release	T2	
lithium citrate	T2	
lofexidine	T5	
LORAZEPAM INTENSOL	T2	PA; QL (155 ML per 31 days)
lorazepam oral tablet 0.5 mg	T2	PA; QL (124 EA per 31 days)
lorazepam oral tablet 1 mg	T2	PA; QL (186 EA per 31 days)
lorazepam oral tablet 2 mg	T2	PA; QL (155 EA per 31 days)
loxapine succinate	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg	T4	PA-NC; QL (31 EA per 31 days)
lurasidone oral tablet 80 mg	T4	PA-NC; QL (62 EA per 31 days)
MARPLAN	T4	
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)
meloxicam oral tablet	T1	
memantine oral capsule,sprinkle,er 24hr	T4	
memantine oral solution	T4	
memantine oral tablet	T2	
memantine oral tablets,dose pack	T4	
memantine-donepezil	T4	PA
methadone oral solution 10 mg/5 ml	T2	PA; QL (620 ML per 31 days)
methadone oral solution 5 mg/5 ml	T2	PA; QL (1240 ML per 31 days)
methadone oral tablet 10 mg	T2	PA; QL (124 EA per 31 days)
methadone oral tablet 5 mg	T2	PA; QL (248 EA per 31 days)
methsuximide	T4	
methylphenidate hcl oral tablet	T2	QL (93 EA per 31 days)
mirtazapine oral tablet 15 mg, 30 mg, 45 mg	T2	
mirtazapine oral tablet 7.5 mg	T3	
mirtazapine oral tablet,disintegrating	T3	
modafinil	T3	PA; QL (31 EA per 31 days)
molindone	T4	
morphine concentrate oral solution	T2	PA; QL (310 ML per 31 days)
morphine oral solution 10 mg/5 ml	T2	PA; QL (2800 ML per 31 days)
morphine oral solution 20 mg/5 ml (4 mg/ml)	T2	PA; QL (1400 ML per 31 days)
morphine oral tablet	T2	PA; QL (186 EA per 31 days)
morphine oral tablet extended release 100 mg	T3	PA; QL (62 EA per 31 days)
morphine oral tablet extended release 15 mg, 30 mg, 60 mg	T3	PA; QL (100 EA per 31 days)
morphine oral tablet extended release 200 mg	T3	PA; QL (31 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
nabumetone	T2	
naloxone injection solution	T2	
naloxone injection syringe	T2	
naltrexone	T2	
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR 7-10 MG	T4	PA
naproxen oral tablet	T1	
naproxen oral tablet,delayed release (dr/ec) 375 mg	T2	
naproxen oral tablet,delayed release (dr/ec) 500 mg	T4	
naproxen sodium oral tablet 550 mg	T2	
naratriptan oral tablet 1 mg	T3	QL (20 EA per 28 days)
naratriptan oral tablet 2.5 mg	T3	QL (9 EA per 28 days)
NAYZILAM	T4	PA-NC; QL (10 EA per 30 days)
nefazodone	T4	
NEUPRO	T4	
nortriptyline	T2	
NUEDEXTA	T3	PA; QL (62 EA per 31 days)
NUPLAZID	T5	PA-NC; QL (31 EA per 31 days)
NURTEC ODT	T3	PA; QL (18 EA per 28 days)
olanzapine intramuscular	T4	
olanzapine oral tablet	T2	QL (31 EA per 31 days)
olanzapine oral tablet,disintegrating	T4	QL (31 EA per 31 days)
OPIPZA	T5	PA-NC
oxcarbazepine oral suspension	T4	
oxcarbazepine oral tablet	T2	
oxycodone oral capsule	T2	PA; QL (186 EA per 31 days)
oxycodone oral concentrate	T4	PA; QL (180 ML per 31 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg	T2	PA; QL (186 EA per 31 days)
oxycodone oral tablet 30 mg	T3	PA; QL (138 EA per 31 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg	T3	PA; QL (372 EA per 31 days)
oxycodone-acetaminophen oral tablet 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	T4	QL (31 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
paliperidone oral tablet extended release 24hr 6 mg	T4	QL (62 EA per 31 days)
paroxetine hcl oral suspension	T4	
paroxetine hcl oral tablet	T1	
perphenazine	T4	
PERSERIS	T5	QL (1 EA per 28 days)
phenelzine	T2	
phenobarbital	T2	PA-NC
PHENYTEK	T4	
phenytoin oral suspension 125 mg/5 ml	T2	
phenytoin oral tablet,chewable	T2	
phenytoin sodium extended oral capsule 100 mg	T2	
pimozide	T4	
piroxicam	T2	
pramipexole oral tablet	T2	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	T2	PA-NC; QL (93 EA per 31 days)
pregabalin oral capsule 225 mg, 300 mg	T2	PA-NC; QL (62 EA per 31 days)
pregabalin oral solution	T2	PA-NC; QL (930 ML per 31 days)
primidone oral tablet 125 mg	T4	
primidone oral tablet 250 mg, 50 mg	T2	
protriptyline	T4	
pyridostigmine bromide oral tablet 60 mg	T3	
pyridostigmine bromide oral tablet extended release 180 mg	T4	
quetiapine oral tablet 100 mg, 200 mg, 300 mg, 400 mg, 50 mg	T2	QL (62 EA per 31 days)
quetiapine oral tablet 150 mg	T3	QL (62 EA per 31 days)
quetiapine oral tablet 25 mg	T1	QL (62 EA per 31 days)
quetiapine oral tablet extended release 24 hr	T3	QL (62 EA per 31 days)
QULIPTA	T3	PA; QL (31 EA per 31 days)
RALDESY	T5	
ramelteon	T4	QL (31 EA per 31 days)
rasagiline	T4	
REXULTI ORAL TABLET	T5	PA-NC; QL (31 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml, 25 mg/2 ml, 37.5 mg/2 ml	T4	QL (2 EA per 28 days)
risperidone microspheres intramuscular suspension,extended rel recon 50 mg/2 ml	T5	QL (2 EA per 28 days)
risperidone oral solution	T2	QL (496 ML per 31 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	T2	QL (31 EA per 31 days)
risperidone oral tablet 3 mg	T2	QL (93 EA per 31 days)
risperidone oral tablet 4 mg	T2	QL (124 EA per 31 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg	T4	QL (31 EA per 31 days)
risperidone oral tablet,disintegrating 3 mg	T4	QL (93 EA per 31 days)
risperidone oral tablet,disintegrating 4 mg	T4	QL (124 EA per 31 days)
rivastigmine	T4	QL (30 EA per 30 days)
rivastigmine tartrate	T3	
rizatriptan oral tablet 10 mg	T2	QL (12 EA per 28 days)
rizatriptan oral tablet 5 mg	T2	QL (24 EA per 28 days)
rizatriptan oral tablet,disintegrating 10 mg	T2	QL (12 EA per 28 days)
rizatriptan oral tablet,disintegrating 5 mg	T2	QL (24 EA per 28 days)
ropinirole oral tablet	T2	
ROWEEPRA ORAL TABLET 500 MG	T2	
rufinamide oral suspension	T5	PA-NC
rufinamide oral tablet 200 mg	T4	PA-NC
rufinamide oral tablet 400 mg	T5	PA-NC
RYTARY	T3	ST
SECUADO	T5	PA-NC; QL (31 EA per 31 days)
selegiline hcl	T2	
sertraline oral concentrate	T2	
sertraline oral tablet	T1	
SKYCLARYS	T5	PA; QL (93 EA per 31 days)
sodium oxybate	T5	PA; QL (540 ML per 30 days)
SPRITAM	T4	
SUBVENITE	T2	
sulindac	T2	
sumatriptan nasal spray,non-aerosol 20 mg/actuation	T4	QL (8 EA per 28 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
sumatriptan nasal spray,non-aerosol 5 mg/actuation	T4	QL (32 EA per 28 days)
sumatriptan succinate oral tablet 100 mg	T2	QL (9 EA per 28 days)
sumatriptan succinate oral tablet 25 mg	T2	QL (36 EA per 28 days)
sumatriptan succinate oral tablet 50 mg	T2	QL (18 EA per 28 days)
sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml	T4	QL (4 ML per 28 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml	T4	QL (6 ML per 28 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	T4	QL (4 ML per 28 days)
sumatriptan succinate subcutaneous solution	T4	QL (4 ML per 28 days)
SUNOSI	T4	PA; QL (31 EA per 31 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	T5	PA-NC; QL (62 EA per 31 days)
SYMPAZAN ORAL FILM 5 MG	T4	PA-NC; QL (62 EA per 31 days)
TASCENSO ODT	T5	PA; QL (31 EA per 31 days)
tasimelteon	T5	PA; QL (31 EA per 31 days)
TEGRETOL ORAL TABLET	T4	
TEGRETOL XR	T4	
teriflunomide	T5	PA; QL (31 EA per 31 days)
tetrabenazine oral tablet 12.5 mg	T5	PA; QL (93 EA per 31 days)
tetrabenazine oral tablet 25 mg	T5	PA; QL (124 EA per 31 days)
thioridazine	T2	
thiothixene	T3	
tiagabine	T4	
tizanidine oral tablet	T2	
topiramate oral capsule, sprinkle 15 mg, 25 mg	T2	
topiramate oral tablet	T2	
tramadol oral tablet 50 mg	T2	PA; QL (240 EA per 30 days)
tramadol-acetaminophen	T2	PA; QL (372 EA per 31 days)
tranylcypromine	T4	
trazodone oral tablet 100 mg, 150 mg, 50 mg	T1	
trifluoperazine	T2	
trimipramine	T3	PA-NC
TRINTELLIX	T4	PA-NC
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)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
valproic acid	T2	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	T2	
VALTOCO NASAL SPRAY,NON-AEROSOL 10 MG/SPRAY (0.1 ML), 5 MG/SPRAY (0.1 ML)	T4	PA-NC; 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-NC; QL (10 EA per 30 days)
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	T2	QL (31 EA per 31 days)
venlafaxine oral capsule,extended release 24hr 75 mg	T2	QL (93 EA per 31 days)
venlafaxine oral tablet	T2	
VERSACLOZ	T5	QL (558 ML per 31 days)
vigabatrin	T5	PA-NC
VIGADRONE	T5	PA-NC
VIGPODER	T5	PA-NC
vilazodone	T3	PA-NC; QL (31 EA per 31 days)
VIVITROL	T5	
VRAYLAR ORAL CAPSULE	T5	PA-NC; QL (31 EA per 31 days)
VUMERITY	T5	PA; QL (124 EA per 31 days)
XCOPRI	T5	PA-NC
XCOPRI MAINTENANCE PACK	T5	PA-NC
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	T4	PA-NC
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	T5	PA-NC
XYREM	T5	PA; QL (540 ML per 30 days)
zaleplon oral capsule 10 mg	T2	PA; QL (62 EA per 31 days)
zaleplon oral capsule 5 mg	T2	PA; QL (93 EA per 31 days)
ZAVZPRET	T5	PA; QL (8 EA per 30 days)
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)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
ZILBRYSQ SUBCUTANEOUS SYRINGE 23 MG/0.574 ML	T5	PA; QL (16.072 ML per 28 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 32.4 MG/0.81 ML	T5	PA; QL (22.68 ML per 28 days)
ziprasidone hcl	T3	QL (62 EA per 31 days)
ziprasidone mesylate	T3	
zolpidem oral tablet	T4	PA; QL (31 EA per 31 days)
ZONISADE	T4	PA-NC; QL (930 ML per 31 days)
zonisamide	T2	
ZTALMY	T5	PA-NC; 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-NC; QL (28 EA per 180 days)
ZURZUVAE ORAL CAPSULE 30 MG	T5	PA-NC; QL (14 EA per 180 days)
Medicamentos Para Oídos, Nariz Y Garganta		
acetic acid otic (ear)	T2	
azelastine nasal spray,non-aerosol 137 mcg (0.1 %)	T2	QL (30 ML per 25 days)
chlorhexidine gluconate mucous membrane	T1	
CIPRO HC	T4	
ciprofloxacin-dexamethasone	T4	
fluocinolone acetonide oil	T4	
ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)	T2	QL (30 ML per 28 days)
ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)	T2	QL (15 ML per 28 days)
KOURZEQ	T2	
neomycin-polymyxin-hc otic (ear)	T3	
ofloxacin otic (ear)	T2	
olopatadine nasal	T3	QL (30.5 GM per 30 days)
PERIOGARD	T1	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
triamcinolone acetonide dental	T2	
Musculoesquelético / Reumatología		
ACTEMRA ACTPEN	T5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
alendronate oral tablet 10 mg, 35 mg, 70 mg	T1	
allopurinol oral tablet 100 mg, 300 mg	T1	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
colchicine oral tablet	T2	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)
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 (6 EA per 365 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA; QL (6 EA per 365 days)
ibandronate oral	T2	
KEVZARA	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
leflunomide	T3	
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)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
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	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51)	T5	PA; QL (110 EA per 365 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (55 EA per 28 days)
penicillamine oral tablet	T5	
probenecid	T2	
probenecid-colchicine	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)
raloxifene	T3	
RINVOQ LQ	T5	PA; QL (372 ML per 31 days)
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)
risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg	T4	
risedronate oral tablet,delayed release (dr/ec)	T4	
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)
teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)	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)
YUFLYMA(CF)	T5	PA; QL (2 EA per 28 days)
YUFLYMA(CF) AI CROHN'S-UC-HS	T5	PA; QL (6 EA per 365 days)
YUFLYMA(CF) AUTOINJECTOR	T5	PA; QL (2 EA per 28 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
Obstetricia / Ginecología		
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
APRI	T2	
ARANELLE (28)	T2	
AVIANE	T2	
AZURETTE (28)	T2	
BALZIVA (28)	T2	
BLISOVI FE 1.5/30 (28)	T2	
BRIELLYN	T2	
CAMILA	T2	
clindamycin phosphate vaginal	T2	
CRYSELLE (28)	T2	
CYRED EQ	T2	
DEPO-SUBQ PROVERA 104	T3	
drospirenone-ethinyl estradiol	T2	
ENPRESSE	T2	
ENSKYCE	T2	
ERRIN	T2	
ESTARYLLA	T2	
estradiol oral	T2	
estradiol transdermal patch weekly 0.025 mg/24 hr, 0.06 mg/24 hr, 0.1 mg/24 hr	T3	
estradiol transdermal patch weekly 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr	T2	
estradiol vaginal	T4	
estradiol-norethindrone acet	T2	
ethynodiol diac-eth estradiol	T2	
etonogestrel-ethinyl estradiol	T3	
FEIRZA	T2	
GALLIFREY	T2	
HAILEY 24 FE	T2	
HALOETTE	T4	
HEATHER	T2	
ICLEVIA	T2	
IMVEXXY MAINTENANCE PACK	T3	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
IMVEXXY STARTER PACK	T3	
INCASSIA	T2	
INTROVALE	T2	
ISIBLOOM	T2	
JASMIEL (28)	T2	
JINTELI	T4	
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	
KARIVA (28)	T2	
KELNOR 1/35 (28)	T2	
KELNOR 1/50 (28)	T2	
KURVELO (28)	T2	
LESSINA	T2	
LEVONEST (28)	T2	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg	T2	
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month	T2	
levonorg-eth estrad triphasic	T2	
LEVORA-28	T2	
LILETTA	T3	
LORYNA (28)	T2	
LOW-OGESTREL (28)	T2	
LUTERA (28)	T2	
LYLEQ	T2	
LYZA	T2	
MARLISSA (28)	T2	
medroxyprogesterone	T2	
metronidazole vaginal gel 0.75 % (37.5mg/5 gram)	T3	
MICONAZOLE-3 VAGINAL SUPPOSITORY	T2	
MICROGESTIN 1.5/30 (21)	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
MICROGESTIN 1/20 (21)	T2	
MICROGESTIN FE 1.5/30 (28)	T2	
MICROGESTIN FE 1/20 (28)	T2	
MILI	T2	
NECON 0.5/35 (28)	T2	
NEXPLANON	T3	
noreth-ethinyl estradiol-iron oral tablet,chewable 0.4mg-35mcg(21) and 75 mg (7)	T2	
norethindrone (contraceptive)	T2	
norethindrone acetate	T2	
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	T3	
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg	T2	
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)	T2	
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-0.035mg (28), 0.25-0.035 mg	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	
PIMTREA (28)	T2	
PORTIA 28	T2	
PREMARIN VAGINAL	T3	
RECLIPSEN (28)	T2	
SETLAKIN	T2	
SPRINTEC (28)	T2	
SRONYX	T2	
SYEDA	T2	
terconazole	T2	
tranexamic acid oral	T3	
TRI-ESTARYLLA	T2	
TRI-MILI	T2	
TRI-SPRINTEC (28)	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
TRIVORA (28)	T2	
TRI-VYLIBRA	T2	
TURQOZ (28)	T2	
VALTYA	T2	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VESTURA (28)	T2	
VIENVA	T2	
VYFEMLA (28)	T2	
VYLIBRA	T2	
XELRIA FE	T2	
YUVAFEM	T4	
ZAFEMY	T3	
ZOVIA 1-35 (28)	T2	
Oftalmología		
acetazolamide	T3	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
apraclonidine	T3	
azelastine ophthalmic (eye)	T2	
bacitracin ophthalmic (eye)	T2	
bacitracin-polymyxin b	T2	
BESIVANCE	T4	
betaxolol ophthalmic (eye)	T3	
brimonidine ophthalmic (eye) drops 0.1 %	T3	
brimonidine ophthalmic (eye) drops 0.15 %	T4	
brimonidine ophthalmic (eye) drops 0.2 %	T2	
brimonidine-timolol	T3	
brinzolamide	T4	
carteolol	T2	
CILOXAN OPHTHALMIC (EYE) OINTMENT	T4	
ciprofloxacin hcl ophthalmic (eye)	T2	
COMBIGAN	T3	
cromolyn ophthalmic (eye)	T2	
cyclosporine ophthalmic (eye)	T3	QL (60 EA per 30 days)
CYSTARAN	T5	PA; QL (60 ML per 28 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
dexamethasone sodium phosphate ophthalmic (eye)	T2	
diclofenac sodium ophthalmic (eye)	T2	
difluprednate	T4	
dorzolamide	T2	
dorzolamide-timolol	T2	
erythromycin ophthalmic (eye)	T2	
fluorometholone	T3	
flurbiprofen sodium	T2	
gatifloxacin	T3	
gentamicin ophthalmic (eye) drops	T2	
ketorolac ophthalmic (eye) drops 0.4 %	T3	
ketorolac ophthalmic (eye) drops 0.5 %	T2	
latanoprost	T1	
levobunolol ophthalmic (eye) drops 0.5 %	T1	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
methazolamide	T4	
moxifloxacin ophthalmic (eye) drops	T3	
NATACYN	T4	
neomycin-bacitracin-poly-hc	T3	
neomycin-bacitracin-polymyxin	T2	
neomycin-polymyxin b-dexameth	T2	
neomycin-polymyxin-gramicidin	T3	
neomycin-polymyxin-hc ophthalmic (eye)	T3	
NEO-POLYCIN	T2	
NEO-POLYCIN HC	T2	
ofloxacin ophthalmic (eye)	T2	
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	T3	
POLYCIN	T2	
polymyxin b sulf-trimethoprim	T1	
prednisolone acetate	T2	
prednisolone sodium phosphate ophthalmic (eye)	T2	
RESTASIS	T3	QL (60 EA per 30 days)
RESTASIS MULTIDOSE	T3	QL (5.5 ML per 27 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
RHOPRESSA	T4	ST
ROCKLATAN	T4	ST
SIMBRINZA	T4	
sulfacetamide sodium ophthalmic (eye)	T2	
sulfacetamide-prednisolone	T2	
timolol maleate ophthalmic (eye) drops	T1	
timolol maleate ophthalmic (eye) gel forming solution	T3	
tobramycin ophthalmic (eye)	T1	
tobramycin-dexamethasone	T3	
TOBREX OPHTHALMIC (EYE) OINTMENT	T4	
travoprost	T3	
trifluridine	T3	
XDEMVY	T5	PA; QL (10 ML per 42 days)
XIIDRA	T3	QL (60 EA per 30 days)
ZIRGAN	T4	ST
Respiratorio Y Alergia		
acetylcysteine	T2	PA-BvD
ADEMPAS	T5	PA; QL (93 EA per 31 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	T3	QL (17 GM per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)	T3	QL (13.4 GM per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)	NF	
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	T2	PA-BvD
albuterol sulfate oral syrup	T1	
ALYQ	T5	PA; QL (62 EA per 31 days)
ambrisentan	T5	PA; QL (31 EA per 31 days)
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
ASMANEX HFA	T3	QL (13 GM per 30 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
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	T4	QL (25.8 GM per 30 days)
azelastine-fluticasone	T4	QL (23 GM per 30 days)
BERINERT INTRAVENOUS KIT	T5	PA
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)
budesonide inhalation	T4	PA-BvD
budesonide-formoterol	T3	QL (10.2 GM per 30 days)
CINRYZE	T5	PA; QL (20 EA per 28 days)
COMBIVENT RESPIMAT	T3	QL (4 GM per 30 days)
cromolyn inhalation	T4	PA-BvD
cyproheptadine	T2	PA
desloratadine oral tablet	T2	QL (31 EA per 31 days)
DULERA	T3	QL (13 GM per 30 days)
epinephrine injection auto-injector	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)
flunisolide	T3	QL (50 ML per 25 days)
fluticasone propionate inhalation blister with device 100 mcg/actuation, 50 mcg/actuation	T4	ST; QL (60 EA per 30 days)
fluticasone propionate inhalation blister with device 250 mcg/actuation	T4	ST; QL (240 EA per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation	T4	ST; QL (12 GM per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation	T4	ST; QL (24 GM per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation	T4	ST; QL (10.6 GM per 30 days)
fluticasone propionate nasal	T1	QL (16 GM per 30 days)
fluticasone propion-salmeterol inhalation aerosol powdr breath activated	T3	QL (1 EA per 30 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
fluticasone propion-salmeterol inhalation blister with device	T3	QL (60 EA per 30 days)
HAEGARDA	T5	PA
hydroxyzine hcl oral solution 10 mg/5 ml	T2	PA
hydroxyzine hcl oral tablet	T2	PA
icatibant	T5	PA; QL (18 ML per 30 days)
ipratropium bromide inhalation	T2	PA-BvD
ipratropium-albuterol	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)
levalbuterol hcl inhalation solution for nebulization 1.25 mg/3 ml	T3	PA-BvD
levalbuterol tartrate	T3	QL (30 GM per 30 days)
levocetirizine oral solution	T4	QL (310 ML per 31 days)
levocetirizine oral tablet	T1	QL (31 EA per 31 days)
mometasone nasal	T3	QL (34 GM per 30 days)
montelukast oral tablet	T2	QL (31 EA per 31 days)
montelukast oral tablet,chewable	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)
OPSYNVI	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)
pirfenidone oral capsule	T5	PA; QL (279 EA per 31 days)
pirfenidone oral tablet	T5	PA; QL (93 EA per 31 days)
promethazine oral tablet	T4	PA
PULMOZYME	T5	PA

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
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)
roflumilast	T4	QL (31 EA per 31 days)
SAJAZIR	T5	PA; QL (18 ML per 30 days)
SEREVENT DISKUS	T3	QL (60 EA per 30 days)
sildenafil (pulm.hypertension) oral suspension for reconstitution	T5	PA; QL (784 ML per 31 days)
sildenafil (pulm.hypertension) oral tablet	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)
tadalafil (pulm. hypertension)	T5	PA; QL (62 EA 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)
terbutaline oral	T4	
THEO-24	T4	
theophylline oral solution	T2	
theophylline oral tablet extended release 12 hr	T2	
theophylline oral tablet extended release 24 hr	T2	
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)
VENTOLIN HFA	T3	QL (36 GM per 30 days)
WIXELA INHUB	T3	QL (60 EA per 30 days)
XOLAIR	T5	PA
zafirlukast oral tablet 10 mg	T4	QL (93 EA per 31 days)
zafirlukast oral tablet 20 mg	T4	QL (62 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
Suministros Variados		
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T2	PA
insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge	T3	
pen needle, diabetic needle 29 gauge x 1/2"	T3	
Urológicos		
alfuzosin	T2	QL (31 EA per 31 days)
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg	T2	
bethanechol chloride oral tablet 50 mg	T3	
CYSTAGON	T4	
darifenacin	T4	QL (31 EA per 31 days)
dutasteride	T2	QL (31 EA per 31 days)
dutasteride-tamsulosin	T4	QL (31 EA per 31 days)
ELMIRON	T4	
finasteride oral tablet 5 mg	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)
oxybutynin chloride oral syrup	T2	
oxybutynin chloride oral tablet 5 mg	T2	
oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg	T2	QL (31 EA per 31 days)
oxybutynin chloride oral tablet extended release 24hr 15 mg	T3	QL (62 EA per 31 days)
potassium citrate oral tablet extended release	T3	
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)
silodosin	T4	
solifenacin	T4	QL (31 EA per 31 days)
tadalafil oral tablet 2.5 mg	T4	PA; QL (62 EA per 31 days)
tadalafil oral tablet 5 mg	T4	PA; QL (31 EA per 31 days)

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
tamsulosin	T1	
tolterodine oral capsule,extended release 24hr	T3	QL (31 EA per 31 days)
tolterodine oral tablet	T3	QL (62 EA per 31 days)
trospium oral capsule,extended release 24hr	T3	QL (31 EA per 31 days)
trospium oral tablet	T2	QL (93 EA per 31 days)
Vitaminas, Hematinicos / Electrolitos		
CLINIMIX 5%/D15W SULFITE FREE	T4	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T4	PA-BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	T4	PA-BvD
fluoride (sodium) oral tablet	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	T4	
KLOR-CON M10	T2	
KLOR-CON M15	T2	
KLOR-CON M20	T2	
magnesium sulfate injection	T2	
PLENAMINE	T3	PA-BvD
potassium chlorid-d5-0.45%nacl	T2	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	T2	
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l	T2	
potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	T2	
potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml	T2	
potassium chloride intravenous	T2	
potassium chloride oral capsule, extended release	T2	
potassium chloride oral liquid	T2	
potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq	T2	
potassium chloride oral tablet,er particles/crystals	T2	

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Nombre del medicamento	Nivel de medicamento	Requisitos/Límites
potassium chloride-0.45 % nacl	T2	
potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l	T2	
potassium chloride-d5-0.9%nacl	T2	
PRENATAL VITAMIN PLUS LOW IRON	T2	PA
PROSOL 20 %	T4	PA-BvD
sodium chloride 0.45 % intravenous	T2	
sodium chloride 3 % hypertonic	T2	
sodium chloride 5 % hypertonic	T2	
TRAVASOL 10 %	T3	PA-BvD
TROPHAMINE 10 %	T4	PA-BvD

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla al principio de esta tabla.

Índice de drogas

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**

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. 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

- *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	For everolimus only, documentation of advanced, hormone receptor-positive, HER2-negative breast cancer -AND- all of the following (1-3): 1) member is a postmenopausal woman 2) using in combination with exemestane 3) therapeutic failure or intolerance to prior treatment with letrozole or anastrozole. For everolimus only, documentation of non-functional neuroendocrine tumors -AND- all of the following (1-2): 1) disease is classified as progressive, well-differentiated, non-functional 2) disease is of gastrointestinal or lung origin that are unresectable, locally advanced or metastatic. For everolimus only, documentation of advanced renal cell carcinoma -AND- therapeutic failure or intolerance to prior treatment with sunitinib or sorafenib. For everolimus only, documentation of renal angiomyolipoma and tuberous sclerosis complex (TSC), member does not require immediate surgery. For everolimus and everolimus tablets for oral suspension, documentation of TSC with Subependymal Giant Cell Astrocytoma -AND- member is not a candidate for curative surgical resection. For everolimus only, documentation of progressive neuroendocrine tumors of pancreatic origin -AND- disease is unresectable, locally advanced or metastatic. For everolimus tablets for oral suspension only, documentation of use for adjunctive treatment of TSC-associated partial-onset seizures.
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

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: 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 (1-2): 1) metastatic disease, 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

Alpha1-Proteinase Inhibitors

Products Affected

- **PROLASTIN-C INTRAVENOUS SOLUTION**

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

- **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 oral solution*
- *aripiprazole oral tablet,disintegrating*

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).
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 ORAL CAPSULE 160 MG, 40 MG**

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

Austedo

Products Affected

- **AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG**
- **AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG**
- **AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3) 1) Chorea associated with Huntington's disease 2) In patients with comorbid depression, attestation of adequate treatment for depression is required. 3) Attestation that patient is not actively suicidal. -OR- 4) Tardive Dyskinesia
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 unresectable or metastatic gastrointestinal stromal tumor -AND- tumors harbor a PDGFRA exon 18 mutation. Documentation of agressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm, mast cell leukemia, or indolent systemic mastocytosis -AND- 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	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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.

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	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.
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. For metastatic colorectal cancer (mCRC) and using in combination with cetuximab, all of the following (1-3): 1) BRAF V600E mutation status 2) using in combination with cetuximab 3) member has received prior therapy for CRC. For mCRC and using in combination with cetuximab and modified FOLFOX6, all of the following (4-5): 4) BRAF V600E mutation status, as detected by an FDA-approved test 5) using in combination with cetuximab and modified FOLFOX6. For unresectable or metastatic melanoma, all of the following (6-7): 6) BRAF V600E or V600K mutation status 7) using in combination with binimetinib. For metastatic non-small cell lung cancer, all of the following (8-9): 8) BRAF V600E mutation status 9) using in combination with binimetinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
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- one of the following (1-6): 1) diagnosis of advanced renal cell carcinoma (RCC), 2) diagnosis of advanced RCC and using as a first-line treatment in combination with nivolumab, 3) member has previously been treated with sorafenib for hepatocellular carcinoma, 4) member has experienced disease progression following prior VEGFR-targeted therapy and is either radioactive iodine-refractory or is ineligible for radioactive iodine therapy for locally advanced or metastatic differentiated thyroid cancer, 5) diagnosis of previously treated, unresectable, locally advanced or metastatic, well-differentiated pancreatic neuroendocrine tumors (pNET), 6) diagnosis of previously treated, unresectable, locally advanced or metastatic, well-differentiated extra-pancreatic neuroendocrine tumors (epNET)
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. For mantle cell lymphoma, member has received at least one prior therapy -OR- all of the following (1-3): 1) member has not received prior therapy for MCL, 2) member is ineligible for autologous hematopoietic stem cell transplantation (HSCT), and 3) using in combination with bendamustine and rituximab.
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

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

- **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

Cialis

Products Affected

- *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	
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) or all nonbiologic DMARDs are contraindicated. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) or all are contraindicated. For non-radiographic axial spondyloarthritis, inadequate response or intolerance to two nonsteroidal anti-inflammatory drugs (NSAIDs) or all are contraindicated. 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 juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- all nonbiologic 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	Deny if less than 2 years of age for juvenile idiopathic arthritis or less than 18 years of age for all other indications.
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred biologic products: a preferred adalimumab product, 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, 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, Cosentyx, 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, Enbrel, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For Psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cosentyx, Enbrel, a preferred adalimumab product, Xeljanz/Xeljanz XR, Otezla, 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, Enbrel, Rinvoz/Rinvoq LQ, Xeljanx/Xeljanz solution and Actemra SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. 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.
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

Cobenfy

Products Affected

- **COBENFY**
- **COBENFY STARTER PACK**

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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
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- member is no longer responding or is intolerant to at least 2 prior therapies for chronic lymphocytic leukemia and small lymphocytic leukemia.
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) Resting heart rate greater than or equal to 70 beats per minute, 3) Left ventricular ejection fraction less than or equal to 35 percent, when applicable, 4) In adult patients (greater than or equal to 18 years), concurrent use, therapeutic failure, or intolerance to the maximum tolerated dose of one beta-blocker used for treatment of 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) or all are contraindicated. For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs or all are contraindicated.
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 for unresectable or metastatic melanoma (1-2): 1) BRAF V600E or V600K mutation status 2) Concomitant therapy with vemurafenib. For cobimetinib monotherapy, documentation of histiocytic neoplasms.
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

- **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

Danziten

Products Affected

- **DANZITEN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For Ph+ chronic myeloid leukemia (CML), member's CML is in the chronic or accelerated phase and the member is no longer responding to or is intolerant to imatinib -OR- member is newly diagnosed in the chronic phase.
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

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

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

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 x 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 x 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

Drizalma

Products Affected

- **DRIZALMA SPRINKLE ORAL**
  CAPSULE, DELAYED REL SPRINKLE
  20 MG, 30 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- inability to swallow tablets/capsules. For fibromyalgia, members must also have widespread bilateral pain above and below the waist for greater than 3 months duration -AND- At least 1 fibromyalgia-related symptom (e.g., cognitive impairment, fatigue, sleep disturbance, neurologic symptoms, exercise intolerance).
Age Restrictions	Deny if less than 18 years of age in the treatment of fibromyalgia, major depressive disorder, diabetic peripheral neuropathy and chronic musculoskeletal pain -OR- if less than 7 years of age in generalized anxiety disorder
Prescriber Restrictions	
Coverage Duration	12 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 200 MG/1.14 ML, 300 MG/2 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Moderate to severe atopic dermatitis: trial/failure or intolerance to 1 topical corticosteroid or, if 2 yrs or older, topical calcineurin inhibitor (e.g. tacrolimus, pimecrolimus) -OR- severe atopic dermatitis and incapable of applying topical therapies due to the extent of body surface area involvement or topical therapies are contraindicated due to severely damaged skin. Moderate-to-severe asthma: history of at least 2 asthma exacerbations requiring oral or injectable corticosteroids in past 12mos or at least 1 asthma exacerbation requiring hospitalization in past 12mos -AND- blood eosinophils of at least 150cells/uL or current daily or alternate-day oral corticosteroid (OCS) therapy -AND- inadequate symptom control despite regular treatment w/ medium- or high-dose inhaled corticosteroids (ICS) and at least 1 add'l asthma controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline) w/ or w/o OCS, unless intolerant or contraindicated to all -AND- will continue treatment with a medium- or high-dose ICS and at least 1 add'l asthma controller medication w/ or w/o OCS. Chronic rhinosinusitis with nasal polyposis: trial/ failure, intolerance or contraindication to intra-nasal corticosteroid and 14 day course of OCS. Eosinophilic esophagitis: esophageal eosinophil count of at least 15eos/hpf on esophageal biopsy -AND- clinical symptoms of esophageal dysfunction. Prurigo nodularis. COPD: blood eosinophils of at least 300cells/uL or current daily or alternate-day OCS therapy -AND- inadequate symptom control despite regular treatment for at least 3 months with LAMA, LABA, and ICS, unless intolerant or contraindicated to all. Chronic Spontaneous Urticaria: trial/failure, contraindication or intolerance to 1 second-generation non-sedating H1 antihistamine at the maximum recommended dose (e.g. cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine).
Age Restrictions	

PA Criteria	Criteria Details
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 atopic dermatitis reauthorization, attestation of positive clinical response to therapy. For 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 exacerbations, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For CRSwNP reauthorization, attestation of decrease in nasal polyp score or reduction in nasal congestion/obstruction severity score. For EoE reauthorization, attestation of histological remission (less than 15 eos/hpf) on esophageal biopsy or reduced severity or frequency of clinical symptoms of esophageal dysfunction. For prurigo nodularis reauthorization, attestation of reduction in itch or number of nodules or lesions from baseline. For COPD reauthorization, attestation of one of the following is required (1-4): 1) reduction in COPD symptoms, 2) improvement in exercise tolerance, 3) delayed disease progression, or 4) reduction in the number of COPD exacerbations. For CSU reauthorization, improved CSU symptoms.
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	For afatinib, documentation of metastatic non-small cell lung cancer (NSCLC) -AND- one of the following, as detected by an FDA-approved test (1-3): 1) disease harbors EGFR exon 19 deletions 2) disease harbors EGFR exon 21 (L858R) substitution mutation 3) disease harbors non-resistant EGFR mutation (i.e., S768I, L861Q, G719X) -OR- documentation of squamous metastatic NSCLC and member has experienced progression on platinum-based chemotherapy. For erlotinib, documentation of metastatic NSCLC -AND- one of the following, as detected by an FDA-approved test (1-2): 1) disease harbors EGFR exon 19 deletions 2) disease harbors EGFR exon 21 (L858R) substitution mutations -OR- documentation of locally advanced, unresectable or metastatic pancreatic cancer -AND- all of the following (1-2): 1) using erlotinib as first-line therapy 2) using in combination with gemcitabine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
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

Epclusa

Products Affected

- *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	
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 ORAL RECON SOLN**
- **EVRYSDI ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of spinal muscular atrophy (SMA) -AND- Baseline motor function test results (e.g. MFM, CHOP, HINE, RULM, HFMSE, 6MWT) -AND- Not using concomitantly with Spinraza (nusinersen) -AND- Molecular genetic testing of 5q SMA showing Homozygous gene deletion, Homozygous conversion mutation or Compound heterozygote -AND- No history of gene replacement therapy to treat of SMA or experienced a decline in clinical status following gene replacement therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For reauthorization, attestation of stable or clinically significant improvement in SMA-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) -AND- Not using concomitantly with Spinraza (nusinersen) -AND- No history of gene replacement therapy to treat of SMA or experienced a decline in clinical status following gene replacement therapy.
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	Documentation of diagnosis. For paroxysmal nocturnal hemoglobinuria (PNH), 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. For diagnosis of primary immunoglobulin A nephrology (IgAN) confirmed by biopsy, member is at risk for rapid disease progression evidenced by one of the following (7 or 8): 7) Urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g or 8) Proteinuria greater than or equal to 1 g/day -AND- has experienced therapeutic failure, contraindication, or intolerance to a maximally tolerated dose of one of the following (a or b): a) Angiotensin converting enzyme (ACE) inhibitor, b) Angiotensin receptor blocker (ARB) -AND- experienced therapeutic failure, contraindication, or intolerance to one of the following (c or d): c) Filspari (sparsentan) or d) Tarpeyo (budesonide). For Complement 3 Glomerulopathy (C3G) confirmed by biopsy, meets all of the following (13-14): 13) UPCR greater than or equal to 1.0 g/g, 14) currently therapy of the member should be on the maximally tolerated dose of one of the following (e or f): e) ACE-inhibitor, f) ARB.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization of PNH, 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)). For reauthorization of IgAN, reduction in urine protein-to-creatinine ratio (UPCR) or proteinuria from baseline. For reauthorization of C3G, reduction in UPCR from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fanapt

Products Affected

- **FANAPT**
- **FANAPT TITRATION PACK A**

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

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 severe asthma and all of the following (1-4): 1) history of at least 2 asthma exacerbations requiring oral or injectable corticosteroid treatment in past 12 mos or at least 1 asthma exacerbation requiring hospitalization in past 12 mos 2) blood eosinophils greater than or equal to 150cells/uL within the past 6 weeks or greater than or equal to 300cells/uL within the past 12 mos in without other potential causes of eosinophilia (e.g. hypereosinophilic syndromes, neoplastic disease, known suspected parasitic infection) 3) inadequate symptom control despite regular treatment with medium or high dose inhaled corticosteroid (ICS) and at least 1 add'l asthma controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline), with or without oral corticosteroids (OCS), unless intolerant or contraindicated to all 4) will continue treatment with medium or high dose ICS and at least 1 add'l asthma controller medication, with or without OCS -OR- Documentation of eosinophilic granulomatosis with polyangiitis (EGPA) and all of the following (5-6): 5) history of relapsing or refractory disease 6) will be receiving standard of care while on Fasenra therapy with glucocorticoid treatment (e.g. prednisone or prednisolone), with or without immunosuppressive therapy (e.g. cyclosporine, leflunomide, azathioprine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

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 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 EPGA reauthorization, attestation of one of the following is required (5-8): 5) reduction in the frequency and/or severity of relapses, 6) reduction or discontinuation of doses of corticosteroids and/or immunosuppressant, 7) disease remission, or 8) reduction in severity or frequency of EGPA-related symptoms.
Indications	All FDA-approved Indications.
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 Clostridioides difficile 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)**
- **FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder and trial and failure of two other generic antidepressants.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
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

Firmagon

Products Affected

- **FIRMAGON KIT W DILUENT SYRINGE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced prostate cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
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 (560mcg/2.24ml)*

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- member has received at least two prior systemic therapies.
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 -AND- member has received previous threatment with a fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy -AND- member has received previous treatment with an anti-VEGF therapy -AND- one of the following, if member is RAS wild-type (1-2): 1) member has received previous therapy with an anti-EGFR therapy 2) prescriber attests that treatment with an anti-EGFR therapy would not be medically appropriate.
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	Documentation of diagnosis -AND- 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

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- Dependence on parenteral/intravenous nutrition -AND- weight of at least 10 kg.
Age Restrictions	
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. For metastatic non-small cell lung cancer, disease is RET fusion-positive as detected by an FDA approved test. For advanced or metastatic thyroid cancer, all of the following (1-2): 1) disease is RET fusion-positive 2) if radioactive iodine is appropriate, the member is radioactive iodine-refractory.
Age Restrictions	
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 Ph+ chronic myeloid leukemia -AND- one of the following: 1) member is newly diagnosed in chronic phase 2) member is in blast crisis, the accelerated phase or the chronic phase after failure of interferon-alpha therapy. Documentation of Ph+ acute lymphocytic leukemia -AND- one of the following: 1) for adults, member has relapsed or refractory disease 2) for pediatric patients, member is newly diagnosed and will be using imatinib in combination with a chemotherapy regimen. Documentation of adult agressive systemic mastocytosis -AND- one of the following: 1) documentation that the member does not have D816V c-KIT status 2) member's c-KIT status is unknown. For gastrointestinal stromal tumors (GIST) one of the following: 1) member has diagnosis of KIT (CD117)-positive unresectable and/or metastatic malignant GIST 2) imatinib will be used as adjuvent treatment following resection of KIT (CD117)-positive GIST. Documentation of unresectable, recurrent or metastatic dermatofibrosarcoma protuberans. Documentation of Hypereosinophilic Syndrome/Chronic Eosinophilic Leukemia. Documentation of myeloproliferative disease -AND- disease is associated with PDGFR gene rearrangements. Documentation of myelodysplastic syndrome -AND- disease is associated with PDGFR gene rearrangements.
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

Gleostine

Products Affected

- **GLEOSTINE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of primary or metastatic brain tumor(s) -AND- member has previously received surgical and/or radiotherapeutic procedure(s). Documentation of Hodgkin's lymphoma -AND- all of the following (1-2): 1) using lomustine in combination with other chemotherapies 2) member has experienced disease progression with initial chemotherapy.
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**

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

Gomekli

Products Affected

- **GOMEKLI ORAL CAPSULE 1 MG, 2 MG**
- **GOMEKLI ORAL TABLET FOR SUSPENSION**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of neurofibromatosis type 1 (NF1) -AND- presence of symptomatic plexiform neurofibromas (PN) not amenable to complete resection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Growth Hormone

Products Affected

- **NORDITROPIN FLEXPRO**

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	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.
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

High-risk meds

Products Affected

- *amitriptyline*
- *benztropine oral*
- *clomipramine*
- *cyproheptadine*
- *doxepin oral capsule*
- *doxepin oral concentrate*
- *doxepin oral tablet*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *imipramine hcl*
- *promethazine oral tablet*
- *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

Humira

Products Affected

- **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 PSOR-UV-ADOL HS**
- **YUFLYMA(CF)**
- **YUFLYMA(CF) AI CROHN'S-UC-HS**
- **YUFLYMA(CF) AUTOINJECTOR**

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.
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	Plan Year

PA Criteria	Criteria Details
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: This criteria is applicable to Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
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. Documentation of endocrine-resistant, locally advanced or metastatic breast cancer -AND- all of the following (3-6): 3) disease is HR-positive, HER2-negative 4) disease is PIK3CA-mutated, as detected by an FDA-approved test 5) the member is using in combination with inavolisib and fulvestrant 6) the member has experienced recurrence on or after completing adjuvant 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 1 GRAM/10 ML (10 %)**
- **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	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 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. 4) For Bone Marrow Transplantation, the member is 20 years of age or older and within the first 100 days after transplantation. 5) For Dermatomyositis/Polymyositis, trial and failure, intolerance, or contraindication to standard fist line therapy (i.e. corticosteroids or immunosuppressants). 6) 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. 7) 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. 8) 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.
Age Restrictions	

PA Criteria	Criteria Details
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, 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. For chronic graft versus host disease, previous treatment with at least 1 prior systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For suspension, inability to swallow oral tablets or oral capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Imkeldi

Products Affected

- **IMKELDI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Ph+ chronic myeloid leukemia -AND- one of the following: 1) member is newly diagnosed in chronic phase 2) member is in blast crisis, the accelerated phase or the chronic phase after failure of interferon-alpha therapy. Documentation of Ph+ acute lymphocytic leukemia -AND- one of the following: 1) for adults, member has relapsed or refractory disease 2) for pediatric patients, member is newly diagnosed and will be using imatinib in combination with a chemotherapy regimen. Documentation of adult agressive systemic mastocytosis -AND- one of the following: 1) documentation that the member does not have D816V c-KIT status 2) member's c-KIT status is unknown. For gastrointestinal stromal tumors (GIST) one of the following: 1) member has diagnosis of KIT (CD117)-positive unresectable and/or metastatic malignant GIST 2) imatinib will be used as adjuvent treatment following resection of KIT (CD117)-positive GIST. Documentation of unresectable, recurrent or metastatic dermatofibrosarcoma protuberans. Documentation of Hypereosinophilic Syndrome/Chronic Eosinophilic Leukemia. Documentation of myeloproliferative disease -AND- disease is associated with PDGFR gene rearrangements. Documentation of myelodysplastic syndrome -AND- disease is associated with PDGFR gene rearrangements.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of an inability to swallow oral tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
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) Member has open epiphyses. -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) Member has open epiphyses
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation member has a growth velocity of at least 2 cm/year -AND- member has open epiphyses.
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**
- **INGREZZA SPRINKLE**

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 advanced renal cell carcinoma -AND- one of the following (1-2): 1) if using axitinib as first line therapy, member is using axitinib in combination with avelumab or pembrolizumab 2) if using axitinib as a single-agent, member has been treated with at least one prior systemic 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 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 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 or equal to 50x10*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

Insulin Supplies

Products Affected

- **ALCOHOL PADS**
- **GAUZE PAD TOPICAL BANDAGE 2 X 2 "**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation the product is being used for the delivery of insulin into the body.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
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

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

Itovebi

Products Affected

- **ITOVEBI ORAL TABLET 3 MG, 9 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of endocrine-resistant, locally advanced or metastatic breast cancer -AND- all of the following (1-4): 1) disease is HR-positive, HER2-negative 2) disease is PIK3CA-mutated, as detected by an FDA-approved test 3) the member is using in combination with palbociclib and fulvestrant 4) the member has experienced recurrence on or after completing adjuvant endocrine therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Itraconazole

Products Affected

- *itraconazole oral capsule*

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 tablet 3 mg*

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 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 or equal to 50x10*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. For relapsed or refractory mantle cell lymphoma, member has received at least two (2) previous lines of systemic therapy, at least one (1) of which was a BTK inhibitor. For Chronic Lymphocytic Leukemia/Small Lymphocytic Leukemia, member has received at least two (2) prior lines of therapy, including at least one (1) from all of the following classes (1-2): 1) BTK inhibitor 2) BCL-2 inhibitor.
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

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 ORAL TABLET 10 MG, 20 MG**

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 2 of the following preferred products: a preferred adalimumab product, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR. For juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Rinvoz/Rinvoq LQ, Xeljanx/Xeljanz solution and Actemra SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
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: a preferred adalimumab product, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kisqali

Products Affected

- **KISQALI FEMARA CO-PACK ORAL TABLET 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 (1-3): 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. 3) disease is classified as stage II or stage III early breast cancer at high risk of recurrence, ribociclib is being used in combination with an aromatase inhibitor as adjuvant treatment.
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 (250 MG)**

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	
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 or older 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

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- using 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- using in combination with cetuximab -AND- 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

Lazcluze

Products Affected

- **LAZCLUZE ORAL TABLET 240 MG, 80 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of non-small cell lung cancer (NSCLC) -AND- all of the following (1-4): 1) disease harbors EGFR exon 19 deletions or EGFR exon 21 (L858R) substitution mutation, as detected by an FDA-approved test 2) disease is locally advanced or metastatic, 3) member is treatment naive for advanced disease, 4) using in combination with amivantinib.
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 differentiated thyroid cancer -AND- meets all of the following (1-3): 1) disease is locally recurrent or metastatic 2) disease is progressive 3) disease is radioactive iodine refractory. Documentation of advanced renal cell carcinoma -AND- one of the following (4-5): 4) member is using lenvatinib in combination with pembrolizumab and is using lenvatinib and pembrolizumab as first-line treatment 5) member is using lenvatinib in combination with everolimus and has experienced therapeutic failure or intolerance to one prior anti-angiogenic therapy. Documentation of unresectable hepatocellular carcinoma -AND- member is using lenvatinib as first-line treatment. Documentation of endometrial cancer -AND- meets all of the following (6-10): 6) member is using lenvatinib in combination with pembrolizumab 7) disease is advanced 8) disease is not classified as microsatellite instability-high or disease is classified as mismatch repair proficient as determined by an FDA-approved test 9) member has experienced disease progression following prior systemic therapy 10) member is not a candidate for curative surgery or radiation.
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

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

Lidoderm

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of postherpetic neuralgia (PHN) or diabetic peripheral neuropathy (DPN) -AND- One of the following (1-3): 1) trial and failure of 1 other agent used to treat diagnosis (e.g. gabapentin for PHN, duloxetine for DPN), 2) inability to swallow oral medication, 3) 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

Livtencity

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, 240 MG, 320 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic 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- using as a single agent. Documentation of metastatic colorectal cancer -AND- disease is KRAS G12C-mutated as determined by an FDA approved test -AND- using in combination with panitumumab -AND- 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

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 IU/L or leuprolide-stimulating LH level greater than 3.3-5 IU/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 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. For advanced epithelial ovarian, fallopian tube or primary peritoneal cancer, all of the following (1-2): 1) in complete or partial response to first-line platinum-based chemotherapy 2) diagnosis of deleterious or suspected deleterious BRCA mutated disease or disease is associated with homologous recombination deficiency (HRD) positive status with a deleterious or suspected deleterious BRCA mutation or genomic instability and will be using in combination with bevacizumab. For recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, all of the following (1-2): 1) deleterious or suspected deleterious germline or somatic BRCA mutation 2) in complete or partial response to platinum-based chemotherapy. For deleterious or suspected deleterious gBRCAm, HER2-negative breast cancer, 1 of the following (1-2): 1) classified as high-risk, early breast cancer and has been treated with neoadjuvant or adjuvant chemotherapy 2) has been treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting and if hormone receptor (HR)-positive, has been previously treated with or considered inappropriate for treatment with endocrine therapy. For metastatic pancreatic adenocarcinoma, all of the following (1-2): 1) a deleterious or suspected deleterious gBRCA mutation 2) did not progress on at least 16 weeks of a first-line platinum-based chemotherapy regimen. For deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene mutation metastatic castration-resistant prostate cancer, all of the following (1-2): 1) progressed following prior treatment with enzalutamide or abiraterone 2) concurrently receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy. For deleterious or suspected deleterious BRCA mutation metastatic castration-resistant prostate cancer, using in combination with all of the following (1-2): 1) abiraterone 2) prednisone or prednisolone.
Age Restrictions	

PA Criteria	Criteria Details
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*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of DPN and trial/failure or intolerance to duloxetine -OR- PHN and trial/failure or intolerance to gabapentin -OR- 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 (1-2): 1) disease harbors FGFR2 fusions or other rearrangements 2) member has experienced therapeutic failure or intolerance to at least one prior 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

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For trametinib monotherapy, documentation of unresectable or metastatic melanoma -AND- meets all of the following (1-2): 1) member has a BRAF V600E or V600K mutation 2) member is BRAF inhibitor treatment naive. For use in combination with dabrafenib, documentation of unresectable or metastatic melanoma or melanoma with lymph node(s) involvement following complete resection and member is using trametinib and dabrafenib as adjuvant therapy -AND- member has a BRAF V600E or V600K mutation. For use in combination with dabrafenib, documentation of metastatic non-small cell lung cancer, locally advanced or metastatic anaplastic thyroid cancer, or low-grade glioma -AND- member has a BRAF V600E mutation, as detected by an FDA approved test when FDA indicated. For use in combination with dabrafenib, documentation of unresectable or metastatic solid tumors -AND- all of the following (1-3): 1) BRAF V600E mutation 2) disease has progressed following prior treatment 3) member has no satisfactory alternative treatment options.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Mekinist powder for oral solution, attestation of inability to swallow Mekinist (trametinib) 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. For unresectable or metastatic melanoma, all of the following (1-2): 1) BRAF V600E or V600K mutation status 2) using in combination with encorafenib. For metastatic non-small cell lung cancer, all of the following (1-2): 1) BRAF V600E mutation status 2) using in combination with encorafenib.
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

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

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

Namzaric

Products Affected

- *memantine-donepezil*
- **NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR 7-10 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and intolerance to 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

Nemluvio

Products Affected

- **NEMLUVIO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prurigo nodularis -OR- Documentation of moderate to severe atopic dermatitis and one of the following (1-3): 1) trial and failure or intolerance to at least one topical corticosteroid or one topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus), 2) severe atopic dermatitis and the member is incapable of applying topical therapies due to the extent of body surface area involvement, or 3) severe atopic dermatitis and topical therapies are contraindicated due to severely damaged skin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For prurigo nodularis, must follow recommended dosing guidelines based upon weight. For atopic dermatitis, must follow recommended dosing based on FDA approved dosing guidelines. For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For prurigo nodularis reauthorization, attestation of reduction in itch or number of nodules or lesions from baseline.
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 early-stage, HER2-positive breast cancer -AND- meets all of the following: 1)member has received adjuvant trastuzumab-based therapy 2) member is using neratinib as a single agent. Documentation of advanced HER-2 positive, or metastatic HER2-positive breast cancer and meets all of the following 1) using neratinib in combination with capecitabine 2) member has received two or more prior anti-HER2 based regimens in the metastatic setting.
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	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.
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*

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	
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

Nubeqa

Products Affected

- **NUBEQA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of non-metastatic castration-resistant prostate cancer -AND- one of the following (1-2): 1) using in combination with a GnRH analog 2) member has had a bilateral orchiectomy. Documentation of metastatic hormone-sensitive prostate cancer -AND- will be using in combination with docetaxel -AND- one of the following (1-2): 1) using in combination with a GnRH analog 2) 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

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	Severe asthma: history of at least 2 asthma exacerbations requiring oral or injectable corticosteroid treatment in past 12mos or at least 1 asthma exacerbation requiring hospitalization in past 12mos -AND- blood eosinophils of at least 150cells/uL within past 6wks or at least 300cells/uL within past 12mos w/o other potential causes of eosinophilia (e.g. hypereosinophilic syndromes, neoplastic disease, known suspected parasitic infection) -AND- inadequate symptom control despite regular treatment w/ medium or high dose inhaled corticosteroids (ICS) and at least 1 add'l asthma controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline), w/ or w/o oral corticosteroids (OCS) -AND- will continue treatment with medium or high dose ICS and at least 1 add'l asthma controller medication, w/ or w/o OCS. Eosinophilic granulomatosis with polyangiitis (EGPA): history of relapsing or refractory disease -AND- will be receiving concomitant glucocorticoid treatment w/ or w/o immunosuppressive therapy. Hypereosinophilic syndrome (HES) w/o identifiable non-hematologic secondary cause for at least 6mos: at least 2 HES flares (HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy) within past 12mos -AND- Stable on HES therapy for at least 4wks (chronic or episodic OCS, immunosuppressive or cytotoxic therapy). Chronic rhinosinusitis with nasal polyps (CRSwNP): trial/failure, contraindication, or intolerance to intranasal corticosteroid. Chronic obstructive pulmonary disease: blood eosinophils of at least 300cells/uL or current daily or alternate-day OCS therapy -AND- inadequate symptom control despite regular treatment for at least 3 months with LAMA, LABA, and ICS, unless intolerant or contraindicated to all.
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	12 months
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. For COPD reauthorization, attestation of one of the following is required (13-16): 13) reduction in COPD symptoms, 14) improvement in exercise tolerance, 15) delayed disease progression, or 16) reduction in the number of COPD exacerbations.
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	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 or equal to 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than or equal to 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
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

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 400 MG/WEEK (100 MG X 4), 500 MG/WEEK (100 MG X 5), 600 MG/WEEK (100 MG X 6)**

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: a preferred adalimumab product, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR, with at least 1 being a tumor necrosis factor blocker. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
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

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

Opipza

Products Affected

- **OPIPZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- 1 of the following (1-2): 1) intolerance to generic aripiprazole tablets, 2) inability to swallow oral tablets. 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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
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, 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, Enbrel, Cosentyx, 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, Enbrel, Xeljanx/Xeljanz solution and Actemra SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
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

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

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 (1-4): 1) member is male or a postmenopausal female 2) tumor status is ER-positive, HER2-negative 3) an ESR1 gene mutation is present in the tumor 4) member has experienced disease progression on or after an endocrine based regimen.
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** **(47)**
- **OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG**

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 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

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 unresectable locally advanced cholangiocarcinoma or metastatic cholangiocarcinoma -AND- all of the following (1-2): 1) disease harbors FGFR2 fusion or other rearrangement as detected by an FDA-approved test 2) member has experienced therapeutic failure or intolerance to at least on prior therapy. Documentation of relapsed or refractory myeloid/lymphoid neoplasms -AND- disease harbors an FGFR1 rearrangement.
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 intolerence 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

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

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 oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *buprenorphine*
- *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**
- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*
- *hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg*
- *hydromorphone oral liquid*
- *hydromorphone oral tablet 2 mg, 4 mg, 8 mg*
- **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 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*
- *oxycodone oral capsule*
- *oxycodone oral concentrate*
- *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*
- *tramadol oral tablet 50 mg*
- *tramadol-acetaminophen*
- *zaleplon oral capsule 10 mg, 5 mg*
- *zolpidem oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	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, attestations that non-opiate therapies (e.g. NSAIDs) and non-benzodiazepine therapies (e.g. SSRI, SNRI) have been considered, 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Opiate tx for pain+subs. abuse, approve opiate x 1mo. All other combos and dx approve x 12mo.
Other Criteria	Opiate agonists will receive automatic approval if no recent claims for a substance abuse therapy (e.g. buprenorphine-naloxone) 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 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.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Prevymis Oral Pellets

Products Affected

- **PREVYMIS ORAL PELLETS IN PACKET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	Deny if less than 6 months of age with HSCT. Deny if less than 12 years of age with kidney transplant.
Prescriber Restrictions	
Coverage Duration	7 months
Other Criteria	One of the following is required (1-2): 1) inability to swallow tablets, 2) unable to use Prevymis (letermovir) tablets due to body weight dosing limitations.
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	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 or equal to 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than or equal to 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)
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*
- **OPSUMIT**
- **OPSYNVI**
- **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)*
- **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 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
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
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

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

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

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

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	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
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**
- **RETEVMO ORAL TABLET 120 MG, 160 MG, 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 after previous treatment -OR- diagnosis of marginal zone lymphoma in combination with a rituximab product after previous treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Revuforj

Products Affected

- **REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rexulti

Products Affected

- **REXULTI ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. 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 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

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. For giant cell arteritis, patients must have therapeutic failure or intolerance to one systemic corticosteroid (e.g., prednisone).
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

Rinvoq LQ

Products Affected

- **RINVOQ LQ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. 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	For PsA, deny if 18 years of age or older
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

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 m2), 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 m2) -AND- reduction in urinary oxalate levels from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Romvimza

Products Affected

- **ROMVIMZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic tenosynovial giant cell tumor -AND- attestation that surgical resection may cause one of the following (1-2): 1) worsening functional limitation, 2) severe morbidity
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
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. For recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, all of the following (1-2): 1) Disease harbors a deleterious BRCA mutation (germline or somatic) 2) member is in complete or partial response to platinum-based chemotherapy. For metastatic castration-resistant prostate cancer, all of the following (1-3): 1) disease harbors a deleterious BRCA mutation (germline and/or somatic) 2) member has been treated with androgen receptor-directed therapy and taxane-based chemotherapy 3) member is concurrently receiving a gonadotropin-releasing hormone (GnRH) analog or 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

Rydapt

Products Affected

- **RYDAPT**

PA Criteria	Criteria Details
Exclusion Criteria	Use as single agent induction therapy for AML
Required Medical Information	Documentation of diagnosis. For a new diagnosis of acute myeloid leukemia, member is using in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy regimens and member is FLT3 mutation positive 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

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

Scemblix

Products Affected

- **SCEMBLIX 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 (1-3): 1) the member is newly-diagnosed, 2) member has been previously treated for Ph+ CML in chronic phase, 3) 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

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, Cosentyx, Otezla, Stelara SC, Enbrel, and Skyrizi SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. 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
Other Criteria	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Cosentyx, 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, Enbrel, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For ulcerative colitis, patients must have therapeutic failure or intolerance to the preferred products: a preferred adalimumab product, Stelara SC, Rinvoq, and Xeljanz/Xeljanz XR. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. For ulcerative colitis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.

PA Criteria	Criteria Details
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 diagnosis. Criteria will be applied consistent with the current ATS/CDC/ERS/IDSA Clinical Practice Guideline for the Treatment of Drug-Susceptible and Drug-Resistant Tuberculosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of disease improvement -AND- member requires additional antimicrobial therapy.
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**
- **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 receiving or currently undergoing IV administration of Skyrizi within 3 months of initiating therapy with Skyrizi SC. For moderate to severe ulcerative colitis, attestation of receiving or currently undergoing 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

- *dasatinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For adults with Ph+ chronic myeloid leukemia, the member is newly diagnosed in the chronic phase -OR- the member is in chronic, accelerated, or myeloid or lymphoid blast phase and has resistance or intolerance to prior therapy including imatinib. For adults with Ph+ acute lymphocytic leukemia, member has had resistance or intolerance to prior therapy. For pediatric patients with Ph+ CML, the member is in the chronic phase. For pediatric patients with Ph+ acute lymphoblastic leukemia, the member is newly diagnosed and will be using 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

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 receiving or currently undergoing a single induction dose of IV Stelara within 2 months of initiating therapy with Stelara SC. For Ulcerative colitis, attestation of receiving or currently undergoing a 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	Plan Year
Other Criteria	Must follow recommended dosing guidelines based upon weight. Subcutaneous 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

Steroidogenesis Inhibitors

Products Affected

- **RECORLEV**
- **SIGNIFOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -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 decrease in urinary free cortisol levels from baseline
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

Sunosi

Products Affected

- **SUNOSI**

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. 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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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.
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. For gastrointestinal stromal tumor (GIST), the member has experienced therapeutic failure, intolerance, or contraindication to imatinib. For a high risk of recurrent renal cell carcinoma, member has had a nephrectomy and sunitinib is to be used as adjuvant treatment.
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

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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tafinlar

Products Affected

- **TAFINLAR ORAL CAPSULE**
- **TAFINLAR ORAL TABLET FOR SUSPENSION**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For dabrafenib monotherapy, documentation of unresectable or metastatic melanoma -AND- documentation of a BRAF V600E mutation. For use in combination with trametinib, documentation of unresectable or metastatic melanoma or melanoma with lymph node(s) involvement following complete resection and member is using trametinib and dabrafenib as adjuvant therapy -AND- member has a BRAF V600E or V600K mutation. For use in combination with trametinib, documentation of metastatic non-small cell lung cancer, locally advanced or metastatic anaplastic thyroid cancer, or low-grade glioma -AND- member has a BRAF V600E mutation, as detected by an FDA-approved test when FDA indicated. For use in combination with trametinib, documentation of unresectable or metastatic solid tumors -AND- all of the following (1-3): 1) BRAF V600E mutation 2) disease has progressed following prior treatment 3) member has no satisfactory alternative treatment options.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Tafinlar tablets for oral suspension, attestation of inability to swallow Tafinlar (dabrafenib) 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 (1-5): 1) Adjuvant therapy after tumor resection -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test 2) Locally advanced disease -AND- using as first-line therapy -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test -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, as detected by an FDA-approved test -AND- used with or without combination therapy of pemetrexed and platinum-based chemotherapy, 4) Metastatic disease -AND- disease harbors EGFR T790M mutations, as detected by an FDA-approved test -AND- has progressed on or after EGFR TKI therapy, 5) Locally advanced, unresectable (stage III) disease -AND- disease has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy -AND- disease harbors EGFR exon 19 deletions or EGFR 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	

PA Criteria	Criteria Details
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 20 MG/0.25 ML, 40 MG/0.5 ML, 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

PA Criteria	Criteria Details
Other Criteria	For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cosentyx, Enbrel, a preferred adalimumab product, Xeljanz/Xeljanz XR, Otezla, Stelara SC, Rinvoq, and Skyrizi SC. For plaque psoriasis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, 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, Enbrel, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For non-radiographic axial spondyloarthritis patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cimzia, Rinvoq, Cosentyx. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. 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	
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. For adult patients with Ph+ chronic myeloid leukemia (CML), member's CML is in the chronic or accelerated phase and the member is no longer responding to or is intolerant to imatinib -OR- member is newly diagnosed in the chronic phase. For pediatric patients, one of the following (1-2): 1) member has chronic phase or accelerated phase Ph+ CML and is is resistant or intolerant to prior tyrosine kinase inhibitor therapy 2) member is newly diagnosed with Ph+ CML in the chronic phase.
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

Tazorac

Products Affected

- *tazarotene topical cream*

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

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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Testosterone (androgens)

Products Affected

- *testosterone cypionate*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)*

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	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	HIV Wasting
Part B Prerequisite	No

Thalomid

Products Affected

- **THALOMID ORAL CAPSULE 100 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

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 persistent or 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 -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- disease is IDH1 mutation positive as detected by an FDA-approved test. For newly-diagnosed acute myeloid leukemia, member is using as monotherapy or in combination with azacitidine -AND- member meets one of the following (1-5): 1) age is greater than or equal to 75 years of age 2) severe cardiac or pulmonary comorbidity 3) reduced renal function 4) hepatic impairment 5) or prescriber attestation that member is not a candidate for intensive induction therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
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

Tretinoin

Products Affected

- *tretinoin topical cream*
- *tretinoin topical gel 0.01 %, 0.025 %*

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

Trintellix

Products Affected

- **TRINTELLIX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder -AND- Therapeutic failure, intolerance or contraindication to one generic antidepressant (e.g. SSRI, TCA, MAOI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
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. For advanced unresectable HER2-positive breast cancer or metastatic HER2-positive breast cancer, member will be using in combination with trastuzumab and capecitabine -AND- member has received one or more prior anti-HER2 based regimens in the metastatic setting. For RAS wild-type HER2-positive unresectable or metastatic colorectal cancer, member will be using in combination with trastuzumab -AND- member has experienced disease progression following 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

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. For advanced HER2-positive, or metastatic HER2-positive breast cancer, the member has received prior therapy with an anthracycline, a taxane, and trastuzumab -AND- will be using in combination with capecitabine. For HR+, metastatic breast cancer, the member is post-menopausal -AND- the member's cancer over expresses the HER2 receptor -AND- the member will be using lapatinib in combination with letrozole.
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	
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- disease is FLT3-ITD-positive as detected by an FDA-approved test -AND- one of the following (1-3): 1) member is receiving induction therapy and is using Vanflyta in combination with standard cytarabine and anthracycline induction therapy 2) member is receiving consolidation therapy and is using Vanflyta in combination with standard cytarabine consolidation therapy 3) member is receiving maintenance therapy and is using Vanflyta as monotherapy.
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	For newly-diagnosed AML, member is using in combination with azacitidine, decitabine, cytarabine -AND- 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- disease is classified as HR-positive, HER2-negative. For early breast cancer that is at high risk of recurrence and is node-positive, all of the following (1-2): 1) used in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) 2) used as adjuvant treatment. For advanced or metastatic breast cancer, used as initial endocrine-based therapy and used in combination with an aromatase inhibitor -OR- used after documented disease progression following endocrine therapy and used in combination with fulvestrant -OR- used after documented disease progression and used following endocrine therapy and prior chemotherapy in the metastatic setting and will be used as monotherapy.
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

Viibryd

Products Affected

- *vilazodone*

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

Vijoice

Products Affected

- **VIJOICE ORAL GRANULES IN MG PACKET**
- **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

Vitrakvi

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) -AND- the member has experienced therapeutic failure, contraindication, or intolerance to a six-month maintenance course of oral fluconazole.
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, as detected by an FDA-approved test (1 or 2): 1) Epidermal growth factor (EGFR) exon 19 deletions, 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 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

Voranigo

Products Affected

- **VORANIGO ORAL TABLET 10 MG, 40 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following (1-3): 1) grade 2 astrocytoma or grade 2 oligodendroglioma, 2) disease harbors a susceptible isocitrate dehydrogenase (IDH)-1 or IDH-2 mutation, as detected by an FDA-approved test, 3) will be used following surgery including biopsy, sub-total resection, or gross total resection.
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

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 one of the following regimens recommended by the AASLD/IDSA guidelines containing the following agents: sofosbuvir/velpatasvir (i.e. Epclusa authorized generic), Mavyret.
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

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 with a clear cell component, 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 PELLET 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 m2 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

- **XDEMVY**

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 the following (1-2): 1) Chronic Spontaneous Urticaria, 2) 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 the following (3-9): 3) moderate to severe persistent asthma, 4) a positive skin test or in vitro reactivity to a perennial aeroallergen, 5) Baseline IgE titer greater than or equal to 30 IU/mL, 6) documented pretreatment FEV1 less than 80% predicted in adults or less than 90% predicted in children and adolescents or FEV1 reversibility of at least 12% and 200mL after albuterol administration, 7) history of at least 2 asthma exacerbations requiring oral or injectable corticosteroid treatment in past 12 mos or at least 1 asthma exacerbation requiring hospitalization in past 12 mos, 8) inadequately controlled symptoms despite a 3-month trial of both of the following (a-b) a) medium-dose inhaled corticosteroid or systemic steroid b) a long-acting beta-agonist or leukotriene antagonist, 9) currently on 1 of the following (c, d, e): c) a long-acting beta2-agonist, d) leukotriene modifier, or e) theophylline. -OR- Documentation of the following (10-11): 10) chronic rhinosinusitis with nasal polyps (CRSwNP), 11) will use concomitantly with nasal corticosteroid maintenance treatment, -OR- Documentation of the following (12-17): 12) IgE mediated food allergy, 13) diagnosis confirmed by skin prick test or food-specific antibodies, 14) previous allergic reaction to food, 15) using for the reduction of allergic reactions (type 1), including anaphylaxis, 16) will be used in conjunction with food allergen avoidance, 17) member has a documented prescription for epinephrine.
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	For asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of asthma exacerbations, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For CSU reauthorization, improved CSU symptoms. For CRSwNP reauthorization, attestation of decrease in nasal polyp score or reduction in nasal congestion/obstruction severity score. For IgE-mediated food allergy reauthorization, member requires continuation of therapy and will continue food allergen avoidance.
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- member is FLT3 mutation-positive.
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 (10 MG X 4), 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 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. For castration-resistant prostate cancer and metastatic castration sensitive-prostate cancer, the member is using in combination with a GnRH analog or the member has had a bilateral orchiectomy. For non-metastatic castration-sensitive prostate cancer, the member has biochemical recurrence at high risk for metastasis.
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	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, attestation supporting improvement in symptoms of narcolepsy 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- using in combination with methylprednisolone.
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

Yorvipath

Products Affected

- **YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML, 294 MCG/0.98 ML, 420 MCG/1.4 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of hypoparathyroidism -AND- albumin-corrected serum calcium greater than or equal to 7.8 mg/dL -AND- trial and failure of calcium -AND- trial and failure of an active form of vitamin D (e.g. calcitriol, alfacalcidol).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of an improvement in total serum calcium from baseline is required.
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

- **ZELBORAF**

PA Criteria	Criteria Details
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	Documentation of diagnosis. For unresectable or metastatic melanoma and use in combination with cobimetinib, member has a BRAF V600E or V600K mutation. For unresectable or metastatic melanoma and use as monotherapy, member has a BRAF V600E mutation. For Erdheim-Chester Disease and use as monotherapy, member has a BRAF V600 mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
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: a preferred adalimumab product, Rinvoq, Xeljanz/Xeljanz XR and Stelara SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
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 (1-6): 1) generic carbamazepine suspension/chewable tablet/extended-release capsule, 2) generic gabapentin capsules/solution, 3) generic lacosamide solution, 4) generic levetiracetam solution, 5) generic oxcarbazepine suspension, 6) generic pregabalin capsules/solution.
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

Zurzuvae

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 relapsed chronic lymphocytic leukemia -AND- all of the following (1-2): 1) will be used in combination with rituximab 2) use of rituximab alone would be appropriate due to other due to other comorbidities.
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*
- **ABIRTEGA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- using in combination with prednisone.
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

Index of Drugs

GnRH Agonists

Products Affected

- **ELIGARD 22.5 MG (3 MONTH) SUBCUTANEOUS SYRINGE**
- **ELIGARD 30 MG (4 MONTH) SUBCUTANEOUS SYRINGE**
- **ELIGARD 45 MG (6 MONTH) SUBCUTANEOUS SYRINGE**
- **ELIGARD 7.5 MG (1 MONTH) SUBCUTANEOUS SYRINGE**
- **TRELSTAR 11.25 MG IM SUSPENSION**
- **TRELSTAR 22.5 MG IM SUSPENSION**
- **TRELSTAR 3.75 MG IM SUSPENSION**

Details

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

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

Pulmonary Antiinflammatory

Products Affected

- *fluticasone propionate 100 mcg/actuation blister powder for inhalation*
- *fluticasone propionate 110 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 220 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 250 mcg/actuation blister powder for inhalation*
- *fluticasone propionate 44 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 50 mcg/actuation blister powder for inhalation*

Details

Criteria	Require a 1 month trial of Qvar and Asmanex/Asmanex HFA (Step 1 drugs) in the last 180 days

Rho Kinase Inhibitors

Products Affected

- **RHOPRESSA 0.02 % EYE DROPS DROPS**
- **ROCKLATAN 0.02 %-0.005 % EYE**

Details

Criteria	Require a 1 month trial of one preferred glaucoma drug (Step 1 drug) in the last 120 days

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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