

## Medicare Part D: 5 Tier Closed Performance Formulary 2026

Please click here.

### For Medicare Part D: Prior Authorization Criteria

Please click here.

### For Medicare Part D: Step Therapy Criteria

Please click here.

Plans covered in Pennsylvania:

Community Blue Medicare HMO Distinct (HMO)

Community Blue Medicare HMO Merit (HMO)

Community Blue Medicare HMO Signature (HMO)

Community Blue Medicare PPO Signature (PPO)

Community Blue Medicare Plus PPO Signature (PPO)

Complete Blue HMO Distinct (HMO)

Complete Blue PPO Distinct (PPO)

Complete Blue PPO Merit (PPO)

Complete Blue PPO Signature (PPO)

Complete Blue Plus PPO Distinct (PPO)

Complete Blue Plus PPO Merit (PPO)

Freedom Blue PPO ValueRx (PPO)

Together Blue Medicare HMO Signature (HMO)

Security Blue HMO-POS ValueRx (HMO-POS)

For more recent information or other questions, please contact:

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

Complete Blue HMO Pharmacy Service at 1-888-234-5397.

Together Blue Medicare HMO Pharmacy Service at 1-888-328-5704.

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

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

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

Freedom Blue PPO Pharmacy Service at 1-800-550-8722.

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

Formulary ID: 26018 Version: 13

Updated: 4/2026

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

When this Drug List (formulary) refers to “we,” “us,” or “our,” it means Highmark Senior Health Company, Highmark Choice Company, or Highmark Health Insurance Company.

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

This document includes a Drug List (formulary) for our plan, which is current as of January 1, 2026. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

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

## **What is the Community Blue Medicare HMO, Complete Blue HMO, Together Blue HMO, Security Blue HMO-POS, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO, and Freedom Blue PPO formulary?**

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Community Blue Medicare HMO, Complete Blue HMO, Security Blue HMO-POS, Together Blue HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO, or Freedom Blue PPO network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

## **Can the formulary change?**

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website: [medicare.highmark.com/formulary](https://www.medicare.highmark.com/formulary).

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

- **Immediate substitutions of certain new versions of brand name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription.)

If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the Community Blue Medicare HMO, Complete Blue HMO, Together Blue HMO, Security Blue HMO-POS, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO, and Freedom Blue PPO’s formulary?”

Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 31-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Community Blue Medicare HMO, Complete Blue HMO, Together Blue HMO, Security Blue HMO-POS, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO, and Freedom Blue PPO’s formulary?”

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2026 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2026 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of April 1, 2026. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, members will be notified by mail and prospective members will receive an update with this formulary. The most up-to-date formulary is available on our website [medicare.highmark.com/formulary](https://www.medicare.highmark.com/formulary).

## How do I use the formulary?

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

### Medical Condition

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

### Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 9. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## What are generic drugs?

Our plan covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

## What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

For discussion of drug types, please see the Evidence of Coverage, Chapter 3, Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered.”

## Are there any restrictions on my coverage?

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

- **Prior Authorization:** Our plan requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides 31 tablets, per prescription for 100mg Drug A. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

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

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Community Blue Medicare HMO, Complete Blue HMO, Together Blue HMO, Security Blue HMO-POS, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO, and Freedom Blue PPO’s formulary?” on page 6 for information about how to request an exception.

## **What if my drug is not on the formulary?**

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

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

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

## **How do I request an exception to the Community Blue Medicare HMO, Complete Blue HMO, Together Blue HMO, Security Blue HMO-POS, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO, and Freedom Blue PPO’s formulary?**

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

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

Generally, our plan will only approve your request for an exception if the alternative drugs included on the plan’s formulary, the lower cost-sharing drug, or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or, formulary exception, including an exception to a coverage restriction. ***When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.*** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

## **What can I do if my drug is not on the formulary or has a restriction?**

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

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

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

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

## **For more information**

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

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

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

## Community Blue Medicare HMO, Complete Blue HMO, Together Blue HMO, Security Blue HMO-POS, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, Complete Blue Plus PPO, and Freedom Blue PPO formulary

The formulary that begins on the next page provides coverage information about the drugs covered by your plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 9.

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

The information in the Requirements/Limits column tells you if your plan has any special requirements for coverage of your drug.

*The following is a formulary Format Example Only:*

<b>Drug Name</b>	<b>Performance Drug Tier</b>	<b>Requirements/Limits</b>
<b>Anti-Infectives</b>		
<i>XYZ DRUG</i>	NF	QL-28

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**Requirements/Limits**

LA = Limited access

PA = Prior authorization required

PA-BvD = This drug may be covered under Medicare part B or D depending on the circumstance.

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

PA-NS = Prior authorization required for new starts only

QL = Quantity limit applies. The quantity limit is noted for each drug. For example, if the quantity limit is QL (90 EA per 180 days), the quantity limit would be 90 units per 180-day supply.

ST = Step therapy applies

ST-NS = Step therapy applies to new starts only

**Drug Tier****T1** = Cost-Sharing Tier 1 includes preferred generic drugs. This is the lowest cost-sharing tier.**T2** = Cost-Sharing Tier 2 includes generic drugs.**T3** = Cost-Sharing Tier 3 includes preferred brand name drugs and may include some single-sourced drugs (those generic drugs made by a single manufacturer).**T4** = Cost-Sharing Tier 4 includes non-preferred brand name drugs and may include some single-sourced generic drugs (those generic drugs made by a single manufacturer).**T5** = Cost-Sharing Tier 5 includes specialty drugs. This is the highest cost-sharing tier.**lowercase italics** = Generic drugs**UPPERCASE BOLD** = Brand name drugs

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>Anti - Infectives</b>		
<i>abacavir</i>	T4	
<i>abacavir-lamivudine</i>	T4	
<i>acyclovir oral capsule</i>	T2	
<i>acyclovir oral suspension 200 mg/5 ml</i>	T4	
<i>acyclovir oral tablet</i>	T2	
<i>acyclovir sodium intravenous solution</i>	T4	PA-BvD
<i>adefovir</i>	T4	
<i>albendazole</i>	T4	
<i>amantadine hcl oral capsule</i>	T3	QL (124 EA per 31 days)
<i>amantadine hcl oral solution</i>	T3	
<i>amantadine hcl oral tablet</i>	T3	
<i>amikacin injection solution 500 mg/2 ml</i>	T4	
<i>amoxicillin oral capsule</i>	T1	
<i>amoxicillin oral suspension for reconstitution</i>	T1	
<i>amoxicillin oral tablet</i>	T2	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	T1	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	T2	
<i>amoxicillin-pot clavulanate oral tablet</i>	T2	
<i>amphotericin b</i>	T4	PA-BvD
<i>amphotericin b liposome</i>	T5	PA-BvD

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ampicillin oral capsule 500 mg</i>	T2	
<i>ampicillin sodium injection recon soln 1 gram, 10 gram</i>	T4	
<i>ampicillin sodium injection recon soln 2 gram</i>	T2	
<i>ampicillin-sulbactam injection</i>	T4	
<b>APTIVUS</b>	T5	
<b>ARIKAYCE</b>	T5	PA
<i>atazanavir</i>	T4	
<i>atovaquone</i>	T4	
<i>atovaquone-proguanil</i>	T3	
<i>azithromycin intravenous</i>	T2	
<i>azithromycin oral tablet</i>	T2	
<i>aztreonam</i>	T4	
<b>BICILLIN C-R</b>	T3	
<b>BICILLIN L-A INTRAMUSCULAR SYRINGE 600,000 UNIT/ML</b>	T3	
<b>BIKTARVY</b>	T5	QL (31 EA per 31 days)
<b>BLUJEP</b>	T4	QL (20 EA per 5 days)
<i>caspofungin</i>	T4	
<b>CAYSTON</b>	T5	PA
<i>cefaclor oral capsule 500 mg</i>	T2	
<i>cefadroxil oral capsule</i>	T2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml</i>	T2	
<i>cefadroxil oral suspension for reconstitution 500 mg/5 ml</i>	T4	
<i>cefadroxil oral tablet</i>	T3	
<i>cefazolin injection recon soln 1 gram, 500 mg</i>	T2	
<i>cefazolin intravenous recon soln 10 gram</i>	T4	
<i>cefdinir oral capsule</i>	T2	
<i>cefepime injection</i>	T4	
<i>cefixime oral capsule</i>	T2	
<i>cefoxitin</i>	T4	
<i>cefpodoxime oral suspension for reconstitution 100 mg/5 ml</i>	T4	
<i>cefpodoxime oral suspension for reconstitution 50 mg/5 ml</i>	T3	
<i>cefpodoxime oral tablet</i>	T3	
<i>cefprozil</i>	T2	
<i>ceftazidime</i>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	T2	
<i>cefuroxime axetil oral tablet</i>	T2	
<i>cefuroxime sodium injection recon soln 750 mg</i>	T3	
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	T3	
<i>cephalexin oral capsule 250 mg, 500 mg</i>	T2	
<i>cephalexin oral suspension for reconstitution</i>	T2	
<i>chloroquine phosphate oral tablet 250 mg</i>	T3	QL (50 EA per 30 days)
<i>chloroquine phosphate oral tablet 500 mg</i>	T3	QL (25 EA per 30 days)
<b>CIMDUO</b>	T5	QL (31 EA per 31 days)
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	T1	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	T2	
<i>clarithromycin oral suspension for reconstitution</i>	T4	
<i>clarithromycin oral tablet</i>	T2	
<i>clarithromycin oral tablet extended release 24 hr</i>	T2	
<i>clindamycin hcl</i>	T2	
<i>clindamycin in 5 % dextrose</i>	T2	
<b>CLINDAMYCIN PEDIATRIC</b>	T4	
<i>clindamycin phosphate injection</i>	T2	
<i>clotrimazole mucous membrane</i>	T2	
<b>COARTEM</b>	T4	
<i>colistin (colistimethate na)</i>	T4	
<b>CRESEMBA ORAL</b>	T5	
<i>dapsone oral</i>	T3	
<i>daptomycin intravenous recon soln 350 mg</i>	T4	
<i>daptomycin intravenous recon soln 500 mg</i>	T5	
<i>darunavir oral tablet 600 mg</i>	T4	
<i>darunavir oral tablet 800 mg</i>	T5	
<b>DELSTRIGO</b>	T5	QL (31 EA per 31 days)
<b>DESCOVY</b>	T5	QL (31 EA per 31 days)
<i>dicloxacillin</i>	T2	
<b>DOVATO</b>	T5	QL (31 EA per 31 days)
<b>DOXY-100</b>	T4	
<i>doxycycline hyclate intravenous</i>	T4	
<i>doxycycline hyclate oral capsule</i>	T2	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 100 mg</i>	T4	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	T2	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg</i>	T2	
<b>EDURANT</b>	T5	
<b>EDURANT PED</b>	T5	
<i>efavirenz oral tablet</i>	T4	
<i>efavirenz-emtricitabin-tenofov</i>	T5	
<i>efavirenz-lamivu-tenofov disop</i>	T5	QL (31 EA per 31 days)
<i>emtricitabine</i>	T4	
<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 167-250 mg, 200-300 mg</i>	T4	
<i>emtricitabine-tenofovir (tdf) oral tablet 133-200 mg</i>	T5	
<i>emtricitabine-rilpivirine-tenofov df</i>	T5	
<b>EMTRIVA ORAL SOLUTION</b>	T3	
<i>entecavir</i>	T4	
<i>ertapenem</i>	T4	
<i>erythromycin ethylsuccinate oral tablet</i>	T4	
<i>erythromycin oral tablet</i>	T4	
<i>ethambutol</i>	T2	
<i>etravirine</i>	T5	
<b>EVOTAZ</b>	T5	
<i>famciclovir</i>	T3	
<i>fidaxomicin</i>	T5	QL (20 EA per 10 days)
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	T2	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	T3	
<i>fluconazole oral suspension for reconstitution</i>	T3	
<i>fluconazole oral tablet</i>	T2	
<i>flucytosine</i>	T5	
<i>fosamprenavir</i>	T5	
<i>fosfomycin tromethamine</i>	T4	
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	T2	
<i>gentamicin injection</i>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>GENVOYA</b>	T5	
<i>griseofulvin microsize</i>	T4	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	T4	
<i>hydroxychloroquine oral tablet 200 mg</i>	T2	QL (93 EA per 31 days)
<i>imipenem-cilastatin</i>	T4	
<b>IMPAVIDO</b>	T5	
<b>INTELENCE ORAL TABLET 25 MG</b>	T4	
<b>ISENTRESS HD</b>	T5	
<b>ISENTRESS ORAL POWDER IN PACKET</b>	T5	
<b>ISENTRESS ORAL TABLET</b>	T5	
<b>ISENTRESS ORAL TABLET,CHEWABLE 100 MG</b>	T5	
<b>ISENTRESS ORAL TABLET,CHEWABLE 25 MG</b>	T3	
<i>isoniazid oral solution</i>	T2	
<i>isoniazid oral tablet</i>	T1	
<i>itraconazole oral capsule</i>	T4	PA
<i>ivermectin oral</i>	T3	PA
<b>JULUCA</b>	T5	
<b>KALETRA ORAL SOLUTION</b>	T5	
<i>ketoconazole oral</i>	T2	
<b>LAGEVRIO (EUA)</b>	T3	
<i>lamivudine oral solution</i>	T2	
<i>lamivudine oral tablet 100 mg</i>	T3	
<i>lamivudine oral tablet 150 mg, 300 mg</i>	T2	
<i>lamivudine-zidovudine</i>	T3	
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	T2	
<i>levofloxacin oral solution</i>	T4	
<i>levofloxacin oral tablet</i>	T2	
<i>linezolid in dextrose 5%</i>	T4	
<i>linezolid oral tablet</i>	T4	
<b>LIVTENCITY</b>	T5	PA; QL (372 EA per 31 days)
<i>lopinavir-ritonavir oral tablet</i>	T4	
<i>maraviroc oral tablet 150 mg</i>	T5	
<i>maraviroc oral tablet 300 mg</i>	T3	
<b>MAVYRET ORAL PELLETS IN PACKET</b>	T5	PA; QL (140 EA per 28 days)
<b>MAVYRET ORAL TABLET</b>	T5	PA; QL (84 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>mefloquine</i>	T2	
<i>meropenem intravenous recon soln 1 gram, 500 mg</i>	T3	
<i>methenamine hippurate</i>	T4	
<i>metronidazole in nacl (iso-os)</i>	T2	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T2	
<i>micafungin</i>	T4	
<i>minocycline oral capsule</i>	T2	
<i>minocycline oral tablet</i>	T2	
<i>moxifloxacin oral</i>	T3	
<i>moxifloxacin-sod.chloride(iso)</i>	T4	
<i>nafcillin injection recon soln 1 gram, 2 gram</i>	T4	
<i>nafcillin injection recon soln 10 gram</i>	T5	
<i>neomycin</i>	T2	
<i>nevirapine oral suspension</i>	T2	
<i>nevirapine oral tablet</i>	T2	
<i>nevirapine oral tablet extended release 24 hr 400 mg</i>	T4	
<i>nitazoxanide</i>	T5	
<i>nitrofurantoin macrocrystal oral capsule 100 mg</i>	T2	QL (90 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 50 mg</i>	T2	QL (180 EA per 365 days)
<i>nitrofurantoin monohyd/m-cryst</i>	T2	QL (90 EA per 365 days)
<b>NORVIR ORAL POWDER IN PACKET</b>	T4	
<i>nystatin oral suspension</i>	T2	
<i>nystatin oral tablet</i>	T2	
<b>ODEFSEY</b>	T5	QL (31 EA per 31 days)
<i>ofloxacin oral tablet 300 mg</i>	T4	
<i>ofloxacin oral tablet 400 mg</i>	T2	
<b>ORLYNVAH</b>	T4	QL (10 EA per 5 days)
<i>oseltamivir oral capsule 30 mg</i>	T2	QL (170 EA per 365 days)
<i>oseltamivir oral capsule 45 mg, 75 mg</i>	T2	QL (90 EA per 365 days)
<i>oseltamivir oral suspension for reconstitution</i>	T3	QL (1080 ML per 365 days)
<i>oxacillin injection recon soln 1 gram, 2 gram</i>	T2	
<b>PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (10)- 100 MG (10)</b>	T3	QL (180 EA per 365 days)
<b>PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (6)- 100 MG (5)</b>	T3	QL (99 EA per 365 days)
<b>PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG</b>	T3	QL (270 EA per 365 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml</i>	T4	
<i>penicillin g potassium injection recon soln 20 million unit</i>	T4	
<i>penicillin v potassium oral tablet</i>	T1	
<i>pentamidine inhalation</i>	T4	PA-BvD
<i>pentamidine injection</i>	T4	
<b>PIFELTRO</b>	T5	QL (62 EA per 31 days)
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	T4	
<i>posaconazole oral tablet, delayed release (dr/ec)</i>	T5	PA
<i>praziquantel</i>	T4	
<b>PREVYMIS ORAL PELLETS IN PACKET</b>	T5	PA; QL (124 EA per 31 days)
<b>PREVYMIS ORAL TABLET</b>	T5	QL (31 EA per 31 days)
<b>PREZCOBIX</b>	T5	
<b>PREZISTA ORAL SUSPENSION</b>	T5	
<b>PREZISTA ORAL TABLET 150 MG</b>	T5	
<b>PREZISTA ORAL TABLET 75 MG</b>	T4	
<b>PRIFTIN</b>	T3	
<i>primaquine</i>	T3	
<i>pyrazinamide</i>	T4	
<i>pyrimethamine</i>	T5	PA
<i>quinine sulfate</i>	T4	PA; QL (42 EA per 28 days)
<b>RELENZA DISKHALER</b>	T3	
<b>REYATAZ ORAL POWDER IN PACKET</b>	T5	
<i>ribavirin oral capsule</i>	T3	
<i>ribavirin oral tablet 200 mg</i>	T3	
<i>rifabutin</i>	T4	
<i>rifampin</i>	T4	
<i>rimantadine</i>	T4	
<i>ritonavir</i>	T3	
<b>RUKOBIA</b>	T5	QL (62 EA per 31 days)
<b>SELZENTRY ORAL SOLUTION</b>	T5	
<b>SIRTURO</b>	T5	PA
<i>sofosbuvir-velpatasvir</i>	T5	PA; QL (28 EA per 28 days)
<i>streptomycin</i>	T5	
<b>STRIBILD</b>	T5	
<i>sulfadiazine</i>	T4	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sulfamethoxazole-trimethoprim oral tablet</i>	T1	
<b>SUNLENCA ORAL</b>	T5	
<b>SYMTUZA</b>	T5	QL (31 EA per 31 days)
<b>TEFLARO</b>	T5	
<i>tenofovir disoproxil fumarate</i>	T3	
<i>terbinafine hcl oral</i>	T1	QL (90 EA per 180 days)
<i>tetracycline oral capsule</i>	T4	
<i>tigecycline</i>	T4	
<i>tinidazole</i>	T2	
<b>TIVICAY ORAL TABLET 50 MG</b>	T5	
<b>TIVICAY PD</b>	T5	
<b>TOBI PODHALER</b>	T5	PA; QL (224 EA per 56 days)
<i>tobramycin in 0.225 % nacl</i>	T5	PA
<i>tobramycin inhalation</i>	T5	PA
<i>tobramycin sulfate injection solution</i>	T4	
<i>trimethoprim</i>	T2	
<b>TRIUMEQ</b>	T5	
<b>TRIUMEQ PD</b>	T4	QL (186 EA per 31 days)
<b>TYBOST</b>	T3	
<i>valacyclovir</i>	T2	
<i>valganciclovir oral recon soln</i>	T4	
<i>valganciclovir oral tablet</i>	T3	
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg</i>	T4	
<i>vancomycin oral capsule 125 mg</i>	T4	QL (124 EA per 31 days)
<i>vancomycin oral capsule 250 mg</i>	T4	QL (248 EA per 31 days)
<b>VEMLIDY</b>	T5	QL (31 EA per 31 days)
<b>VIRACEPT ORAL TABLET</b>	T5	
<b>VIREAD ORAL POWDER</b>	T5	
<b>VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG</b>	T5	
<b>VIVJOA</b>	T4	PA; QL (18 EA per 84 days)
<i>voriconazole intravenous</i>	T5	PA
<i>voriconazole oral</i>	T4	
<b>VOSEVI</b>	T5	PA; QL (28 EA per 28 days)
<b>XIFAXAN ORAL TABLET 200 MG</b>	T4	QL (27 EA per 365 days)
<b>XIFAXAN ORAL TABLET 550 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>XOFLUZA ORAL TABLET 40 MG, 80 MG</b>	T3	QL (9 EA per 365 days)
<i>zidovudine</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>Antineoplastic / Immunosuppressant Drugs</b>		
<i>abiraterone oral tablet 250 mg</i>	T5	PA-NS; QL (124 EA per 31 days)
<i>abiraterone oral tablet 500 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<b>ABIRTEGA</b>	T3	PA-NS; QL (124 EA per 31 days)
<b>AKEEGA</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>ALECENSA</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>ALUNBRIG ORAL TABLET 180 MG, 90 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>ALUNBRIG ORAL TABLET 30 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>ALUNBRIG ORAL TABLETS,DOSE PACK</b>	T5	PA-NS; QL (60 EA per 365 days)
<i>anastrozole</i>	T2	
<b>AUGTYRO ORAL CAPSULE 160 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>AUGTYRO ORAL CAPSULE 40 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>AVMAPKI-FAKZYNJA</b>	T5	PA-NS; QL (66 EA per 28 days)
<b>AYVAKIT</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>azathioprine oral tablet 50 mg</i>	T2	PA-BvD
<b>BALVERSA</b>	T5	PA-NS
<i>bexarotene oral</i>	T5	PA-NS
<i>bexarotene topical</i>	T5	PA-NS; QL (60 GM per 28 days)
<i>bicalutamide</i>	T2	
<b>BOSULIF ORAL CAPSULE 100 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>BOSULIF ORAL CAPSULE 50 MG</b>	T5	PA-NS; QL (341 EA per 31 days)
<b>BOSULIF ORAL TABLET 100 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>BOSULIF ORAL TABLET 400 MG, 500 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>BRAFTOVI</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>BRUKINSA ORAL TABLET</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>CABOMETYX</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>CALQUENCE (ACALABRUTINIB MAL)</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>CAPRELSA ORAL TABLET 100 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>CAPRELSA ORAL TABLET 300 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)</b>	T5	PA-NS; QL (56 EA per 28 days)
<b>COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)</b>	T5	PA-NS; QL (112 EA per 28 days)
<b>COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)</b>	T5	PA-NS; QL (84 EA per 28 days)
<b>COPIKTRA</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>COTELLIC</b>	T5	PA-NS; LA; QL (63 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cyclophosphamide oral</i>	T3	PA-BvD
<i>cyclosporine modified oral capsule</i>	T2	PA-BvD
<i>cyclosporine modified oral solution</i>	T5	PA-BvD
<i>cyclosporine oral capsule</i>	T2	PA-BvD
<b>DANZITEN</b>	T5	PA-NS; QL (124 EA per 31 days)
<i>dasatinib</i>	T5	PA-NS; QL (31 EA per 31 days)
<b>DAURISMO ORAL TABLET 100 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>DAURISMO ORAL TABLET 25 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>ELIGARD</b>	T4	ST-NS; QL (1 EA per 30 days)
<b>ELIGARD (3 MONTH)</b>	T4	ST-NS; QL (1 EA per 90 days)
<b>ELIGARD (4 MONTH)</b>	T4	ST-NS; QL (1 EA per 120 days)
<b>ELIGARD (6 MONTH)</b>	T4	ST-NS; QL (1 EA per 180 days)
<b>ENSACOVE</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>ENVARUSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG</b>	T4	PA-BvD
<b>ENVARUSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 4 MG</b>	T5	PA-BvD
<b>ERIVEDGE</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>ERLEADA ORAL TABLET 240 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>ERLEADA ORAL TABLET 60 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<i>erlotinib</i>	T5	PA-NS; QL (31 EA per 31 days)
<b>EULEXIN</b>	T4	
<i>everolimus (antineoplastic) oral tablet</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg, 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>everolimus (immunosuppressive) oral tablet 0.25 mg</i>	T4	PA-BvD
<i>everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg</i>	T5	PA-BvD
<i>exemestane</i>	T4	
<b>FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG</b>	T5	PA-NS
<b>FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG</b>	T4	PA-NS
<b>FOTIVDA</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>FRUZAQLA ORAL CAPSULE 1 MG</b>	T5	PA-NS; QL (84 EA per 28 days)
<b>FRUZAQLA ORAL CAPSULE 5 MG</b>	T5	PA-NS; QL (21 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>GAVRETO</b>	T5	PA-NS; QL (124 EA per 31 days)
<i>gefitinib</i>	T5	PA-NS; QL (31 EA per 31 days)
<b>GENGRAF ORAL CAPSULE</b>	T2	PA-BvD
<b>GILOTRIF</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>GOMEKLI ORAL CAPSULE 1 MG</b>	T5	PA-NS; QL (126 EA per 28 days)
<b>GOMEKLI ORAL CAPSULE 2 MG</b>	T5	PA-NS; QL (84 EA per 28 days)
<b>GOMEKLI ORAL TABLET FOR SUSPENSION</b>	T5	PA-NS; QL (168 EA per 28 days)
<b>HERNEXEOS</b>	T5	PA-NS; QL (93 EA per 31 days)
<i>hydroxyurea</i>	T2	
<b>HYRNUO</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>IBRANCE</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>IBTROZI</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>ICLUSIG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>IDHIFA</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>imatinib oral tablet 100 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>imatinib oral tablet 400 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<b>IMBRUVICA ORAL CAPSULE 140 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>IMBRUVICA ORAL CAPSULE 70 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>IMBRUVICA ORAL SUSPENSION</b>	T5	PA-NS; QL (216 ML per 25 days)
<b>IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>IMKELDI</b>	T5	PA-NS; QL (280 ML per 28 days)
<b>INLURIYO</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>INLYTA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>INQOVI</b>	T5	PA-NS; QL (5 EA per 28 days)
<b>INREBIC</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>ITOVEBI ORAL TABLET 3 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>ITOVEBI ORAL TABLET 9 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>IWILFIN</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>JAKAFI</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>JAYPIRCA ORAL TABLET 100 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>JAYPIRCA ORAL TABLET 50 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG</b>	T5	PA-NS; QL (70 EA per 28 days)
<b>KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG</b>	T5	PA-NS; QL (91 EA per 28 days)
<b>KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)</b>	T5	PA-NS; QL (21 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)</b>	T5	PA-NS; QL (42 EA per 28 days)
<b>KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)</b>	T5	PA-NS; QL (63 EA per 28 days)
<b>KOSELUGO ORAL CAPSULE 10 MG</b>	T5	PA-NS; QL (279 EA per 31 days)
<b>KOSELUGO ORAL CAPSULE 25 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>KOSELUGO ORAL CAPSULE, SPRINKLE 5 MG</b>	T5	PA-NS; QL (600 EA per 30 days)
<b>KOSELUGO ORAL CAPSULE, SPRINKLE 7.5 MG</b>	T5	PA-NS; QL (360 EA per 30 days)
<b>KRAZATI</b>	T5	PA-NS; QL (186 EA per 31 days)
<i>lapatinib</i>	T5	PA-NS; QL (186 EA per 31 days)
<b>LAZCLUZE ORAL TABLET 240 MG</b>	T5	PA-NS; QL (30 EA per 30 days)
<b>LAZCLUZE ORAL TABLET 80 MG</b>	T5	PA-NS; QL (60 EA per 30 days)
<i>lenalidomide</i>	T5	PA-NS; QL (21 EA per 28 days)
<b>LENVIMA</b>	T5	PA-NS
<i>letrozole</i>	T2	
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg</i>	T3	
<i>leucovorin calcium oral tablet 5 mg</i>	T2	
<b>LEUKERAN</b>	T5	
<i>leuprolide acetate (3 month)</i>	T4	QL (1 EA per 30 days)
<i>leuprolide subcutaneous kit</i>	T4	QL (2 EA per 28 days)
<i>lomustine oral capsule 10 mg, 40 mg</i>	T4	PA-NS
<i>lomustine oral capsule 100 mg</i>	T5	PA-NS
<b>LONSURF</b>	T5	PA-NS
<b>LORBRENA ORAL TABLET 100 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>LORBRENA ORAL TABLET 25 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>LUMAKRAS ORAL TABLET 120 MG, 240 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>LUMAKRAS ORAL TABLET 320 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG</b>	T5	QL (1 EA per 90 days)
<b>LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG</b>	T5	QL (1 EA per 30 days)
<b>LYNPARZA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>LYSODREN</b>	T5	
<b>LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)</b>	T5	PA-NS; QL (93 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)</b>	T5	PA-NS; QL (155 EA per 31 days)
<b>MATULANE</b>	T5	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml)</i>	T2	PA
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	T4	PA
<i>megestrol oral tablet</i>	T2	PA-NS
<b>MEKINIST ORAL RECON SOLN</b>	T5	PA-NS; QL (1260 ML per 31 days)
<b>MEKINIST ORAL TABLET 0.5 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>MEKINIST ORAL TABLET 2 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>MEKTOVI</b>	T5	PA-NS; QL (186 EA per 31 days)
<i>mercaptopurine oral suspension</i>	T5	
<i>mercaptopurine oral tablet</i>	T2	
<i>mesna oral</i>	T4	
<i>methotrexate sodium</i>	T2	PA-BvD
<i>methotrexate sodium (pf) injection solution</i>	T2	PA-BvD
<b>MODEYSO</b>	T5	PA-NS; QL (20 EA per 28 days)
<i>mycophenolate mofetil oral capsule</i>	T2	PA-BvD
<i>mycophenolate mofetil oral suspension for reconstitution</i>	T5	PA-BvD
<i>mycophenolate mofetil oral tablet</i>	T2	PA-BvD
<i>mycophenolate sodium</i>	T4	PA-BvD
<b>NEMLUVIO</b>	T5	PA; QL (2 EA per 28 days)
<b>NERLYNX</b>	T5	PA-NS; QL (186 EA per 31 days)
<i>nilotinib hcl</i>	T5	PA-NS; QL (124 EA per 31 days)
<i>nilutamide</i>	T5	
<b>NINLARO</b>	T5	PA-NS; QL (3 EA per 28 days)
<b>NUBEQA</b>	T5	PA-NS; QL (124 EA per 31 days)
<i>octreotide acetate injection solution</i>	T4	PA
<b>ODOMZO</b>	T5	PA-NS; LA; QL (31 EA per 31 days)
<b>OGSIVEO ORAL TABLET 100 MG, 150 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>OJEMDA ORAL SUSPENSION FOR RECONSTITUTION</b>	T5	PA-NS; QL (96 ML per 28 days)
<b>OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)</b>	T5	PA-NS; QL (16 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)</b>	T5	PA-NS; QL (20 EA per 28 days)
<b>OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)</b>	T5	PA-NS; QL (24 EA per 28 days)
<b>OJJAARA</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>ONUREG</b>	T5	PA-NS; QL (14 EA per 28 days)
<b>ORGOVYX</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>ORSERDU ORAL TABLET 345 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>ORSERDU ORAL TABLET 86 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<i>pazopanib oral tablet 200 mg</i>	T5	PA-NS; QL (124 EA per 31 days)
<b>PEMAZYRE</b>	T5	PA-NS; QL (14 EA per 21 days)
<b>PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)</b>	T5	PA-NS; QL (28 EA per 28 days)
<b>PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)</b>	T5	PA-NS; QL (56 EA per 28 days)
<b>POMALYST</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>PROGRAF ORAL GRANULES IN PACKET</b>	T4	PA-BvD
<b>QINLOCK</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>RETEVMO ORAL TABLET 40 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>REVUFORJ ORAL TABLET 110 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>REVUFORJ ORAL TABLET 160 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>REVUFORJ ORAL TABLET 25 MG</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>REZLIDHIA</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>ROMVIMZA</b>	T5	PA-NS; QL (8 EA per 28 days)
<b>ROZLYTREK ORAL CAPSULE 100 MG</b>	T5	PA-NS; QL (155 EA per 31 days)
<b>ROZLYTREK ORAL CAPSULE 200 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>ROZLYTREK ORAL PELLETS IN PACKET</b>	T5	PA-NS; QL (372 EA per 31 days)
<b>RUBRACA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>RYDAPT</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>SCEMBLIX ORAL TABLET 100 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>SCEMBLIX ORAL TABLET 20 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>SCEMBLIX ORAL TABLET 40 MG</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>SIGNIFOR</b>	T5	PA
<i>sirolimus</i>	T4	PA-BvD
<b>SOLTAMOX</b>	T4	
<i>sorafenib</i>	T5	PA-NS; QL (124 EA per 31 days)
<b>STIVARGA</b>	T5	PA-NS; QL (84 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sunitinib malate</i>	T5	PA-NS; QL (31 EA per 31 days)
<b>TABLOID</b>	T4	
<b>TABRECTA</b>	T5	PA-NS; QL (124 EA per 31 days)
<i>tacrolimus oral capsule 0.5 mg, 1 mg</i>	T2	PA-BvD
<i>tacrolimus oral capsule 5 mg</i>	T4	PA-BvD
<b>TAFINLAR ORAL CAPSULE</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>TAFINLAR ORAL TABLET FOR SUSPENSION</b>	T5	PA-NS; QL (930 EA per 31 days)
<b>TAGRISSE</b>	T5	PA-NS; LA; QL (31 EA per 31 days)
<b>TALZENNA</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>tamoxifen</i>	T1	
<b>TAZVERIK</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>TEPMETKO</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>THALOMID ORAL CAPSULE 100 MG</b>	T5	PA-NS; QL (112 EA per 28 days)
<b>THALOMID ORAL CAPSULE 50 MG</b>	T5	PA-NS; QL (28 EA per 28 days)
<b>TIBSOVO</b>	T5	PA-NS; QL (62 EA per 31 days)
<i>toremifene</i>	T4	
<b>TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG</b>	T4	ST-NS; QL (1 EA per 84 days)
<b>TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 22.5 MG</b>	T4	ST-NS; QL (1 EA per 168 days)
<b>TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG</b>	T4	ST-NS; QL (1 EA per 28 days)
<i>tretinoin (antineoplastic)</i>	T5	
<b>TRUQAP</b>	T5	PA-NS; QL (64 EA per 28 days)
<b>TUKYSA ORAL TABLET 150 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>TUKYSA ORAL TABLET 50 MG</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>TURALIO</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>VANFLYTA</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>VENCLEXTA ORAL TABLET 10 MG</b>	T3	PA-NS; QL (62 EA per 31 days)
<b>VENCLEXTA ORAL TABLET 100 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>VENCLEXTA ORAL TABLET 50 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>VENCLEXTA STARTING PACK</b>	T5	PA-NS; QL (84 EA per 365 days)
<b>VERZENIO</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>VIJOICE ORAL GRANULES IN PACKET</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>VIJOICE ORAL TABLET 125 MG, 50 MG</b>	T5	PA-NS; QL (28 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)</b>	T5	PA-NS; QL (56 EA per 28 days)
<b>VITRAKVI ORAL CAPSULE 100 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>VITRAKVI ORAL CAPSULE 25 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>VITRAKVI ORAL SOLUTION</b>	T5	PA-NS; QL (310 ML per 31 days)
<b>VIZIMPRO</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>VONJO</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>VORANIGO ORAL TABLET 10 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>VORANIGO ORAL TABLET 40 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>WELIREG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>XALKORI ORAL CAPSULE</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>XALKORI ORAL PELLETT 150 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>XALKORI ORAL PELLETT 20 MG, 50 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>XATMEP</b>	T4	PA-BvD
<b>XERMELO</b>	T5	PA; QL (93 EA per 31 days)
<b>XGEVA</b>	T5	PA-NS
<b>XOSPATA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2)</b>	T5	PA-NS; QL (8 EA per 28 days)
<b>XPOVIO ORAL TABLET 40 MG/WEEK (10 MG X 4)</b>	T5	PA-NS; QL (16 EA per 28 days)
<b>XPOVIO ORAL TABLET 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1)</b>	T5	PA-NS; QL (4 EA per 28 days)
<b>XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)</b>	T5	PA-NS; QL (24 EA per 28 days)
<b>XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)</b>	T5	PA-NS; QL (32 EA per 28 days)
<b>XTANDI ORAL CAPSULE</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>XTANDI ORAL TABLET 40 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>XTANDI ORAL TABLET 80 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>YONSA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>ZEJULA ORAL TABLET</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>ZELBORAF</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>ZOLINZA</b>	T5	PA-NS
<b>ZYDELIG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>ZYKADIA</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>Autonomic / Cns Drugs, Neurology / Psych</b>		
<b>ABILIFY MAINTENA</b>	T5	QL (1 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	T2	PA; QL (5167 ML per 31 days)
<i>acetaminophen-codeine oral tablet</i>	T2	PA; QL (403 EA per 31 days)
<b>AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML</b>	T3	PA; QL (1 ML per 28 days)
<b>AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML</b>	T3	PA; QL (2 ML per 28 days)
<i>alprazolam oral tablet 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>amitriptyline</i>	T2	PA-NS
<i>amoxapine</i>	T2	
<i>aripiprazole oral solution</i>	T4	PA-NS
<i>aripiprazole oral tablet</i>	T3	
<i>aripiprazole oral tablet, disintegrating 10 mg</i>	T4	PA-NS
<i>aripiprazole oral tablet, disintegrating 15 mg</i>	T5	PA-NS
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
<i>asenapine maleate</i>	T4	PA-NS; QL (62 EA per 31 days)
<i>atomoxetine oral capsule 10 mg, 25 mg, 40 mg</i>	T3	QL (62 EA per 31 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	T3	QL (31 EA per 31 days)
<i>atomoxetine oral capsule 18 mg</i>	T3	QL (124 EA per 31 days)
<b>AUSTEDO ORAL TABLET 12 MG, 6 MG</b>	T5	PA; QL (124 EA per 31 days)
<b>AUSTEDO ORAL TABLET 9 MG</b>	T5	PA; QL (155 EA per 31 days)
<b>AUSTEDO XR</b>	T5	PA; QL (31 EA per 31 days)
<b>AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG</b>	T5	PA; QL (56 EA per 365 days)
<b>AUVELITY</b>	T5	PA-NS; QL (62 EA per 31 days)
<i>baclofen oral tablet 10 mg, 20 mg</i>	T2	
<b>BAFIERTAM</b>	T5	PA; QL (124 EA per 31 days)
<i>benztropine oral</i>	T2	PA
<b>BRIVIACT ORAL SOLUTION</b>	T5	QL (620 ML per 31 days)
<b>BRIVIACT ORAL TABLET</b>	T5	QL (62 EA per 31 days)
<i>bromocriptine</i>	T4	
<i>buprenorphine</i>	T4	PA; QL (4 EA per 28 days)
<i>buprenorphine hcl sublingual</i>	T3	
<i>buprenorphine-naloxone sublingual film</i>	T2	
<i>buprenorphine-naloxone sublingual tablet</i>	T4	
<i>bupropion hcl oral tablet</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	T2	QL (31 EA per 31 days)
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	T2	QL (62 EA per 31 days)
<i>bupirone</i>	T2	
<i>butorphanol nasal</i>	T4	QL (5 ML per 28 days)
<b>CAPLYTA</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	T3	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	T2	
<i>carbamazepine oral tablet</i>	T2	
<i>carbamazepine oral tablet extended release 12 hr</i>	T3	
<i>carbamazepine oral tablet, chewable 100 mg</i>	T2	
<i>carbidopa-levodopa oral tablet</i>	T2	
<i>carbidopa-levodopa oral tablet extended release</i>	T2	
<i>carbidopa-levodopa oral tablet, disintegrating</i>	T2	
<i>carbidopa-levodopa-entacapone</i>	T4	
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	T2	QL (62 EA per 31 days)
<i>celecoxib oral capsule 400 mg</i>	T3	QL (62 EA per 31 days)
<i>chlorpromazine oral</i>	T4	
<i>citalopram oral solution</i>	T3	
<i>citalopram oral tablet</i>	T1	
<i>clobazam oral suspension</i>	T4	PA-NS; QL (496 ML per 31 days)
<i>clobazam oral tablet</i>	T3	PA-NS; QL (62 EA per 31 days)
<i>clomipramine</i>	T4	PA-NS
<i>clonazepam oral tablet 0.5 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>clonazepam oral tablet 1 mg</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>clonazepam oral tablet 2 mg</i>	T2	PA-NS; QL (310 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 1 mg</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 2 mg</i>	T2	PA-NS; QL (310 EA per 31 days)
<i>clorazepate dipotassium oral tablet 15 mg</i>	T3	PA-NS; QL (186 EA per 31 days)
<i>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</i>	T3	PA-NS; QL (93 EA per 31 days)
<i>clozapine oral tablet 100 mg</i>	T3	QL (279 EA per 31 days)
<i>clozapine oral tablet 200 mg</i>	T3	QL (124 EA per 31 days)
<i>clozapine oral tablet 25 mg</i>	T2	QL (279 EA per 31 days)
<i>clozapine oral tablet 50 mg</i>	T2	QL (93 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>clozapine oral tablet, disintegrating 100 mg, 25 mg</i>	T4	QL (279 EA per 31 days)
<i>clozapine oral tablet, disintegrating 12.5 mg</i>	T4	QL (93 EA per 31 days)
<i>clozapine oral tablet, disintegrating 150 mg</i>	T4	QL (186 EA per 31 days)
<i>clozapine oral tablet, disintegrating 200 mg</i>	T4	QL (124 EA per 31 days)
<b>COBENFY</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>COBENFY STARTER PACK</b>	T5	PA-NS; QL (112 EA per 365 days)
<b>COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML</b>	T5	PA; QL (31 ML per 31 days)
<b>COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML</b>	T5	PA; QL (12 ML per 28 days)
<i>cyclobenzaprine oral tablet 10 mg</i>	T2	QL (93 EA per 31 days)
<i>cyclobenzaprine oral tablet 5 mg</i>	T2	QL (155 EA per 31 days)
<i>dalfampridine</i>	T5	PA; QL (62 EA per 31 days)
<i>dantrolene oral</i>	T4	
<i>desipramine oral tablet 10 mg, 25 mg</i>	T3	
<i>desipramine oral tablet 100 mg, 150 mg, 50 mg, 75 mg</i>	T4	
<i>desvenlafaxine succinate</i>	T3	QL (31 EA per 31 days)
<i>dexmethylphenidate oral capsule, er biphasic 50-50</i>	T4	QL (31 EA per 31 days)
<i>dexmethylphenidate oral tablet 10 mg</i>	T2	QL (62 EA per 31 days)
<i>dexmethylphenidate oral tablet 2.5 mg, 5 mg</i>	T2	QL (93 EA per 31 days)
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr</i>	T3	QL (31 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	T1	QL (62 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 20 mg</i>	T1	QL (93 EA per 31 days)
<b>DIACOMIT ORAL CAPSULE 250 MG</b>	T5	PA-NS; QL (341 EA per 31 days)
<b>DIACOMIT ORAL CAPSULE 500 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>DIACOMIT ORAL POWDER IN PACKET 250 MG</b>	T5	PA-NS; QL (341 EA per 31 days)
<b>DIACOMIT ORAL POWDER IN PACKET 500 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>DIAZEPAM INTENSOL</b>	T2	PA-NS; QL (248 ML per 31 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	T2	PA-NS; QL (1500 ML per 31 days)
<i>diazepam oral tablet</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>diazepam rectal</i>	T4	
<i>diclofenac potassium oral tablet 50 mg</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diclofenac sodium oral</i>	T2	
<i>diclofenac sodium topical drops</i>	T2	QL (450 ML per 28 days)
<i>diflunisal</i>	T2	
<i>dihydroergotamine nasal</i>	T5	PA; QL (8 ML per 28 days)
<b>DILANTIN</b>	T3	
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg</i>	T4	PA; QL (62 EA per 31 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg (14)- 240 mg (46)</i>	T5	PA; QL (120 EA per 365 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 240 mg</i>	T5	PA; QL (62 EA per 31 days)
<i>divalproex oral capsule, delayed rel sprinkle</i>	T2	
<i>divalproex oral tablet extended release 24 hr 250 mg</i>	T2	
<i>divalproex oral tablet extended release 24 hr 500 mg</i>	T3	
<i>divalproex oral tablet, delayed release (dr/ec)</i>	T2	
<i>donepezil oral tablet 10 mg, 5 mg</i>	T1	
<i>donepezil oral tablet 23 mg</i>	T3	QL (31 EA per 31 days)
<i>donepezil oral tablet, disintegrating</i>	T2	
<i>doxepin oral capsule</i>	T2	PA-NS
<i>doxepin oral concentrate</i>	T2	PA-NS
<i>doxepin oral tablet</i>	T3	PA
<b>DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG</b>	T3	PA-NS; QL (93 EA per 31 days)
<b>DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 30 MG, 60 MG</b>	T3	PA-NS; QL (62 EA per 31 days)
<b>DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG</b>	T3	PA-NS; QL (31 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 60 mg</i>	T2	QL (62 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 30 mg</i>	T2	QL (31 EA per 31 days)
<b>EMGALITY PEN</b>	T3	PA; QL (1 ML per 28 days)
<b>EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML</b>	T3	PA; QL (1 ML per 28 days)
<b>EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)</b>	T5	PA; QL (3 ML per 28 days)
<b>EMSAM</b>	T5	QL (30 EA per 30 days)
<i>entacapone</i>	T3	
<b>EPIDIOLEX</b>	T5	PA-NS

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ergotamine-caffeine</i>	T3	PA
<i>escitalopram oxalate oral capsule</i>	T4	PA-NS; QL (31 EA per 31 days)
<i>escitalopram oxalate oral solution</i>	T4	QL (620 ML per 31 days)
<i>escitalopram oxalate oral tablet 10 mg</i>	T2	QL (45 EA per 30 days)
<i>escitalopram oxalate oral tablet 20 mg, 5 mg</i>	T2	QL (30 EA per 30 days)
<i>eslicarbazepine oral tablet 200 mg</i>	T4	QL (186 EA per 31 days)
<i>eslicarbazepine oral tablet 400 mg</i>	T5	QL (93 EA per 31 days)
<i>eslicarbazepine oral tablet 600 mg, 800 mg</i>	T5	QL (62 EA per 31 days)
<i>ethosuximide oral capsule</i>	T3	
<i>ethosuximide oral solution</i>	T4	
<i>etodolac oral capsule</i>	T3	
<i>etodolac oral tablet</i>	T2	
<i>etodolac oral tablet extended release 24 hr 400 mg, 500 mg</i>	T3	
<i>etodolac oral tablet extended release 24 hr 600 mg</i>	T4	
<b>EXXUA ORAL TABLET EXTENDED RELEASE 24 HR</b>	T4	PA-NS; QL (31 EA per 31 days)
<b>EXXUA ORAL TABLET, EXT REL 24HR DOSE PACK</b>	T4	PA-NS; QL (64 EA per 365 days)
<b>FANAPT ORAL TABLET 1 MG</b>	T4	PA-NS; QL (62 EA per 31 days)
<b>FANAPT ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>FANAPT TITRATION PACK A</b>	T4	PA-NS; QL (16 EA per 365 days)
<i>felbamate</i>	T4	
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 75 mcg/hr</i>	T4	PA; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 25 mcg/hr, 50 mcg/hr</i>	T2	PA; QL (10 EA per 30 days)
<b>FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)</b>	T4	PA-NS; QL (56 EA per 365 days)
<b>FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG</b>	T4	PA-NS; QL (31 EA per 31 days)
<b>FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG</b>	T4	PA-NS; QL (93 EA per 31 days)
<i>fingolimod</i>	T5	PA; QL (31 EA per 31 days)
<b>FINTEPLA</b>	T5	PA-NS; QL (360 ML per 30 days)
<i>fluoxetine (pmd)</i>	T2	
<i>fluoxetine oral capsule</i>	T1	
<i>fluoxetine oral solution</i>	T3	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fluphenazine decanoate</i>	T3	
<i>fluphenazine hcl injection</i>	T4	
<i>fluphenazine hcl oral concentrate</i>	T4	
<i>fluphenazine hcl oral elixir</i>	T4	
<i>fluphenazine hcl oral tablet 1 mg, 2.5 mg, 5 mg</i>	T2	
<i>fluphenazine hcl oral tablet 10 mg</i>	T4	
<i>flurbiprofen oral tablet 100 mg</i>	T2	
<i>fluvoxamine oral tablet</i>	T2	
<i>gabapentin oral capsule 100 mg, 400 mg</i>	T2	QL (270 EA per 30 days)
<i>gabapentin oral capsule 300 mg</i>	T2	QL (360 EA per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	T4	QL (2160 ML per 30 days)
<i>gabapentin oral tablet 600 mg</i>	T2	QL (180 EA per 30 days)
<i>gabapentin oral tablet 800 mg</i>	T2	QL (120 EA per 30 days)
<i>galantamine oral capsule, ext rel. pellets 24 hr</i>	T3	
<i>galantamine oral solution</i>	T4	
<i>galantamine oral tablet</i>	T3	
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	T5	PA; QL (31 ML per 31 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	T5	PA; QL (12 ML per 28 days)
<b>GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML</b>	T5	PA; QL (31 ML per 31 days)
<b>GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML</b>	T5	PA; QL (12 ML per 28 days)
<i>guanfacine oral tablet extended release 24 hr</i>	T2	PA
<i>haloperidol</i>	T2	
<i>haloperidol decanoate</i>	T2	
<i>haloperidol lactate injection</i>	T1	
<i>haloperidol lactate oral</i>	T2	
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>hydromorphone oral liquid</i>	T4	PA; QL (1240 ML per 31 days)
<i>hydromorphone oral tablet 2 mg, 4 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>hydromorphone oral tablet 8 mg</i>	T3	PA; QL (155 EA per 31 days)
<b>IBU ORAL TABLET 600 MG, 800 MG</b>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>imipramine hcl</i>	T2	PA-NS
<i>indomethacin oral capsule</i>	T2	
<i>indomethacin oral capsule, extended release</i>	T2	
<b>INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML</b>	T5	QL (3.5 ML per 180 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML</b>	T5	QL (5 ML per 180 days)
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML</b>	T5	QL (0.75 ML per 28 days)
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML</b>	T5	QL (1 ML per 28 days)
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML</b>	T5	QL (1.5 ML per 28 days)
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML</b>	T4	QL (0.25 ML per 28 days)
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML</b>	T5	QL (0.5 ML per 28 days)
<b>INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML</b>	T5	QL (0.88 ML per 84 days)
<b>INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML</b>	T5	QL (1.32 ML per 84 days)
<b>INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML</b>	T5	QL (1.75 ML per 84 days)
<b>INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML</b>	T5	QL (2.63 ML per 84 days)
<b>KESIMPTA PEN</b>	T5	PA; QL (0.4 ML per 28 days)
<b>KLOXXADO</b>	T3	
<i>lacosamide oral</i>	T4	
<i>lamotrigine oral tablet</i>	T2	
<i>lamotrigine oral tablet extended release 24hr</i>	T4	
<i>lamotrigine oral tablet, chewable dispersible</i>	T2	
<i>levetiracetam oral solution 100 mg/ml</i>	T2	
<i>levetiracetam oral tablet</i>	T2	
<i>levetiracetam oral tablet extended release 24 hr</i>	T2	
<i>lithium carbonate oral capsule</i>	T1	
<i>lithium carbonate oral tablet</i>	T1	
<i>lithium carbonate oral tablet extended release</i>	T2	
<i>lithium citrate</i>	T2	
<i>lofexidine</i>	T5	
<b>LORAZEPAM INTENSOL</b>	T2	PA; QL (155 ML per 31 days)
<i>lorazepam oral tablet 0.5 mg</i>	T2	PA; QL (124 EA per 31 days)
<i>lorazepam oral tablet 1 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>lorazepam oral tablet 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>loxapine succinate</i>	T2	
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	T4	PA-NS; QL (31 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lurasidone oral tablet 80 mg</i>	T4	PA-NS; QL (62 EA per 31 days)
<b>MARPLAN</b>	T4	
<i>meloxicam oral tablet</i>	T1	
<i>memantine oral capsule, sprinkle, er 24hr</i>	T4	
<i>memantine oral solution</i>	T4	
<i>memantine oral tablet</i>	T2	
<i>memantine-donepezil</i>	T4	PA
<i>methadone oral solution 10 mg/5 ml</i>	T2	PA; QL (620 ML per 31 days)
<i>methadone oral solution 5 mg/5 ml</i>	T2	PA; QL (1240 ML per 31 days)
<i>methadone oral tablet 10 mg</i>	T2	PA; QL (124 EA per 31 days)
<i>methadone oral tablet 5 mg</i>	T2	PA; QL (248 EA per 31 days)
<i>methsuximide</i>	T4	
<i>methylphenidate hcl oral tablet</i>	T2	QL (93 EA per 31 days)
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg</i>	T2	
<i>mirtazapine oral tablet 7.5 mg</i>	T3	
<i>mirtazapine oral tablet, disintegrating</i>	T3	
<i>modafinil</i>	T3	PA; QL (31 EA per 31 days)
<i>molindone</i>	T4	
<i>morphine concentrate oral solution</i>	T2	PA; QL (310 ML per 31 days)
<i>morphine oral solution 10 mg/5 ml</i>	T2	PA; QL (2800 ML per 31 days)
<i>morphine oral solution 20 mg/5 ml (4 mg/ml)</i>	T2	PA; QL (1400 ML per 31 days)
<i>morphine oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<i>morphine oral tablet extended release 100 mg</i>	T3	PA; QL (62 EA per 31 days)
<i>morphine oral tablet extended release 15 mg, 30 mg, 60 mg</i>	T3	PA; QL (100 EA per 31 days)
<i>morphine oral tablet extended release 200 mg</i>	T3	PA; QL (31 EA per 31 days)
<i>nabumetone</i>	T2	
<i>naloxone injection solution</i>	T2	
<i>naloxone injection syringe</i>	T2	
<i>naltrexone</i>	T2	
<i>naproxen oral tablet</i>	T1	
<i>naproxen oral tablet, delayed release (dr/ec) 375 mg</i>	T2	
<i>naproxen oral tablet, delayed release (dr/ec) 500 mg</i>	T4	
<i>naproxen sodium oral tablet 550 mg</i>	T2	
<i>naratriptan oral tablet 1 mg</i>	T3	QL (20 EA per 28 days)
<i>naratriptan oral tablet 2.5 mg</i>	T3	QL (9 EA per 28 days)
<b>NAYZILAM</b>	T4	PA-NS; QL (10 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nefazodone</i>	T4	
<i>nortriptyline</i>	T2	
<b>NUEDEXTA</b>	T5	PA; QL (62 EA per 31 days)
<b>NUPLAZID</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>NURTEC ODT</b>	T5	PA; QL (18 EA per 28 days)
<i>olanzapine intramuscular</i>	T4	
<i>olanzapine oral tablet</i>	T2	QL (31 EA per 31 days)
<i>olanzapine oral tablet,disintegrating</i>	T4	QL (31 EA per 31 days)
<b>OPIPZA</b>	T5	PA-NS
<i>oxcarbazepine oral suspension</i>	T4	
<i>oxcarbazepine oral tablet</i>	T2	
<i>oxycodone oral capsule</i>	T3	PA; QL (186 EA per 31 days)
<i>oxycodone oral concentrate</i>	T4	PA; QL (180 ML per 31 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg</i>	T3	PA; QL (186 EA per 31 days)
<i>oxycodone oral tablet 30 mg</i>	T3	PA; QL (138 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg</i>	T3	PA; QL (372 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	T4	QL (31 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	T4	QL (62 EA per 31 days)
<i>paroxetine hcl oral suspension</i>	T4	PA-NS
<i>paroxetine hcl oral tablet</i>	T1	PA-NS
<i>perampanel oral suspension</i>	T5	QL (744 ML per 31 days)
<i>perampanel oral tablet 10 mg, 12 mg, 4 mg, 6 mg, 8 mg</i>	T5	QL (31 EA per 31 days)
<i>perampanel oral tablet 2 mg</i>	T4	QL (31 EA per 31 days)
<i>perphenazine</i>	T4	
<b>PERSERIS</b>	T5	QL (1 EA per 28 days)
<i>phenelzine</i>	T2	
<i>phenobarbital</i>	T2	PA-NS
<b>PHENYTEK</b>	T3	
<i>phenytoin oral suspension 125 mg/5 ml</i>	T2	
<i>phenytoin oral tablet,chewable</i>	T2	
<i>phenytoin sodium extended oral capsule 100 mg</i>	T2	
<i>pimozide</i>	T4	
<i>piroxicam</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pramipexole oral tablet</i>	T2	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	T2	PA-NS; QL (62 EA per 31 days)
<i>pregabalin oral solution</i>	T2	PA-NS; QL (930 ML per 31 days)
<i>primidone oral tablet 125 mg</i>	T3	
<i>primidone oral tablet 250 mg, 50 mg</i>	T2	
<i>protriptyline</i>	T4	
<i>pyridostigmine bromide oral tablet 60 mg</i>	T3	
<i>pyridostigmine bromide oral tablet extended release 180 mg</i>	T4	
<i>quetiapine oral tablet 100 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	T2	QL (62 EA per 31 days)
<i>quetiapine oral tablet 150 mg</i>	T3	QL (62 EA per 31 days)
<i>quetiapine oral tablet 25 mg</i>	T1	QL (62 EA per 31 days)
<i>quetiapine oral tablet extended release 24 hr</i>	T3	QL (62 EA per 31 days)
<b>QULIPTA</b>	T5	PA; QL (31 EA per 31 days)
<b>RALDESY</b>	T5	
<i>ramelteon</i>	T4	QL (31 EA per 31 days)
<i>rasagiline</i>	T4	
<b>REXULTI ORAL TABLET</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml</i>	T4	QL (2 EA per 28 days)
<i>risperidone microspheres intramuscular suspension,extended rel recon 25 mg/2 ml, 37.5 mg/2 ml, 50 mg/2 ml</i>	T5	QL (2 EA per 28 days)
<i>risperidone oral solution</i>	T2	QL (496 ML per 31 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T2	QL (31 EA per 31 days)
<i>risperidone oral tablet 3 mg</i>	T2	QL (93 EA per 31 days)
<i>risperidone oral tablet 4 mg</i>	T2	QL (124 EA per 31 days)
<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T4	QL (31 EA per 31 days)
<i>risperidone oral tablet,disintegrating 3 mg</i>	T4	QL (93 EA per 31 days)
<i>risperidone oral tablet,disintegrating 4 mg</i>	T4	QL (124 EA per 31 days)
<i>rivastigmine</i>	T4	QL (30 EA per 30 days)
<i>rivastigmine tartrate</i>	T3	
<i>rizatriptan oral tablet 10 mg</i>	T2	QL (12 EA per 28 days)
<i>rizatriptan oral tablet 5 mg</i>	T2	QL (24 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 10 mg</i>	T2	QL (12 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>rizatriptan oral tablet,disintegrating 5 mg</i>	T2	QL (24 EA per 28 days)
<i>ropinirole oral tablet</i>	T2	
<b>ROWEEPRA</b>	T2	
<i>rufinamide oral suspension</i>	T5	PA-NS
<i>rufinamide oral tablet 200 mg</i>	T4	PA-NS
<i>rufinamide oral tablet 400 mg</i>	T5	PA-NS
<b>RYTARY</b>	T3	ST
<b>SECUADO</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>selegiline hcl</i>	T2	
<i>sertraline oral concentrate</i>	T2	
<i>sertraline oral tablet</i>	T1	
<b>SKYCLARYS</b>	T5	PA; QL (93 EA per 31 days)
<i>sodium oxybate</i>	T5	PA; QL (540 ML per 30 days)
<b>SPRITAM ORAL TABLET FOR SUSPENSION 250 MG, 500 MG</b>	T4	
<b>SUBVENITE ORAL TABLET</b>	T2	
<i>sulindac</i>	T2	
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation</i>	T4	QL (8 EA per 28 days)
<i>sumatriptan nasal spray,non-aerosol 5 mg/actuation</i>	T4	QL (32 EA per 28 days)
<i>sumatriptan succinate oral tablet 100 mg</i>	T2	QL (9 EA per 28 days)
<i>sumatriptan succinate oral tablet 25 mg</i>	T2	QL (36 EA per 28 days)
<i>sumatriptan succinate oral tablet 50 mg</i>	T2	QL (18 EA per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous solution</i>	T4	QL (4 ML per 28 days)
<b>SYMPAZAN ORAL FILM 10 MG, 20 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>SYMPAZAN ORAL FILM 5 MG</b>	T4	PA-NS; QL (62 EA per 31 days)
<b>TASCENSO ODT</b>	T5	PA; QL (31 EA per 31 days)
<i>tasimelteon</i>	T5	PA; QL (31 EA per 31 days)
<i>teriflunomide</i>	T5	PA; QL (31 EA per 31 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>tetrabenazine oral tablet 25 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>thioridazine</i>	T2	
<i>thiothixene oral capsule 1 mg, 2 mg</i>	T2	
<i>thiothixene oral capsule 10 mg, 5 mg</i>	T3	
<i>tiagabine</i>	T4	
<i>tizanidine oral tablet</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>topiramate oral capsule, sprinkle 15 mg, 25 mg</i>	T2	
<i>topiramate oral solution</i>	T4	PA-NS; QL (496 ML per 31 days)
<i>topiramate oral tablet</i>	T2	
<i>tramadol oral tablet 50 mg</i>	T2	PA; QL (240 EA per 30 days)
<i>tramadol-acetaminophen</i>	T2	PA; QL (372 EA per 31 days)
<i>tranylcypromine</i>	T4	
<i>trazodone oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>trifluoperazine</i>	T2	
<i>trimipramine oral capsule 100 mg</i>	T4	PA-NS
<i>trimipramine oral capsule 25 mg, 50 mg</i>	T3	PA-NS
<b>TRINTELLIX</b>	T4	PA-NS
<b>UBRELVY ORAL TABLET 100 MG</b>	T5	PA; QL (17 EA per 28 days)
<b>UBRELVY ORAL TABLET 50 MG</b>	T5	PA; QL (34 EA per 28 days)
<i>valproic acid</i>	T2	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	T2	
<b>VALTOCO</b>	T5	PA-NS; QL (10 EA per 30 days)
<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg</i>	T2	QL (31 EA per 31 days)
<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	T2	QL (93 EA per 31 days)
<i>venlafaxine oral tablet</i>	T2	
<b>VERSACLOZ</b>	T5	QL (558 ML per 31 days)
<i>vigabatrin</i>	T5	PA-NS
<b>VIGADRONE</b>	T5	PA-NS
<i>vilazodone</i>	T3	PA-NS; QL (31 EA per 31 days)
<b>VIVITROL</b>	T5	
<b>VRAYLAR ORAL CAPSULE</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>VUMERITY</b>	T5	PA; QL (124 EA per 31 days)
<b>XCOPRI</b>	T5	PA-NS
<b>XCOPRI MAINTENANCE PACK</b>	T5	PA-NS
<b>XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)</b>	T4	PA-NS
<b>XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)</b>	T5	PA-NS
<i>zaleplon oral capsule 10 mg</i>	T4	PA; QL (62 EA per 31 days)
<i>zaleplon oral capsule 5 mg</i>	T4	PA; QL (93 EA per 31 days)
<b>ZAVZPRET</b>	T5	PA; QL (8 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ZEPOSIA</b>	T5	PA; QL (31 EA per 31 days)
<b>ZEPOSIA STARTER KIT (28-DAY)</b>	T5	PA; QL (56 EA per 365 days)
<b>ZEPOSIA STARTER PACK (7-DAY)</b>	T5	PA; QL (14 EA per 365 days)
<b>ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML</b>	T5	PA; QL (11.648 ML per 28 days)
<b>ZILBRYSQ SUBCUTANEOUS SYRINGE 23 MG/0.574 ML</b>	T5	PA; QL (16.072 ML per 28 days)
<b>ZILBRYSQ SUBCUTANEOUS SYRINGE 32.4 MG/0.81 ML</b>	T5	PA; QL (22.68 ML per 28 days)
<i>ziprasidone hcl</i>	T3	QL (62 EA per 31 days)
<i>ziprasidone mesylate</i>	T4	
<i>zolpidem oral tablet</i>	T2	PA; QL (31 EA per 31 days)
<b>ZONISADE</b>	T5	PA-NS; QL (930 ML per 31 days)
<i>zonisamide</i>	T2	
<b>ZTALMY</b>	T5	PA-NS; QL (1100 ML per 30 days)
<b>ZUBSOLV</b>	T3	
<b>ZURZUVAE ORAL CAPSULE 20 MG, 25 MG</b>	T5	PA-NS; QL (28 EA per 180 days)
<b>ZURZUVAE ORAL CAPSULE 30 MG</b>	T5	PA-NS; QL (14 EA per 180 days)
<b>Cardiovascular, Hypertension / Lipids</b>		
<i>acebutolol</i>	T2	
<i>aliskiren</i>	T4	
<i>amiloride</i>	T2	
<i>amiloride-hydrochlorothiazide</i>	T2	
<i>amiodarone oral</i>	T2	
<i>amlodipine</i>	T1	
<i>amlodipine-benazepril</i>	T1	
<i>amlodipine-olmesartan</i>	T2	QL (31 EA per 31 days)
<i>amlodipine-valsartan</i>	T2	
<i>aspirin-dipyridamole</i>	T4	
<i>atenolol</i>	T1	
<i>atenolol-chlorthalidone</i>	T2	
<i>atorvastatin</i>	T1	
<b>ATTRUBY</b>	T5	PA; QL (124 EA per 31 days)
<i>benazepril</i>	T1	
<i>benazepril-hydrochlorothiazide</i>	T1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T2	
<i>bisoprolol-hydrochlorothiazide</i>	T1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>bumetanide oral</i>	T2	
<i>candesartan</i>	T2	
<i>candesartan-hydrochlorothiazid</i>	T2	
<i>captopril</i>	T1	
<b>CARTIA XT</b>	T2	
<i>carvedilol</i>	T1	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>cholestyramine (with sugar) oral powder in packet</i>	T2	
<b>CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET</b>	T2	
<i>cilostazol</i>	T2	
<i>clonidine</i>	T4	
<i>clonidine hcl oral tablet</i>	T1	
<i>clopidogrel oral tablet 75 mg</i>	T1	
<i>colesevelam</i>	T4	
<i>colestipol oral packet</i>	T4	
<i>colestipol oral tablet</i>	T3	
<b>CORLANOR ORAL SOLUTION</b>	T4	PA; QL (420 ML per 28 days)
<i>dabigatran etexilate oral capsule 110 mg</i>	T4	QL (124 EA per 31 days)
<i>dabigatran etexilate oral capsule 150 mg, 75 mg</i>	T4	QL (62 EA per 31 days)
<i>digoxin oral solution</i>	T3	QL (155 ML per 31 days)
<i>digoxin oral tablet 125 mcg (0.125 mg)</i>	T1	QL (62 EA per 31 days)
<i>digoxin oral tablet 250 mcg (0.25 mg)</i>	T2	QL (31 EA per 31 days)
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	T2	
<i>diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg</i>	T2	
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	T2	
<i>diltiazem hcl oral tablet</i>	T2	
<i>diltiazem hcl oral tablet extended release 24 hr</i>	T2	
<b>DILT-XR</b>	T2	
<i>dofetilide</i>	T4	
<i>doxazosin</i>	T2	
<b>ELIQUIS DVT-PE TREAT 30D START</b>	T3	QL (74 EA per 30 days)
<b>ELIQUIS ORAL TABLET 2.5 MG</b>	T3	QL (60 EA per 30 days)
<b>ELIQUIS ORAL TABLET 5 MG</b>	T3	QL (74 EA per 30 days)
<i>eltrombopag olamine oral powder in packet 12.5 mg</i>	T5	PA; QL (372 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>eltrombopag olamine oral powder in packet 25 mg</i>	T5	PA; QL (31 EA per 31 days)
<i>eltrombopag olamine oral tablet 12.5 mg, 25 mg</i>	T5	PA; QL (31 EA per 31 days)
<i>eltrombopag olamine oral tablet 50 mg, 75 mg</i>	T5	PA; QL (62 EA per 31 days)
<i>enalapril maleate oral tablet</i>	T1	
<i>enalapril-hydrochlorothiazide</i>	T1	
<i>enoxaparin subcutaneous syringe</i>	T4	
<b>ENTRESTO ORAL TABLET 24-26 MG</b>	T4	ST; QL (186 EA per 31 days)
<b>ENTRESTO ORAL TABLET 49-51 MG</b>	T4	ST; QL (93 EA per 31 days)
<b>ENTRESTO ORAL TABLET 97-103 MG</b>	T4	ST; QL (62 EA per 31 days)
<b>ENTRESTO SPRINKLE</b>	T3	PA; QL (248 EA per 31 days)
<i>eplerenone</i>	T4	
<i>ethacrynic acid</i>	T4	
<i>ezetimibe</i>	T2	
<i>ezetimibe-simvastatin</i>	T3	QL (31 EA per 31 days)
<i>felodipine</i>	T2	
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg</i>	T2	
<i>fenofibrate nanocrystallized</i>	T2	
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	T2	
<i>flecainide</i>	T2	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	T5	
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	T4	
<i>fosinopril</i>	T1	
<i>fosinopril-hydrochlorothiazide</i>	T1	
<i>furosemide injection solution</i>	T2	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	T2	
<i>furosemide oral tablet</i>	T1	
<i>gemfibrozil</i>	T1	
<i>heparin (porcine) injection solution</i>	T3	PA-BvD
<i>hydralazine oral</i>	T1	
<i>hydrochlorothiazide</i>	T1	
<i>icosapent ethyl oral capsule 0.5 gram</i>	T4	QL (248 EA per 31 days)
<i>icosapent ethyl oral capsule 1 gram</i>	T4	QL (124 EA per 31 days)
<i>indapamide</i>	T1	
<i>irbesartan</i>	T1	QL (31 EA per 31 days)
<i>irbesartan-hydrochlorothiazide</i>	T1	QL (31 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	T2	
<i>isosorbide mononitrate</i>	T2	
<i>isradipine</i>	T4	
<i>ivabradine oral tablet 5 mg</i>	T4	PA; QL (93 EA per 31 days)
<i>ivabradine oral tablet 7.5 mg</i>	T4	PA; QL (62 EA per 31 days)
<b>JANTOVEN</b>	T1	
<b>KERENDIA</b>	T4	PA; QL (31 EA per 31 days)
<i>labetalol oral tablet 100 mg, 200 mg, 300 mg</i>	T2	
<i>lisinopril</i>	T1	
<i>lisinopril-hydrochlorothiazide</i>	T1	
<i>losartan oral tablet 100 mg</i>	T1	QL (31 EA per 31 days)
<i>losartan oral tablet 25 mg</i>	T1	QL (93 EA per 31 days)
<i>losartan oral tablet 50 mg</i>	T1	QL (62 EA per 31 days)
<i>losartan-hydrochlorothiazide</i>	T1	
<i>lovastatin</i>	T1	
<i>metolazone</i>	T2	
<i>metoprolol succinate</i>	T2	
<i>metoprolol ta-hydrochlorothiaz</i>	T2	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 37.5 mg, 75 mg</i>	T2	
<i>metyrosine</i>	T5	PA
<i>mexiletine</i>	T3	
<i>minoxidil oral</i>	T2	
<i>moexipril</i>	T1	
<b>MULPLETA</b>	T5	PA
<b>MULTAQ</b>	T4	
<i>nadolol</i>	T4	
<i>nebivolol oral tablet 10 mg, 2.5 mg</i>	T2	QL (93 EA per 31 days)
<i>nebivolol oral tablet 20 mg</i>	T2	QL (62 EA per 31 days)
<i>nebivolol oral tablet 5 mg</i>	T2	QL (217 EA per 31 days)
<b>NEXLETOL</b>	T4	PA; QL (31 EA per 31 days)
<b>NEXLIZET</b>	T4	PA; QL (31 EA per 31 days)
<i>niacin oral tablet extended release 24 hr 1,000 mg, 750 mg</i>	T4	
<i>niacin oral tablet extended release 24 hr 500 mg</i>	T4	QL (31 EA per 31 days)
<i>nicardipine oral</i>	T4	
<i>nifedipine oral tablet extended release</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nifedipine oral tablet extended release 24hr</i>	T2	
<i>nimodipine oral capsule</i>	T4	
<b>NITRO-BID</b>	T2	
<i>nitroglycerin sublingual</i>	T2	
<i>nitroglycerin transdermal patch 24 hour</i>	T2	
<i>nitroglycerin translingual</i>	T4	
<i>olmesartan oral tablet 20 mg, 40 mg</i>	T1	QL (31 EA per 31 days)
<i>olmesartan oral tablet 5 mg</i>	T1	QL (93 EA per 31 days)
<i>olmesartan-amlodipin-hcthiazid</i>	T3	
<i>olmesartan-hydrochlorothiazide</i>	T1	QL (31 EA per 31 days)
<i>omega-3 acid ethyl esters</i>	T3	QL (124 EA per 31 days)
<b>PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG</b>	T2	
<i>pentoxifylline</i>	T2	
<i>perindopril erbumine</i>	T2	
<i>pindolol</i>	T4	
<i>pitavastatin calcium</i>	T3	
<i>prasugrel hcl</i>	T3	
<i>pravastatin</i>	T1	
<i>prazosin</i>	T2	
<b>PREVALITE ORAL POWDER IN PACKET</b>	T4	
<i>propafenone oral capsule,extended release 12 hr</i>	T4	
<i>propafenone oral tablet</i>	T2	
<i>propranolol oral capsule,extended release 24 hr</i>	T2	
<i>propranolol oral tablet</i>	T2	
<i>quinapril</i>	T1	
<i>quinapril-hydrochlorothiazide</i>	T1	
<i>quinidine sulfate oral tablet</i>	T2	
<i>ramipril</i>	T1	
<i>ranolazine</i>	T4	QL (62 EA per 31 days)
<b>REPATHA SURECLICK</b>	T3	PA; QL (3 ML per 28 days)
<b>REPATHA SYRINGE</b>	T3	PA; QL (3 ML per 28 days)
<i>rosuvastatin</i>	T1	
<i>sacubitril-valsartan oral tablet 24-26 mg</i>	T2	QL (186 EA per 31 days)
<i>sacubitril-valsartan oral tablet 49-51 mg</i>	T2	QL (93 EA per 31 days)
<i>sacubitril-valsartan oral tablet 97-103 mg</i>	T2	QL (62 EA per 31 days)
<i>simvastatin</i>	T1	
<b>SOTALOL AF</b>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sotalol oral</i>	T2	
<i>spironolactone oral tablet</i>	T1	
<i>spironolacton-hydrochlorothiaz</i>	T2	
<i>telmisartan</i>	T1	
<i>telmisartan-amlodipine</i>	T2	
<i>telmisartan-hydrochlorothiazid</i>	T1	
<i>terazosin</i>	T1	
<b>TIADYLT ER</b>	T2	
<i>ticagrelor</i>	T2	
<i>timolol maleate oral</i>	T3	
<i>torseamide oral</i>	T1	
<i>trandolapril</i>	T1	
<i>triamterene-hydrochlorothiazid</i>	T1	
<b>UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG</b>	T5	PA; QL (62 EA per 31 days)
<b>UPTRAVI ORAL TABLET 200 MCG</b>	T5	PA; QL (224 EA per 28 days)
<b>UPTRAVI ORAL TABLETS,DOSE PACK</b>	T5	PA; QL (400 EA per 365 days)
<i>valsartan oral tablet 160 mg, 40 mg, 80 mg</i>	T1	QL (62 EA per 31 days)
<i>valsartan oral tablet 320 mg</i>	T1	QL (31 EA per 31 days)
<i>valsartan-hydrochlorothiazide</i>	T1	QL (31 EA per 31 days)
<i>verapamil oral capsule, 24 hr er pellet ct</i>	T4	
<i>verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg</i>	T2	
<i>verapamil oral capsule,ext rel. pellets 24 hr 360 mg</i>	T4	
<i>verapamil oral tablet</i>	T2	
<i>verapamil oral tablet extended release</i>	T2	
<b>VERQUVO</b>	T4	PA; QL (31 EA per 31 days)
<i>warfarin</i>	T1	
<b>XARELTO DVT-PE TREAT 30D START</b>	T3	QL (51 EA per 30 days)
<b>XARELTO ORAL SUSPENSION FOR RECONSTITUTION</b>	T3	QL (930 ML per 31 days)
<b>XARELTO ORAL TABLET 10 MG, 20 MG</b>	T3	QL (31 EA per 31 days)
<b>XARELTO ORAL TABLET 15 MG</b>	T3	QL (52 EA per 31 days)
<b>XARELTO ORAL TABLET 2.5 MG</b>	T3	QL (62 EA per 31 days)
<b>Dermatologicals/Topical Therapy</b>		
<b>AC CUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG</b>	T4	
<i>acitretin</i>	T4	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>acyclovir topical ointment</i>	T3	QL (30 GM per 30 days)
<b>ALA-CORT TOPICAL CREAM</b>	T1	
<i>alclometasone</i>	T2	
<i>ammonium lactate</i>	T2	
<b>AMNESTEEM</b>	T4	
<b>ANZUPGO</b>	T5	PA; QL (60 GM per 30 days)
<i>betamethasone dipropionate topical cream</i>	T2	
<i>betamethasone dipropionate topical lotion</i>	T2	
<i>betamethasone valerate topical cream</i>	T2	
<i>betamethasone valerate topical lotion</i>	T3	
<i>betamethasone valerate topical ointment</i>	T2	
<i>betamethasone, augmented topical cream</i>	T2	
<i>betamethasone, augmented topical gel</i>	T4	
<i>betamethasone, augmented topical lotion</i>	T4	
<i>betamethasone, augmented topical ointment</i>	T3	
<i>calcipotriene scalp</i>	T3	QL (60 ML per 28 days)
<i>calcipotriene topical cream</i>	T4	QL (60 GM per 28 days)
<i>calcipotriene topical ointment</i>	T3	QL (60 GM per 28 days)
<i>ciclopirox topical cream</i>	T2	QL (90 GM per 28 days)
<i>ciclopirox topical gel</i>	T3	QL (45 GM per 28 days)
<i>ciclopirox topical shampoo</i>	T3	QL (120 ML per 28 days)
<i>ciclopirox topical solution</i>	T2	
<i>ciclopirox topical suspension</i>	T3	QL (60 ML per 28 days)
<b>CLARAVIS</b>	T4	
<i>clindamycin phosphate topical gel</i>	T2	QL (60 GM per 28 days)
<i>clindamycin phosphate topical lotion</i>	T2	QL (60 ML per 28 days)
<i>clindamycin phosphate topical solution</i>	T2	QL (60 ML per 28 days)
<i>clindamycin phosphate topical swab</i>	T2	
<i>clindamycin-benzoyl peroxide topical gel 1.2 % (1 % base) -5 %</i>	T2	
<i>clotrimazole topical cream</i>	T2	QL (45 GM per 28 days)
<i>clotrimazole topical solution</i>	T3	QL (30 ML per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	T2	QL (45 GM per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	T3	QL (60 ML per 28 days)
<b>COSENTYX (2 SYRINGES)</b>	T5	PA; QL (2 ML per 28 days)
<b>COSENTYX PEN (2 PENS)</b>	T5	PA; QL (2 ML per 28 days)
<b>COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 28 days)
<b>COSENTYX UNOREADY PEN</b>	T5	PA; QL (2 ML per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>desoximetasone topical cream</i>	T4	QL (100 GM per 28 days)
<i>desoximetasone topical gel</i>	T4	QL (60 GM per 28 days)
<i>diclofenac sodium topical gel 3 %</i>	T4	PA; QL (100 GM per 28 days)
<b>DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML</b>	T5	PA; QL (2.28 ML per 28 days)
<b>DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML</b>	T5	PA; QL (8 ML per 28 days)
<b>DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML</b>	T5	PA; QL (2.28 ML per 28 days)
<b>DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML</b>	T5	PA; QL (8 ML per 28 days)
<b>ERY PADS</b>	T3	
<i>erythromycin with ethanol topical gel</i>	T2	QL (60 GM per 28 days)
<i>erythromycin with ethanol topical solution</i>	T2	QL (60 ML per 28 days)
<b>FILSUEVZ</b>	T5	PA
<i>fluocinolone and shower cap</i>	T4	QL (118.28 ML per 28 days)
<i>fluocinolone topical cream 0.01 %</i>	T3	QL (60 GM per 28 days)
<i>fluocinolone topical cream 0.025 %</i>	T3	QL (120 GM per 28 days)
<i>fluocinolone topical ointment</i>	T3	QL (120 GM per 28 days)
<i>fluocinolone topical solution</i>	T3	QL (90 ML per 28 days)
<i>fluocinonide topical cream 0.05 %</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical gel</i>	T3	QL (60 GM per 28 days)
<i>fluocinonide topical ointment</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical solution</i>	T2	QL (60 ML per 28 days)
<i>fluocinonide-emollient</i>	T4	QL (60 GM per 28 days)
<i>fluorouracil topical cream 5 %</i>	T3	
<i>fluorouracil topical solution 2 %</i>	T2	
<i>fluorouracil topical solution 5 %</i>	T3	
<i>fluticasone propionate topical cream</i>	T2	
<i>gentamicin topical</i>	T3	QL (60 GM per 28 days)
<i>halobetasol propionate topical cream</i>	T4	QL (50 GM per 28 days)
<i>halobetasol propionate topical ointment</i>	T4	QL (50 GM per 28 days)
<i>hydrocortisone topical cream 1 %</i>	T1	
<i>hydrocortisone topical lotion 2.5 %</i>	T2	QL (118 ML per 28 days)
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	T1	
<i>imiquimod topical cream in packet 5 %</i>	T2	
<i>ketoconazole topical cream</i>	T2	QL (60 GM per 28 days)
<i>ketoconazole topical shampoo</i>	T2	QL (120 ML per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	T2	PA; QL (50 ML per 28 days)
<i>lidocaine topical adhesive patch,medicated 5 %</i>	T4	PA; QL (93 EA per 31 days)
<i>lidocaine topical ointment</i>	T4	PA; QL (50 GM per 28 days)
<b>LIDOCAINE VISCOUS</b>	T2	
<i>lidocaine-prilocaine topical cream</i>	T2	PA; QL (30 GM per 28 days)
<i>malathion</i>	T4	
<i>metronidazole topical cream</i>	T3	
<i>metronidazole topical gel 0.75 %</i>	T3	
<i>metronidazole topical gel 1 %</i>	T4	
<i>metronidazole topical lotion</i>	T4	
<i>mometasone topical</i>	T2	
<i>mupirocin</i>	T2	
<b>NYAMYC</b>	T2	QL (60 GM per 28 days)
<i>nystatin topical cream</i>	T2	QL (30 GM per 28 days)
<i>nystatin topical ointment</i>	T2	QL (30 GM per 28 days)
<i>nystatin topical powder</i>	T2	QL (60 GM per 28 days)
<b>NYSTOP</b>	T2	QL (60 GM per 28 days)
<b>PANRETIN</b>	T5	PA-NS
<i>penciclovir</i>	T4	QL (5 GM per 28 days)
<i>permethrin</i>	T2	
<i>podofilox topical solution</i>	T4	
<i>selenium sulfide topical lotion</i>	T1	
<b>SILIQ</b>	T5	PA; QL (6 ML per 28 days)
<i>silver sulfadiazine</i>	T1	
<b>SKYRIZI SUBCUTANEOUS PEN INJECTOR</b>	T5	PA; QL (1 ML per 84 days)
<b>SKYRIZI SUBCUTANEOUS SYRINGE</b>	T5	PA; QL (1 ML per 84 days)
<b>SSD</b>	T4	
<b>STELARA SUBCUTANEOUS SOLUTION</b>	T5	PA; QL (0.5 ML per 84 days)
<b>STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 84 days)
<b>STELARA SUBCUTANEOUS SYRINGE 90 MG/ML</b>	T5	PA; QL (1 ML per 56 days)
<b>STEQEYMA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML</b>	T3	PA; QL (0.5 ML per 84 days)
<b>STEQEYMA SUBCUTANEOUS SYRINGE 90 MG/ML</b>	T5	PA; QL (1 ML per 56 days)
<i>sulfacetamide sodium (acne)</i>	T2	
<b>SULFAMYLON TOPICAL CREAM</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tacrolimus topical</i>	T4	QL (100 GM per 28 days)
<i>tazarotene topical cream</i>	T4	PA; QL (60 GM per 28 days)
<i>tretinoin topical cream</i>	T2	PA; QL (45 GM per 28 days)
<i>tretinoin topical gel 0.01 %, 0.025 %</i>	T4	PA; QL (45 GM per 28 days)
<i>triamcinolone acetonide topical cream</i>	T2	
<i>triamcinolone acetonide topical lotion</i>	T2	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	T2	
<b>TRIDERM TOPICAL CREAM 0.5 %</b>	T4	
<i>ustekinumab subcutaneous solution</i>	T5	PA; QL (0.5 ML per 84 days)
<i>ustekinumab subcutaneous syringe 45 mg/0.5 ml</i>	T5	PA; QL (0.5 ML per 84 days)
<i>ustekinumab subcutaneous syringe 90 mg/ml</i>	T5	PA; QL (1 ML per 56 days)
<b>VALCHLOR</b>	T5	PA-NS
<b>YESINTEK SUBCUTANEOUS SOLUTION</b>	T3	PA; QL (0.5 ML per 84 days)
<b>YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML</b>	T3	PA; QL (0.5 ML per 84 days)
<b>YESINTEK SUBCUTANEOUS SYRINGE 90 MG/ML</b>	T5	PA; QL (1 ML per 56 days)
<b>ZELSUVMI</b>	T5	PA; QL (31 GM per 28 days)
<b>ZORYVE TOPICAL CREAM 0.15 %</b>	T4	PA; QL (60 GM per 28 days)
<b>Diagnostics / Miscellaneous Agents</b>		
<i>acamprosate</i>	T4	
<i>anagrelide</i>	T4	
<i>bupropion hcl (smoking deter)</i>	T2	QL (62 EA per 31 days)
<i>carglumic acid</i>	T5	PA
<b>CHEMET</b>	T4	
<b>CLINIMIX 4.25%/D5W SULFIT FREE</b>	T4	PA-BvD
<i>d10 %-0.45 % sodium chloride</i>	T2	
<i>d2.5 %-0.45 % sodium chloride</i>	T2	
<i>d5 % and 0.9 % sodium chloride</i>	T2	
<i>d5 %-0.45 % sodium chloride</i>	T2	
<i>deferasirox oral tablet, dispersible 125 mg</i>	T4	PA
<i>deferasirox oral tablet, dispersible 250 mg, 500 mg</i>	T5	PA
<i>dextrose 10 % in water (d10w)</i>	T2	
<i>dextrose 5 % in water (d5w) intravenous parenteral solution</i>	T2	
<i>disulfiram</i>	T3	
<i>droxidopa oral capsule 100 mg</i>	T5	PA; QL (465 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>droxidopa oral capsule 200 mg, 300 mg</i>	T5	PA; QL (186 EA per 31 days)
<b>DUVYZAT</b>	T5	PA; QL (420 ML per 35 days)
<b>FABHALTA</b>	T5	PA; QL (62 EA per 31 days)
<i>glycerol phenylbutyrate</i>	T5	PA
<b>INCRELEX</b>	T5	PA
<b>JOENJA</b>	T5	PA; QL (60 EA per 30 days)
<b>KIONEX ORAL SUSPENSION</b>	T2	
<i>levocarnitine (with sugar)</i>	T4	PA-BvD
<i>levocarnitine oral tablet</i>	T4	PA-BvD
<b>LITFULO</b>	T5	PA; QL (28 EA per 28 days)
<b>LOKELMA</b>	T3	PA; QL (93 EA per 31 days)
<i>midodrine</i>	T2	
<b>NICOTROL NS</b>	T4	
<i>nitisinone</i>	T5	PA
<b>PHEBURANE</b>	T5	PA; QL (620 GM per 31 days)
<i>pilocarpine hcl oral</i>	T3	
<b>PROLASTIN-C INTRAVENOUS SOLUTION</b>	T5	PA
<b>REVCOVI</b>	T5	
<b>REZDIFFRA</b>	T5	PA; QL (31 EA per 31 days)
<i>riluzole</i>	T4	
<i>risedronate oral tablet 30 mg</i>	T5	
<i>sevelamer carbonate oral powder in packet</i>	T4	PA-BvD
<i>sevelamer carbonate oral tablet</i>	T3	PA-BvD
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	T2	
<i>sodium chloride irrigation</i>	T2	
<i>sodium phenylbutyrate</i>	T5	PA
<i>sodium polystyrene sulfonate</i>	T2	
<b>SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 2.5 MG, 5 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>SOHONOS ORAL CAPSULE 10 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>SPS (WITH SORBITOL) ORAL</b>	T2	
<i>trientine oral capsule 250 mg</i>	T5	QL (248 EA per 31 days)
<i>varenicline tartrate oral tablet</i>	T4	QL (60 EA per 30 days)
<i>varenicline tartrate oral tablets,dose pack</i>	T4	QL (106 EA per 365 days)
<b>ZOKINVY</b>	T5	PA
<b>Ear, Nose / Throat Medications</b>		
<i>acetic acid otic (ear)</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>azelastine nasal spray,non-aerosol 137 mcg (0.1 %)</i>	T2	QL (30 ML per 25 days)
<i>chlorhexidine gluconate mucous membrane</i>	T1	
<i>ciprofloxacin-dexamethasone</i>	T4	
<i>fluocinolone acetonide oil</i>	T4	
<i>ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)</i>	T2	QL (30 ML per 28 days)
<i>ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)</i>	T2	QL (15 ML per 28 days)
<b>KOURZEQ</b>	T2	
<i>neomycin-polymyxin-hc otic (ear)</i>	T3	
<i>ofloxacin otic (ear)</i>	T2	
<i>olopatadine nasal</i>	T3	QL (30.5 GM per 30 days)
<b>PERIOGARD</b>	T1	
<i>triamcinolone acetonide dental</i>	T2	
<b>Endocrine/Diabetes</b>		
<i>acarbose</i>	T2	QL (93 EA per 31 days)
<b>ALCOHOL PADS</b>	T2	PA
<i>cabergoline</i>	T3	
<i>calcitonin (salmon) nasal</i>	T3	PA-BvD
<i>calcitriol oral capsule</i>	T2	PA-BvD
<i>calcitriol oral solution</i>	T4	PA-BvD
<b>CERDELGA</b>	T5	PA; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	T4	PA-BvD; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 90 mg</i>	T4	PA-BvD; QL (124 EA per 31 days)
<i>danazol</i>	T4	
<i>dapagliflozin propanediol</i>	T3	QL (31 EA per 31 days)
<i>desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)</i>	T4	
<i>desmopressin oral</i>	T2	
<i>dexamethasone oral solution</i>	T2	
<i>dexamethasone oral tablet</i>	T1	
<i>diazoxide</i>	T4	
<i>doxercalciferol oral</i>	T4	PA-BvD
<b>FARXIGA</b>	T3	QL (31 EA per 31 days)
<b>FIASP FLEXTOUCH U-100 INSULIN</b>	T3	
<b>FIASP PENFILL U-100 INSULIN</b>	T3	
<b>FIASP U-100 INSULIN</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fludrocortisone</i>	T2	
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	T1	
<i>glipizide oral tablet 10 mg, 5 mg</i>	T1	
<i>glipizide oral tablet extended release 24hr</i>	T1	
<i>glipizide-metformin</i>	T1	
<b>GLUCAGON EMERGENCY KIT (HUMAN)</b>	T3	
<i>glyburide</i>	T2	
<i>glyburide micronized</i>	T2	
<i>glyburide-metformin</i>	T2	
<b>GLYXAMBI</b>	T3	QL (31 EA per 31 days)
<b>GVOKE</b>	T3	
<b>GVOKE HYPOPEN 2-PACK</b>	T3	
<b>GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML</b>	T3	
<b>HUMALOG JUNIOR KWIKPEN U-100</b>	T3	
<b>HUMALOG KWIKPEN INSULIN</b>	T3	
<b>HUMALOG MIX 50-50 KWIKPEN</b>	T3	
<b>HUMALOG MIX 75-25 KWIKPEN</b>	T3	
<b>HUMALOG MIX 75-25(U-100)INSULN</b>	T3	
<b>HUMALOG U-100 INSULIN</b>	T3	
<b>HUMULIN 70/30 U-100 INSULIN</b>	T3	
<b>HUMULIN 70/30 U-100 KWIKPEN</b>	T3	
<b>HUMULIN N NPH INSULIN KWIKPEN</b>	T3	
<b>HUMULIN N NPH U-100 INSULIN</b>	T3	
<b>HUMULIN R REGULAR U-100 INSULN</b>	T3	
<b>HUMULIN R U-500 (CONC) INSULIN</b>	T3	
<b>HUMULIN R U-500 (CONC) KWIKPEN</b>	T3	
<i>hydrocortisone oral</i>	T1	
<i>insulin lispro</i>	T3	
<i>insulin lispro protamin-lispro</i>	T3	
<b>JANUMET</b>	T3	QL (62 EA per 31 days)
<b>JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG</b>	T3	QL (31 EA per 31 days)
<b>JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG</b>	T3	QL (62 EA per 31 days)
<b>JANUVIA ORAL TABLET 100 MG, 50 MG</b>	T3	QL (31 EA per 31 days)
<b>JANUVIA ORAL TABLET 25 MG</b>	T3	QL (93 EA per 31 days)
<b>JARDIANCE ORAL TABLET 10 MG</b>	T3	QL (62 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>JARDIANCE ORAL TABLET 25 MG</b>	T3	QL (31 EA per 31 days)
<b>JAVYGTOR</b>	T5	PA
<b>JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG</b>	T3	QL (62 EA per 31 days)
<b>JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG</b>	T3	QL (62 EA per 31 days)
<b>JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG</b>	T3	QL (31 EA per 31 days)
<b>LANTUS SOLOSTAR U-100 INSULIN</b>	T3	
<b>LANTUS U-100 INSULIN</b>	T3	
<i>levothyroxine oral tablet</i>	T1	
<b>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</b>	T3	
<b>LIOMNY</b>	T2	
<i>liothyronine oral</i>	T2	
<i>liraglutide</i>	T4	PA; QL (9 ML per 30 days)
<i>metformin oral tablet 1,000 mg, 500 mg, 850 mg</i>	T1	
<i>metformin oral tablet extended release 24 hr</i>	T1	
<i>metformin oral tablet extended release 24hr</i>	NF	
<i>metformin oral tablet,er gast.retention 24 hr</i>	NF	
<i>methimazole oral tablet 10 mg, 5 mg</i>	T2	
<i>methylprednisolone</i>	T2	
<i>mifepristone oral tablet 300 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>miglustat</i>	T5	PA; QL (93 EA per 31 days)
<b>MOUNJARO</b>	T3	PA; QL (2 ML per 28 days)
<i>nateglinide</i>	T1	QL (93 EA per 31 days)
<b>NOVOLIN 70/30 U-100 INSULIN</b>	T3	
<b>NOVOLIN 70-30 FLEXPEN U-100</b>	T3	
<b>NOVOLIN N FLEXPEN</b>	T3	
<b>NOVOLIN N NPH U-100 INSULIN</b>	T3	
<b>NOVOLIN R FLEXPEN</b>	T3	
<b>NOVOLIN R REGULAR U100 INSULIN</b>	T3	
<b>NOVOLOG FLEXPEN U-100 INSULIN</b>	T3	
<b>NOVOLOG MIX 70-30 U-100 INSULN</b>	T3	
<b>NOVOLOG MIX 70-30FLEXPEN U-100</b>	T3	
<b>NOVOLOG PENFILL U-100 INSULIN</b>	T3	
<b>NOVOLOG U-100 INSULIN ASPART</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>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)</b>	T3	PA; QL (3 ML per 28 days)
<i>paricalcitol oral</i>	T4	PA-BvD
<i>pioglitazone</i>	T1	QL (31 EA per 31 days)
<i>pioglitazone-metformin</i>	T2	QL (93 EA per 31 days)
<i>prednisolone oral solution</i>	T2	
<i>prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	T2	
<i>prednisone oral solution</i>	T3	
<i>prednisone oral tablet</i>	T1	
<i>prednisone oral tablets,dose pack</i>	T2	
<i>propylthiouracil</i>	T2	
<b>RECORLEV</b>	T5	
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	T2	QL (124 EA per 31 days)
<i>repaglinide oral tablet 2 mg</i>	T2	QL (248 EA per 31 days)
<b>RYBELSUS</b>	T3	PA; QL (31 EA per 31 days)
<i>sapropterin</i>	T5	PA
<b>SOLQUA 100/33</b>	T3	QL (18 ML per 30 days)
<b>SOMAVERT</b>	T5	PA
<b>SYNAREL</b>	T5	PA
<b>SYNJARDY</b>	T3	QL (62 EA per 31 days)
<b>SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG</b>	T3	QL (62 EA per 31 days)
<b>SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG</b>	T3	QL (31 EA per 31 days)
<b>SYNTHROID</b>	T3	
<i>testosterone cypionate</i>	T2	PA
<i>testosterone enanthate</i>	T3	PA
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	T4	PA
<i>tolvaptan</i>	T5	PA
<i>tolvaptan (polycys kidney dis) oral tablet</i>	T5	PA; QL (112 EA per 28 days)
<i>tolvaptan (polycys kidney dis) oral tablets, sequential</i>	T5	PA; QL (56 EA per 28 days)
<b>TOUJEO MAX U-300 SOLOSTAR</b>	T3	
<b>TOUJEO SOLOSTAR U-300 INSULIN</b>	T3	
<b>TRADJENTA</b>	T3	QL (31 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG</b>	T3	QL (31 EA per 31 days)
<b>TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG</b>	T3	QL (62 EA per 31 days)
<b>TRULICITY</b>	T3	PA; QL (2 ML per 28 days)
<b>UNITHROID</b>	T3	
<b>XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 5-500 MG</b>	T3	QL (31 EA per 31 days)
<b>XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG</b>	T3	QL (62 EA per 31 days)
<b>XULTOPHY 100/3.6</b>	T3	QL (15 ML per 30 days)
<b>YARGESA</b>	T5	PA; QL (93 EA per 31 days)
<b>YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML</b>	T5	PA; QL (1.12 ML per 28 days)
<b>YORVIPATH SUBCUTANEOUS PEN INJECTOR 294 MCG/0.98 ML</b>	T5	PA; QL (1.96 ML per 28 days)
<b>YORVIPATH SUBCUTANEOUS PEN INJECTOR 420 MCG/1.4 ML</b>	T5	PA; QL (2.8 ML per 28 days)
<b>Gastroenterology</b>		
<i>alosetron oral tablet 0.5 mg</i>	T4	PA; QL (93 EA per 31 days)
<i>alosetron oral tablet 1 mg</i>	T5	PA; QL (62 EA per 31 days)
<i>aprepitant oral capsule 125 mg</i>	T5	PA-BvD
<i>aprepitant oral capsule 40 mg, 80 mg</i>	T4	PA-BvD
<i>aprepitant oral capsule, dose pack</i>	T4	PA-BvD
<i>balsalazide</i>	T4	
<i>betaine</i>	T5	
<i>budesonide oral capsule, delayed, extend. release</i>	T4	
<i>budesonide oral tablet, delayed and ext. release</i>	T5	
<b>COMPRO</b>	T4	
<b>CONSTULOSE</b>	T2	
<b>CREON</b>	T3	
<i>cromolyn oral</i>	T4	
<i>dicyclomine oral capsule</i>	T2	
<i>dicyclomine oral solution</i>	T2	
<i>dicyclomine oral tablet 20 mg</i>	T2	
<i>diphenoxylate-atropine oral liquid</i>	T4	
<i>diphenoxylate-atropine oral tablet</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dronabinol</i>	T4	PA-BvD
<b>ENULOSE</b>	T2	
<b>EOHILIA</b>	T5	PA; QL (1800 ML per 365 days)
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec)</i>	T2	QL (31 EA per 31 days)
<i>famotidine oral suspension for reconstitution</i>	T2	
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
<b>GATTEX 30-VIAL</b>	T5	PA
<b>GAVILYTE-C</b>	T1	
<b>GAVILYTE-G</b>	T1	
<b>GAVILYTE-N</b>	T1	
<b>GENERLAC</b>	T2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T2	
<i>granisetron hcl oral</i>	T4	PA-BvD
<i>hydrocortisone rectal</i>	T4	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	T1	
<i>lactulose oral solution</i>	T2	
<b>LINZESS</b>	T3	QL (31 EA per 31 days)
<i>loperamide oral capsule</i>	T2	
<i>lubiprostone</i>	T4	QL (62 EA per 31 days)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	T2	
<i>mesalamine oral capsule (with del rel tablets)</i>	T4	QL (186 EA per 31 days)
<i>mesalamine oral capsule, extended release 24hr</i>	T4	QL (124 EA per 31 days)
<i>mesalamine oral tablet, delayed release (dr/ec) 1.2 gram</i>	T4	QL (124 EA per 31 days)
<i>mesalamine rectal enema</i>	T4	QL (1860 ML per 31 days)
<i>metoclopramide hcl oral solution</i>	T2	
<i>metoclopramide hcl oral tablet</i>	T2	
<i>misoprostol</i>	T2	
<b>MOVANTIK</b>	T3	QL (31 EA per 31 days)
<i>nitroglycerin rectal</i>	T4	
<i>omeprazole oral capsule, delayed release(dr/ec)</i>	T1	
<i>ondansetron hcl oral solution</i>	T3	PA-BvD
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	T2	PA-BvD
<i>ondansetron oral tablet, disintegrating 4 mg, 8 mg</i>	T2	PA-BvD
<i>pantoprazole oral tablet, delayed release (dr/ec)</i>	T1	
<i>peg 3350-electrolytes</i>	T1	
<i>peg3350-sod sul-nacl-kcl-asb-c</i>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>peg-electrolyte soln</i>	T1	
<i>prochlorperazine</i>	T4	
<i>prochlorperazine maleate</i>	T2	
<b>PROCTO-MED HC</b>	T2	
<b>PROCTOSOL HC TOPICAL</b>	T2	
<b>PROCTOZONE-HC</b>	T2	
<i>rabeprazole oral tablet, delayed release (dr/ec)</i>	T2	QL (62 EA per 31 days)
<i>scopolamine base</i>	T3	QL (10 EA per 30 days)
<b>SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)</b>	T5	PA; QL (1.2 ML per 56 days)
<b>SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)</b>	T5	PA; QL (2.4 ML per 56 days)
<i>sodium,potassium,mag sulfates</i>	T4	
<i>sucrafate oral suspension</i>	T4	
<i>sucrafate oral tablet</i>	T2	
<i>sulfasalazine</i>	T2	
<i>ursodiol oral capsule 300 mg</i>	T4	
<i>ursodiol oral tablet</i>	T3	
<b>VOWST</b>	T5	PA; QL (12 EA per 14 days)
<b>ZENPEP ORAL CAPSULE, DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT</b>	T3	
<b>Immunology, Vaccines / Biotechnology</b>		
<b>ABRYSVO (PF)</b>	T3	QL (1 EA per 365 days)
<b>ACTHIB (PF)</b>	T3	
<b>ACTIMMUNE</b>	T5	PA
<b>ADACEL(TDAP ADOLESN/ADULT)(PF)</b>	T3	
<b>AREXVY (PF)</b>	T3	QL (1 EA per 365 days)
<b>AVONEX INTRAMUSCULAR PEN INJECTOR KIT</b>	T5	PA; QL (1 EA per 28 days)
<b>AVONEX INTRAMUSCULAR SYRINGE KIT</b>	T5	PA; QL (1 EA per 28 days)
<i>bcg vaccine, live (pf)</i>	T3	
<b>BESREMI</b>	T5	PA-NS; QL (2 ML per 28 days)
<b>BETASERON SUBCUTANEOUS KIT</b>	T5	PA; QL (14 EA per 28 days)
<b>BEXSERO</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>BOOSTRIX TDAP</b>	T3	
<b>DAPTACEL (DTAP PEDIATRIC) (PF)</b>	T3	
<b>ENGERIX-B (PF)</b>	T3	PA-BvD
<b>ENGERIX-B PEDIATRIC (PF)</b>	T3	PA-BvD
<b>GAMMAGARD LIQUID</b>	T5	PA
<b>GAMMAGARD LIQUID ERC INJECTION SOLUTION 10 (100 ML)</b>	T5	PA
<b>GAMMAGARD S-D (IGA &lt; 1 MCG/ML)</b>	T5	PA
<b>GARDASIL 9 (PF)</b>	T3	
<b>HAVRIX (PF)</b>	T3	
<b>HEPLISAV-B (PF)</b>	T3	PA-BvD
<b>HIBERIX (PF)</b>	T3	
<b>IMOVAX RABIES VACCINE (PF)</b>	T3	PA-BvD
<b>INFANRIX (DTAP) (PF)</b>	T3	
<b>IPOL</b>	T3	
<b>IXIARO (PF)</b>	T3	
<b>JYNNEOS (PF)</b>	T3	PA-BvD
<b>KINRIX (PF)</b>	T3	
<b>LEUKINE INJECTION RECON SOLN</b>	T5	PA
<b>MENQUADFI (PF)</b>	T4	
<b>MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT</b>	T3	
<b>M-M-R II (PF)</b>	T3	
<b>MRESVIA (PF)</b>	T3	QL (1 ML per 365 days)
<b>NIVESTYM</b>	T5	
<b>NORDITROPIN FLEXP RO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)</b>	T5	PA
<b>PEDIARIX (PF)</b>	T3	
<b>PEDVAX HIB (PF)</b>	T3	
<b>PEGASYS</b>	T5	PA
<b>PENBRAYA (PF)</b>	T3	
<b>PENMENVY MEN A-B-C-W-Y (PF)</b>	T3	
<b>PENTACEL (PF)</b>	T3	
<b>PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML</b>	T5	PA; QL (1 ML per 28 days)
<b>PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML</b>	T5	PA; QL (1 ML per 28 days)
<b>PRIORIX (PF)</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PRIVIGEN</b>	T5	PA
<b>PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML</b>	T3	PA-BvD
<b>PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML</b>	T5	PA-BvD
<b>PROQUAD (PF)</b>	T3	
<b>QUADRACEL (PF)</b>	T3	
<b>RABAVERT (PF)</b>	T3	PA-BvD
<b>RECOMBIVAX HB (PF)</b>	T3	PA-BvD
<b>RETACRIT</b>	T3	PA-BvD
<b>ROTARIX ORAL SUSPENSION</b>	T3	
<b>ROTATEQ VACCINE</b>	T3	
<b>SHINGRIX (PF)</b>	T3	QL (2 EA per 999 days)
<b>TENIVAC (PF)</b>	T3	
<b>TICOVAC</b>	T3	
<b>TRUMENBA</b>	T3	
<b>TWINRIX (PF)</b>	T3	
<b>TYPHIM VI</b>	T3	
<b>VAQTA (PF)</b>	T3	
<b>VARIVAX (PF)</b>	T3	
<b>VAXCHORA VACCINE</b>	T3	QL (200 ML per 365 days)
<b>VIMKUNYA</b>	T3	
<b>VIVOTIF</b>	T3	
<b>XOLREMDI</b>	T5	PA; QL (124 EA per 31 days)
<b>YF-VAX (PF)</b>	T3	
<b>ZARXIO</b>	T5	
<b>Miscellaneous Supplies</b>		
<b>ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"</b>	T4	
<b>GAUZE PAD TOPICAL BANDAGE 2 X 2 "</b>	T2	PA
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge</i>	T3	
<i>pen needle, diabetic needle 29 gauge x 1/2"</i>	T4	
<b>Musculoskeletal / Rheumatology</b>		
<b>ACTEMRA ACTPEN</b>	T5	PA; QL (3.6 ML per 28 days)
<b>ACTEMRA SUBCUTANEOUS</b>	T5	PA; QL (3.6 ML per 28 days)
<i>alendronate oral tablet 10 mg, 35 mg, 70 mg</i>	T1	
<i>allopurinol oral tablet 100 mg, 300 mg</i>	T1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>BENLYSTA SUBCUTANEOUS</b>	T5	PA; QL (4 ML per 28 days)
<i>colchicine oral tablet</i>	T2	QL (62 EA per 31 days)
<b>ENBREL MINI</b>	T5	PA; QL (8 ML per 28 days)
<b>ENBREL SUBCUTANEOUS SOLUTION</b>	T5	PA; QL (4 ML per 28 days)
<b>ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)</b>	T5	PA; QL (4 ML per 28 days)
<b>ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)</b>	T5	PA; QL (8 ML per 28 days)
<b>ENBREL SURECLICK</b>	T5	PA; QL (8 ML per 28 days)
<b>HADLIMA</b>	T5	PA; QL (1.6 ML per 28 days)
<b>HADLIMA PUSHTOUCH</b>	T5	PA; QL (1.6 ML per 28 days)
<b>HADLIMA(CF)</b>	T5	PA; QL (0.8 ML per 28 days)
<b>HADLIMA(CF) PUSHTOUCH</b>	T5	PA; QL (0.8 ML per 28 days)
<i>ibandronate oral</i>	T2	
<b>KINERET</b>	T5	PA; QL (18.76 ML per 28 days)
<i>leflunomide</i>	T3	
<b>ORENCIA CLICKJECT</b>	T5	PA; QL (4 ML per 28 days)
<b>ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML</b>	T5	PA; QL (4 ML per 28 days)
<b>ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML</b>	T5	PA; QL (1.6 ML per 28 days)
<b>ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML</b>	T5	PA; QL (2.8 ML per 28 days)
<b>OTEZLA</b>	T5	PA; QL (62 EA per 31 days)
<b>OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)</b>	T5	PA; QL (110 EA per 365 days)
<b>OTEZLA XR</b>	T5	PA; QL (30 EA per 30 days)
<b>OTEZLA XR INITIATION</b>	T5	PA; QL (82 EA per 365 days)
<i>penicillamine oral tablet</i>	T5	
<i>probenecid</i>	T2	
<i>probenecid-colchicine</i>	T2	
<b>PROLIA</b>	T4	PA; QL (1 ML per 180 days)
<i>raloxifene</i>	T3	
<b>RINVOQ LQ</b>	T5	PA; QL (372 ML per 31 days)
<b>RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG</b>	T5	PA; QL (168 EA per 365 days)
<i>risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg</i>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>risedronate oral tablet, delayed release (dr/ec)</i>	T4	
<b>SIMLANDI(CF) AUTOINJECTOR</b>	T5	PA; QL (2 EA per 28 days)
<b>SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML</b>	T5	PA; QL (2 EA per 28 days)
<i>teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)</i>	T5	PA; QL (2.48 ML per 28 days)
<b>TYMLOS</b>	T5	PA; QL (1.56 ML per 30 days)
<b>XELJANZ ORAL SOLUTION</b>	T5	PA; QL (310 ML per 31 days)
<b>XELJANZ ORAL TABLET</b>	T5	PA; QL (62 EA per 31 days)
<b>XELJANZ XR</b>	T5	PA; QL (31 EA per 31 days)
<b>YUFLYMA(CF)</b>	T5	PA; QL (2 EA per 28 days)
<b>YUFLYMA(CF) AI CROHN'S-UC-HS</b>	T5	PA; QL (6 EA per 365 days)
<b>YUFLYMA(CF) AUTOINJECTOR</b>	T5	PA; QL (2 EA per 28 days)
<b>Obstetrics / Gynecology</b>		
<b>ABIGALE</b>	T2	
<b>ALTAVERA (28)</b>	T2	
<b>ALYACEN 1/35 (28)</b>	T2	
<b>APRI</b>	T2	
<b>ARANELLE (28)</b>	T2	
<b>AVIANE</b>	T2	
<b>AZURETTE (28)</b>	T2	
<b>BALZIVA (28)</b>	T2	
<b>BLISOVI FE 1.5/30 (28)</b>	T2	
<b>BRIELLYN</b>	T2	
<b>CAMILA</b>	T2	
<i>clindamycin phosphate vaginal</i>	T2	
<b>CRYSELLE (28)</b>	T2	
<b>CYRED EQ</b>	T2	
<b>DEPO-SUBQ PROVERA 104</b>	T3	
<i>drospirenone-ethinyl estradiol</i>	T2	
<b>ENSKYCE</b>	T2	
<b>ERRIN</b>	T2	
<b>ESTARYLLA</b>	T2	
<i>estradiol oral</i>	T2	
<i>estradiol transdermal patch weekly 0.025 mg/24 hr, 0.06 mg/24 hr, 0.1 mg/24 hr</i>	T3	
<i>estradiol transdermal patch weekly 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr</i>	T2	
<i>estradiol vaginal</i>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>estradiol-norethindrone acet</i>	T2	
<i>etonogestrel-ethinyl estradiol</i>	T3	
<b>GALLIFREY</b>	T2	
<b>HAILEY 24 FE</b>	T2	
<b>HEATHER</b>	T2	
<b>ICLEVIA</b>	T2	
<b>IMVEXXY MAINTENANCE PACK</b>	T3	
<b>IMVEXXY STARTER PACK</b>	T3	
<b>INCASSIA</b>	T2	
<b>INTROVALE</b>	T2	
<b>ISIBLOOM</b>	T2	
<b>JASMIEL (28)</b>	T2	
<b>JINTELI</b>	T4	
<b>JULEBER</b>	T2	
<b>JUNEL 1.5/30 (21)</b>	T2	
<b>JUNEL 1/20 (21)</b>	T2	
<b>JUNEL FE 1.5/30 (28)</b>	T2	
<b>JUNEL FE 1/20 (28)</b>	T2	
<b>JUNEL FE 24</b>	T2	
<b>KARIVA (28)</b>	T2	
<b>KELNOR 1/35 (28)</b>	T2	
<b>KURVELO (28)</b>	T2	
<b>LESSINA</b>	T2	
<b>LEVONEST (28)</b>	T2	
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg</i>	T2	
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month</i>	T2	
<i>levonorg-eth estrad triphasic</i>	T2	
<b>LEVORA-28</b>	T2	
<b>LILETTA</b>	T3	
<b>LORYNA (28)</b>	T2	
<b>LOW-OGESTREL (28)</b>	T2	
<b>LUIZZA</b>	T2	
<b>LUTERA (28)</b>	T2	
<b>LYLEQ</b>	T2	
<b>LYZA</b>	T2	
<b>MARLISSA (28)</b>	T2	
<i>medroxyprogesterone</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	T3	
<b>MICONAZOLE-3 VAGINAL SUPPOSITORY</b>	T2	
<b>MICROGESTIN 1.5/30 (21)</b>	T2	
<b>MICROGESTIN 1/20 (21)</b>	T2	
<b>MICROGESTIN FE 1.5/30 (28)</b>	T2	
<b>MICROGESTIN FE 1/20 (28)</b>	T2	
<b>MILI</b>	T2	
<b>NECON 0.5/35 (28)</b>	T2	
<b>NEXPLANON</b>	T3	
<i>norethindrone (contraceptive)</i>	T2	
<i>norethindrone acetate</i>	T2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	T3	
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	T2	
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-0.035mg (28), 0.25-0.035 mg</i>	T2	
<b>NORTREL 0.5/35 (28)</b>	T2	
<b>NORTREL 1/35 (21)</b>	T2	
<b>NORTREL 1/35 (28)</b>	T2	
<b>NORTREL 7/7/7 (28)</b>	T2	
<b>NYLIA 1/35 (28)</b>	T2	
<b>NYLIA 7/7/7 (28)</b>	T2	
<b>PIMTREA (28)</b>	T2	
<b>PORTIA 28</b>	T2	
<b>PREMARIN VAGINAL</b>	T3	
<b>RECLIPSEN (28)</b>	T2	
<b>SETLAKIN</b>	T2	
<b>SPRINTEC (28)</b>	T2	
<b>SRONYX</b>	T2	
<b>SYEDA</b>	T2	
<i>terconazole</i>	T2	
<i>tranexamic acid oral</i>	T3	
<b>TRI-ESTARYLLA</b>	T2	
<b>TRI-MILI</b>	T2	
<b>TRI-SPRINTEC (28)</b>	T2	
<b>TRI-VYLIBRA</b>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>TURQOZ (28)</b>	T2	
<b>VALTYA</b>	T2	
<b>VELIVET TRIPHASIC REGIMEN (28)</b>	T2	
<b>VESTURA (28)</b>	T2	
<b>VIENVA</b>	T2	
<b>VIORELE (28)</b>	T2	
<b>VYFEMLA (28)</b>	T2	
<b>VYLIBRA</b>	T2	
<b>XELRIA FE</b>	T2	
<b>YUVAFEM</b>	T4	
<b>ZAFEMY</b>	T3	
<b>ZOVIA 1-35 (28)</b>	T2	
<b>Ophthalmology</b>		
<i>acetazolamide</i>	T3	
<b>ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %</b>	T3	
<i>apraclonidine</i>	T3	
<i>azelastine ophthalmic (eye)</i>	T2	
<i>bacitracin ophthalmic (eye)</i>	T2	
<i>bacitracin-polymyxin b</i>	T2	
<b>BESIVANCE</b>	T4	
<i>betaxolol ophthalmic (eye)</i>	T3	
<i>bimatoprost ophthalmic (eye) drops 0.03 %</i>	T2	
<i>brimonidine ophthalmic (eye) drops 0.1 %</i>	T3	
<i>brimonidine ophthalmic (eye) drops 0.15 %</i>	T4	
<i>brimonidine ophthalmic (eye) drops 0.2 %</i>	T2	
<i>brimonidine-timolol</i>	T3	
<i>brinzolamide</i>	T4	
<i>carteolol</i>	T2	
<i>ciprofloxacin hcl ophthalmic (eye)</i>	T2	
<b>COMBIGAN</b>	T3	
<i>cromolyn ophthalmic (eye)</i>	T2	
<i>cyclosporine ophthalmic (eye)</i>	T3	QL (60 EA per 30 days)
<b>CYSTARAN</b>	T5	PA; QL (60 ML per 28 days)
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	T2	
<i>diclofenac sodium ophthalmic (eye)</i>	T2	
<i>difluprednate</i>	T4	
<i>dorzolamide</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dorzolamide-timolol</i>	T2	
<i>erythromycin ophthalmic (eye)</i>	T2	
<i>fluorometholone</i>	T3	
<i>flurbiprofen sodium</i>	T2	
<i>gatifloxacin</i>	T3	
<i>gentamicin ophthalmic (eye) drops</i>	T2	
<i>ketorolac ophthalmic (eye) drops 0.4 %</i>	T3	
<i>ketorolac ophthalmic (eye) drops 0.5 %</i>	T2	
<i>latanoprost</i>	T1	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	T2	
<b>LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %</b>	T3	QL (5 ML per 31 days)
<i>methazolamide</i>	T4	
<i>moxifloxacin ophthalmic (eye) drops</i>	T3	
<i>neomycin-bacitracin-poly-hc</i>	T3	
<i>neomycin-bacitracin-polymyxin</i>	T2	
<i>neomycin-polymyxin b-dexameth</i>	T2	
<i>neomycin-polymyxin-gramicidin</i>	T3	
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	T3	
<i>ofloxacin ophthalmic (eye)</i>	T2	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T3	
<i>polymyxin b sulf-trimethoprim</i>	T1	
<i>prednisolone acetate</i>	T2	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	T2	
<b>RESTASIS</b>	T3	QL (60 EA per 30 days)
<b>RESTASIS MULTIDOSE</b>	T3	QL (5.5 ML per 27 days)
<b>RHOPRESSA</b>	T4	ST
<b>ROCKLATAN</b>	T4	ST
<b>SIMBRINZA</b>	T4	
<i>sulfacetamide sodium ophthalmic (eye) drops</i>	T2	
<i>sulfacetamide-prednisolone</i>	T2	
<i>timolol maleate ophthalmic (eye) drops</i>	T1	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	T3	
<i>tobramycin ophthalmic (eye)</i>	T1	
<i>tobramycin-dexamethasone</i>	T3	
<i>travoprost</i>	T3	
<i>trifluridine</i>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>XDEMVY</b>	T5	PA; QL (10 ML per 42 days)
<b>XIIDRA</b>	T3	QL (60 EA per 30 days)
<b>ZIRGAN</b>	T4	ST
<b>Respiratory And Allergy</b>		
<i>acetylcysteine</i>	T2	PA-BvD
<b>ADEMPAS</b>	T5	PA; QL (93 EA per 31 days)
<b>ADVAIR HFA</b>	T3	QL (12 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	T3	QL (17 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)</i>	T3	QL (13.4 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)</i>	NF	
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml</i>	T2	PA-BvD
<i>albuterol sulfate oral syrup</i>	T1	
<i>ambrisentan</i>	T5	PA; QL (31 EA per 31 days)
<b>ANORO ELLIPTA</b>	T3	QL (60 EA per 30 days)
<b>ASMANEX HFA</b>	T3	QL (13 GM per 30 days)
<b>ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)</b>	T3	QL (1 EA per 30 days)
<b>ATROVENT HFA</b>	T4	QL (25.8 GM per 30 days)
<i>azelastine-fluticasone</i>	T4	QL (23 GM per 30 days)
<b>BREO ELLIPTA</b>	T3	QL (60 EA per 30 days)
<b>BREYNA</b>	T3	QL (10.3 GM per 30 days)
<b>BREZTRI AEROSPHERE</b>	T3	QL (10.7 GM per 30 days)
<b>BRINSUPRI</b>	T5	PA; QL (31 EA per 31 days)
<i>budesonide inhalation</i>	T4	PA-BvD
<i>budesonide-formoterol</i>	T3	QL (10.2 GM per 30 days)
<b>CINRYZE</b>	T5	PA; QL (20 EA per 28 days)
<b>COMBIVENT RESPIMAT</b>	T3	QL (4 GM per 30 days)
<i>cromolyn inhalation</i>	T4	PA-BvD
<i>cyproheptadine oral tablet</i>	T2	PA
<i>desloratadine oral tablet</i>	T2	QL (31 EA per 31 days)
<b>DULERA</b>	T3	QL (13 GM per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	T3	
<b>FASENRA PEN</b>	T5	PA; QL (1 ML per 28 days)
<b>FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 56 days)
<b>FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML</b>	T5	PA; QL (1 ML per 28 days)
<i>flunisolide</i>	T3	QL (50 ML per 25 days)
<i>fluticasone propionate inhalation blister with device 100 mcg/actuation, 50 mcg/actuation</i>	T4	ST; QL (60 EA per 30 days)
<i>fluticasone propionate inhalation blister with device 250 mcg/actuation</i>	T4	ST; QL (240 EA per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation</i>	T4	ST; QL (12 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	T4	ST; QL (24 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation</i>	T4	ST; QL (10.6 GM per 30 days)
<i>fluticasone propionate nasal</i>	T1	QL (16 GM per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	T3	QL (60 EA per 30 days)
<i>hydroxyzine hcl oral tablet</i>	T2	PA
<i>icatibant</i>	T5	PA; QL (18 ML per 30 days)
<i>ipratropium bromide inhalation solution</i>	T2	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
<b>JASCAYD</b>	T5	PA; QL (62 EA per 31 days)
<b>KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 5.8 MG, 50 MG, 75 MG</b>	T5	PA; QL (56 EA per 28 days)
<b>KALYDECO ORAL GRANULES IN PACKET 25 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>KALYDECO ORAL TABLET</b>	T5	PA; QL (62 EA per 31 days)
<i>levalbuterol hcl inhalation solution for nebulization 1.25 mg/3 ml</i>	T3	PA-BvD
<i>levalbuterol tartrate</i>	T3	QL (30 GM per 30 days)
<i>levocetirizine oral solution</i>	T4	QL (310 ML per 31 days)
<i>levocetirizine oral tablet</i>	T1	QL (31 EA per 31 days)
<i>mometasone nasal</i>	T3	QL (34 GM per 30 days)
<i>montelukast oral tablet</i>	T2	QL (31 EA per 31 days)
<i>montelukast oral tablet, chewable</i>	T2	QL (31 EA per 31 days)
<b>OFEV</b>	T5	PA; QL (62 EA per 31 days)
<b>OPSUMIT</b>	T5	PA; QL (31 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>OPSYNVI</b>	T5	PA; QL (31 EA per 31 days)
<b>ORKAMBI ORAL GRANULES IN PACKET</b>	T5	PA; QL (62 EA per 31 days)
<b>ORKAMBI ORAL TABLET</b>	T5	PA; QL (124 EA per 31 days)
<i>pirfenidone oral capsule</i>	T5	PA; QL (279 EA per 31 days)
<i>pirfenidone oral tablet</i>	T5	PA; QL (93 EA per 31 days)
<i>promethazine oral tablet</i>	T4	PA
<b>PULMOZYME</b>	T5	PA
<b>QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION</b>	T3	QL (10.6 GM per 30 days)
<b>QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION</b>	T3	QL (21.2 GM per 30 days)
<i>roflumilast</i>	T4	QL (31 EA per 31 days)
<b>SAJAZIR</b>	T5	PA; QL (18 ML per 30 days)
<b>SEREVENT DISKUS</b>	T3	QL (60 EA per 30 days)
<i>sildenafil (pulm.hypertension) oral tablet</i>	T3	PA; QL (372 EA per 31 days)
<b>SPIRIVA RESPIMAT</b>	T3	QL (4 GM per 30 days)
<b>STIOLTO RESPIMAT</b>	T3	QL (4 GM per 30 days)
<b>STRIVERDI RESPIMAT</b>	T4	QL (4 GM per 30 days)
<i>tadalafil (pulm. hypertension)</i>	T5	PA; QL (62 EA per 31 days)
<i>terbutaline oral</i>	T4	
<b>THEO-24</b>	T3	
<i>theophylline oral solution</i>	T2	
<i>theophylline oral tablet extended release 12 hr</i>	T2	
<i>theophylline oral tablet extended release 24 hr</i>	T2	
<b>TRELEGY ELLIPTA</b>	T3	QL (60 EA per 30 days)
<b>TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL</b>	T5	PA; QL (56 EA per 28 days)
<b>TRIKAFTA ORAL TABLETS, SEQUENTIAL</b>	T5	PA; QL (84 EA per 28 days)
<b>VENTOLIN HFA</b>	T3	QL (36 GM per 30 days)
<b>WINREVAIR</b>	T5	PA
<b>WIXELA INHUB</b>	T3	QL (60 EA per 30 days)
<b>XOLAIR</b>	T5	PA
<b>Urologicals</b>		
<i>alfuzosin</i>	T2	QL (31 EA per 31 days)
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg</i>	T2	
<i>bethanechol chloride oral tablet 50 mg</i>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>CYSTAGON</b>	T4	
<i>dutasteride</i>	T2	QL (31 EA per 31 days)
<i>dutasteride-tamsulosin</i>	T4	QL (31 EA per 31 days)
<b>ELMIRON</b>	T4	
<i>finasteride oral tablet 5 mg</i>	T2	
<b>GEMTESA</b>	T4	QL (31 EA per 31 days)
<b>MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON</b>	T3	QL (300 ML per 30 days)
<b>MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR</b>	T3	QL (31 EA per 31 days)
<i>oxybutynin chloride oral syrup</i>	T2	
<i>oxybutynin chloride oral tablet 5 mg</i>	T2	
<i>oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg</i>	T2	QL (31 EA per 31 days)
<i>oxybutynin chloride oral tablet extended release 24hr 15 mg</i>	T3	QL (62 EA per 31 days)
<i>potassium citrate oral tablet extended release</i>	T3	
<b>RIVFLOZA SUBCUTANEOUS SOLUTION</b>	T5	PA; QL (1 ML per 28 days)
<b>RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML</b>	T5	PA; QL (0.8 ML per 28 days)
<b>RIVFLOZA SUBCUTANEOUS SYRINGE 160 MG/ML</b>	T5	PA; QL (1 ML per 28 days)
<i>silodosin</i>	T4	
<i>solifenacin</i>	T4	QL (31 EA per 31 days)
<i>tadalafil oral tablet 2.5 mg</i>	T4	PA; QL (62 EA per 31 days)
<i>tadalafil oral tablet 5 mg</i>	T4	PA; QL (31 EA per 31 days)
<i>tamsulosin</i>	T1	
<i>tolterodine oral capsule,extended release 24hr</i>	T3	QL (31 EA per 31 days)
<i>tolterodine oral tablet</i>	T3	QL (62 EA per 31 days)
<i>trospium oral tablet</i>	T2	QL (93 EA per 31 days)
<b>Vitamins, Hematinics / Electrolytes</b>		
<i>calcium acetate(phosphat bind)</i>	T2	PA-BvD
<b>CLINIMIX 5%/D15W SULFITE FREE</b>	T4	PA-BvD
<b>CLINIMIX 4.25%/D10W SULF FREE</b>	T4	PA-BvD
<b>CLINIMIX 5%-D20W(SULFITE-FREE)</b>	T4	PA-BvD
<i>fluoride (sodium) oral tablet</i>	T2	
<b>INTRALIPID INTRAVENOUS EMULSION 20 %</b>	T4	PA-BvD
<b>ISOLYTE S PH 7.4</b>	T3	PA-BvD
<b>ISOLYTE-P IN 5 % DEXTROSE</b>	T4	PA-BvD

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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<b>KLOR-CON M10</b>	T2	
<b>KLOR-CON M15</b>	T2	
<b>KLOR-CON M20</b>	T2	
<i>magnesium sulfate injection</i>	T2	
<b>PLENAMINE</b>	T3	PA-BvD
<i>potassium chlorid-d5-0.45%nacl</i>	T2	
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	T2	
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml</i>	T2	
<i>potassium chloride intravenous</i>	T2	
<i>potassium chloride oral capsule, extended release</i>	T2	
<i>potassium chloride oral liquid</i>	T2	
<i>potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq</i>	T2	
<i>potassium chloride oral tablet,er particles/crystals</i>	T2	
<i>potassium chloride-0.45 % nacl</i>	T2	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride-d5-0.9%nacl</i>	T2	
<b>PRENATAL VITAMIN PLUS LOW IRON</b>	T2	PA
<b>PROSOL 20 %</b>	T4	PA-BvD
<i>sodium chloride 0.45 % intravenous</i>	T2	
<i>sodium chloride 3 % hypertonic</i>	T2	
<i>sodium chloride 5 % hypertonic</i>	T2	
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<b>XCOPRI TITRATION PACK</b>	30	<b>ZOVIA 1-35 (28)</b> .....	55
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<b>XELJANZ</b> .....	52	<b>ZUBSOLV</b> .....	31
<b>XELJANZ XR</b> .....	52	<b>ZURZUVAE</b> .....	31
<b>XELRIA FE</b> .....	55	<b>ZYDELIG</b> .....	18
<b>XERMELO</b> .....	18	<b>ZYKADIA</b> .....	18
<b>XGEVA</b> .....	18		
<b>XIFAXAN</b> .....	10		
<b>XIGDUO XR</b> .....	46		
<b>XIIDRA</b> .....	57		
<b>XOFLUZA</b> .....	10		
<b>XOLAIR</b> .....	59		
<b>XOLREMDI</b> .....	50		
<b>XOSPATA</b> .....	18		
<b>XPOVIO</b> .....	18		
<b>XTANDI</b> .....	18		
<b>XULTOPHY 100/3.6</b> .....	46		
<b>YARGESA</b> .....	46		
<b>YESINTEK</b> .....	40		
<b>YF-VAX (PF)</b> .....	50		
<b>YONSA</b> .....	18		
<b>YORVIPATH</b> .....	46		
<b>YUFLYMA(CF)</b> .....	52		
<b>YUFLYMA(CF) AI</b>			
<b>CROHN'S-UC-HS</b> .....	52		
<b>YUFLYMA(CF)</b>			
<b>AUTOINJECTOR</b> .....	52		
<b>YUVAFEM</b> .....	55		
<b>ZAFEMY</b> .....	55		
<i>zaleplon</i> .....	30		
<b>ZARXIO</b> .....	50		
<b>ZAVZPRET</b> .....	30		
<b>ZEJULA</b> .....	18		
<b>ZELBORAF</b> .....	18		
<b>ZELSUVMI</b> .....	40		
<b>ZENPEP</b> .....	48		
<b>ZEPOSIA</b> .....	31		
<b>ZEPOSIA STARTER KIT</b>			
<b>(28-DAY)</b> .....	31		
<b>ZEPOSIA STARTER PACK</b>			
<b>(7-DAY)</b> .....	31		
<i>zidovudine</i> .....	10		
<b>ZILBRYSQ</b> .....	31		
<i>ziprasidone hcl</i> .....	31		

**Section:**  
**Prior Authorization**

# Acitretin

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## Products Affected

- *acitretin*

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

# Actimmune

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## Products Affected

- ACTIMMUNE

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

# ADHD Drugs

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## Products Affected

- *guanfacine oral tablet extended release 24 hr*

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

# Afinitor

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.

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

# Aimovig

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 (1-2): 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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of reduction in migraine frequency
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Akeega

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## Products Affected

- **AKEEGA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. -AND- Concomitant therapy with prednisone. -AND- Concomitant therapy with a gonadotropin-releasing hormone analog or a bilateral orchiectomy, -AND- For metastatic castration-sensitive prostate cancer, disease harbors a deleterious or suspected deleterious BRCA2 mutation based on an FDA-approved test. -AND- For metastatic castration-resistant prostate cancer, BRCA mutations.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Alecensa

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## Products Affected

- ALECENSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive as detected by an FDA-approved test - 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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Alpha1-Proteinase Inhibitors

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## Products Affected

- **PROLASTIN-C INTRAVENOUS SOLUTION**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Covered under Part B when furnished incident to a physician service and is not self-administered.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Alunbrig

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## Products Affected

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

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

# Ampyra

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## Products Affected

- *dalfampridine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	History of seizure disorder, Cr Cl less than 50ml/min
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, documentation supporting improvement in walking impairment from baseline is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Anticholinergic Meds

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## Products Affected

- *paroxetine hcl oral suspension*
- *paroxetine hcl oral tablet*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- Attestation of counseling on risk-benefit profile and potential anticholinergic adverse effects -AND- Therapeutic failure, contraindication, or intolerance to 2 other antidepressants (i.e., SSRI, SNRI).
<b>Age Restrictions</b>	Automatic approval if less than 65 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Anzupgo

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## Products Affected

- ANZUPGO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of chronic hand eczema (CHE) -AND- symptoms persisting for more than 3 months or recurring at least twice within a 12-month timeframe -AND- therapeutic failure, contraindication, or intolerance to 1 generic, on-formulary, medium/high/super-high potency topical corticosteroid.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Arikayce

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## Products Affected

- ARIKAYCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of positive sputum cultures -OR- negative sputum cultures for insufficient period of time (e.g. less than 12 months).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

## ATTR-CM drugs

### Products Affected

- ATTRUBY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitantly with transthyretin-lowering agents
<b>Required Medical Information</b>	Documentation of cardiomyopathy of transthyretin-mediated amyloidosis (ATTR-CM) with amyloid deposits on cardiac biopsy or scintigraphy with heart contralateral greater than 1.5 (Grade III) or visual grade 2 to 3 - AND- Cardiac involvement supported by cardiac magnetic resonance, echocardiography or serum cardiac biomarker (e.g. B-type natriuretic peptide, cardiac troponin) -AND- ATTR-CM type is wild-type or variant
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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)
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Atypical Antipsychotics

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Aubagio

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## Products Affected

- *teriflunomide*

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

# Augtyro

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## Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Austedo

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Auvelity

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## Products Affected

- AUVELITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Avmapki-Fakzynja

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## Products Affected

- **AVMAPKI-FAKZYNJA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For recurrent low-grade serous ovarian cancer (LGSOC), disease is KRAS-mutated -AND- member has received at least one prior systemic therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Ayvakit

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## Products Affected

- AYVAKIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of unresectable or metastatic gastrointestinal stromal tumor -AND- tumors harbor a PDGFRA exon 18 mutation. Documentation of aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm, mast cell leukemia, or indolent systemic mastocytosis -AND- platelet count greater than or equal to $50 \times 10^9/L$ .
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Bafiertam

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## Products Affected

- **BAFIERTAM**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Balversa

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## Products Affected

- **BALVERSA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Banzel

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## Products Affected

- *rufinamide*

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

# Benlysta

## Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>For diagnosis of active systemic lupus erythematosus (SLE), both of the following (1-2): 1) 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, 2) member will continue to receive concomitant standard of care treatment with use of at least one of the following (alone or in combination) (a-c): a) corticosteroids (e.g. prednisone), b) antimalarials (e.g. hydroxychloroquine), c) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate). For diagnosis of active lupus nephritis (LN), one of the following (3 or 4): 3) Diagnosis confirmed by renal biopsy, 4) Contraindication to renal biopsy, laboratory findings specific to LN (e.g., elevated serum creatinine, abnormal urine analysis, decreased eGFR). -AND- Member will continue to receive concomitant standard of care treatment which includes corticosteroids (e.g. prednisone) with at least one of the following (d or e): d) mycophenolate for induction followed by mycophenolate for maintenance, e) cyclophosphamide for induction followed by azathioprine for maintenance.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

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

# Besremi

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## Products Affected

- **BESREMI**

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

# Bosulif

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Braftovi

## Products Affected

- BRAFTOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Use in wild-type BRAF melanoma, wild-type BRAF CRC, or wild-type BRAF NSCLC.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Brinsupri

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## Products Affected

- **BRINSUPRI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of non-cystic fibrosis bronchiectasis (NCFB) confirmed by computed tomography (CT) -AND- at least 1 of the following symptoms consistent with bronchiectasis (1-8): 1) cough on most days of the week, 2) chronic sputum production, 3) history of recurrent respiratory infections, 4) dyspnea, 5) wheezing, 6) rhinosinusitis, 7) hemoptysis, 8) recurrent pleurisy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Brukinsa

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## Products Affected

- BRUKINSA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Buphenyl

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## Products Affected

- *sodium phenylbutyrate*

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

# Cabometyx

## Products Affected

- CABOMETYX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Calquence

## Products Affected

- CALQUENCE (ACALABRUTINIB MAL)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Caplyta

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## Products Affected

- CAPLYTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For schizophrenia, bipolar I disorder, and bipolar II 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).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Caprelsa

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Carbaglu

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## Products Affected

- *carglumic acid*

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

# Cayston

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## Products Affected

- CAYSTON

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

# Cerdelga

## Products Affected

- CERDELGA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 <sup>3</sup> . 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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# CF drugs

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Cialis

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## Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Cinryze

## Products Affected

- CINRYZE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Member should not be on two prophylactic therapies simultaneously.
<b>Required Medical Information</b>	<p>For the prophylactic treatment of abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) due to deficiency of C1INH (type I &amp; 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) with normal C1INH (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, FXII mutation, angiotensin-1 mutation, plasminogen mutation, kininogen-1 mutation, myoferlin mutation, or heparin sulfate-glucosamine 3-O-sulfotransferase 6 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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

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

# Cobenfy

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- therapeutic failure, intolerance, or contraindication to one other generic atypical antipsychotic (e.g. quetiapine).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Cometriq

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## 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)**

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

# Copiktra

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## Products Affected

- **COPIKTRA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Corlanor

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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) For adults, left ventricular ejection fraction less than or equal to 35 percent, 4) For adults, concurrent use of 1 beta-blocker used for treatment of heart failure (i.e. bisoprolol, carvedilol, metoprolol succinate) or therapeutic failure, intolerance, or contraindication to the maximum tolerated dose of 2 beta-blockers used for treatment of heart failure.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For oral solution, attestation of inability to swallow tablets is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	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
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Cotellic

## Products Affected

- COTELLIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Cysteamine Ophthalmic Drops

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## Products Affected

- CYSTARAN

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

# Danziten

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## Products Affected

- DANZITEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Daraprim

## Products Affected

- *pyrimethamine*

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

# Daurismo

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## Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Deferasirox

## Products Affected

- *deferasirox oral tablet, dispersible*

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

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

# Diacomit

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## Products Affected

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

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

# Dihydroergotamine

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## Products Affected

- *dihydroergotamine nasal*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Drizalma

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	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
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# 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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Moderate/Severe atopic dermatitis (AD): failure/intolerance to 1 topical corticosteroid or, if 2 yrs or older, topical calcineurin inhibitor (e.g. tacrolimus, pimecrolimus) -OR- severe AD and unable to apply topical tx due to the extent of body surface area involvement or topical tx are contraindicated due to severely damaged skin. Use of topical corticosteroids in combination with Dupixent for moderate/severe AD is permitted and does not preclude coverage. Moderate/severe asthma: history of 2 or more exacerbations requiring oral/injectable corticosteroids in past 12mos or 1 or more exacerbation requiring hospitalization in past 12mos -AND- blood eosinophils of 150cells/uL or higher or current daily/alternate-day oral corticosteroid (OCS) -AND- inadequate control despite regular medium/high-dose inhaled corticosteroids (ICS) + 1 or more add'l asthma controller (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline) +/- OCS, unless intolerant or contraindicated to all -AND- will continue medium/ high-dose ICS + 1 or more add'l asthma controller medication +/- OCS.</p> <p>Chronic rhinosinusitis with nasal polyposis: failure/intolerance/contraindication to intra-nasal corticosteroid.</p> <p>Eosinophilic esophagitis: esophageal eosinophils of 15eos/hpf or higher on esophageal biopsy -AND- clinical esophageal dysfunction symptoms.</p> <p>Prurigo nodularis. COPD: blood eosinophils of at least 300cells/uL or current daily/alternate-day OCS -AND- inadequate control despite 3 or more months of regular LAMA, LABA, and ICS tx, unless intolerant or contraindicated to all. Chronic Spontaneous Urticaria: failure/contraindication/intolerance to 1 second-generation non-sedating H1 antihistamine at max recommended dose (e.g. cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine). Bullous pemphigoid: failure/intolerance/contraindication on high/super high potency topical corticosteroid or oral corticosteroid.</p>
<b>Age Restrictions</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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. For BP reauthorization, 1 of the following is required (1-4): 1) attestation of disease control, 2) reduction in number of relapses, 3) improvement in BP symptoms, or 4) reduction in oral corticosteroid use.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Duvyzat

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## Products Affected

- DUVYZAT

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

# EGFR Tyrosine Kinase Inhibitors

## Products Affected

- *erlotinib*
- **GILOTRIF**

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

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

# Emgality

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 (1-2). 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). 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Ensacove

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## Products Affected

- ENSACOVE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For locally advanced or metastatic non-small cell lung cancer (NSCLC) -AND- Disease is ALK-positive, as detected by an FDA-approved test -AND- Not previously received an ALK inhibitor.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Entresto Sprinkle

## Products Affected

- ENTRESTO SPRINKLE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of symptomatic heart failure with left ventricular systolic dysfunction -AND- weight less than 40kg, or weight greater than or equal to 40kg and less than 50kg and one of the following (1 or 2): 1) therapeutic failure or intolerance to Entresto (sacubitril/valsartan) tablets, or 2) inability to swallow tablets.
<b>Age Restrictions</b>	Deny if greater than 17 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, all of the following are required (1-3): 1) attestation of positive clinical response to therapy, 2) member is younger than 18 years of age, 3) weight less than 40kg, or weight greater than or equal to 40kg and less than 50kg and one of the following (4 or 5): 4) intolerance to Entresto (sacubitril/valsartan) tablets, or 5) inability to swallow tablets.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Eohilia

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## Products Affected

- EOHILIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Treatment duration greater than 12 weeks
<b>Required Medical Information</b>	Diagnosis of eosinophilic esophagitis -AND- esophageal eosinophil count greater than or equal to 15 eos/hpf on esophageal biopsy -AND- clinical symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, gastroesophageal reflux)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 weeks
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Epclusa

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## Products Affected

- *sofosbuvir-velpatasvir*

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

# Epidiolex

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## Products Affected

- EPIDIOLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Eprontia

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## Products Affected

- *topiramate oral solution*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Ergotamine

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## Products Affected

- *ergotamine-caffeine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use to abort a vascular headache -AND- therapeutic failure, intolerance, or contraindication to a generic triptan -OR- documentation of use to prevent a vascular headache -AND- therapeutic failure, intolerance, or contraindication to generic prophylactic migraine medication (e.g., topiramate, propranolol, timolol).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Erivedge

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## Products Affected

- ERIVEDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Erleada

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## Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Escitalopram Capsule

## Products Affected

- *escitalopram oxalate oral capsule*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of major depressive disorder or generalized anxiety -AND- Therapy has been initiated with escitalopram 10mg or member has been receiving and is experiencing unfavorable tolerability to escitalopram 20mg -AND- Intolerance to generic escitalopram tablets -AND- Therapeutic failure, intolerance or contraindication to at least one other antidepressant (e.g., SSRI, TCA, MAOI).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Etanercept

## 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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 polyarticular 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 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.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Rheumatoid Arthritis and Ankylosing Spondylitis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Psoriatic Arthritis or Less than 4 years of age for Plaque Psoriasis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Therapeutic failure or intolerance to 1 of the following preferred adalimumab products is required, when being utilized for the same medically accepted indication and age: Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
<b>Indications</b>	All FDA-approved Indications.

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

# Exxua

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## Products Affected

- **EXXUA ORAL TABLET EXTENDED RELEASE 24 HR**
- **EXXUA ORAL TABLET, EXT REL 24HR DOSE PACK**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Fabhalta

## Products Affected

- FABHALTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>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 nephropathy (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.</p>
Age Restrictions	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Fanapt

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## Products Affected

- FANAPT
- FANAPT TITRATION PACK A

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

# Fasenra

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

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

# Fecal Microbiota Products

## Products Affected

- VOWST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a recent diagnosis of Clostridioides difficile infection (CDI) confirmed by a positive stool test -AND- Classified as recurrent (e.g., at least 2 CDI episodes) -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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Fetzima

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## Products Affected

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

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

# Filsuvez

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## Products Affected

- **FILSUVEZ**

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

# Fintepla

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## Products Affected

- FINTEPLA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	Deny if less than 2 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Firazyr

## Products Affected

- *icatibant*
- SAJAZIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Member should not be on two acute therapies simultaneously and acute therapy should not be used as prophylactic therapy
<b>Required Medical Information</b>	For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) due to deficiency of C1INH (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) with normal C1INH (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, FXII mutation, angiotensin-converting enzyme mutation, plasminogen mutation, kininogen-1 mutation, myoferlin mutation, or heparin sulfate-glucosamine 3-O-sulfotransferase 6 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

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

# Firmagon

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## Products Affected

- **FIRMAGON KIT W DILUENT SYRINGE**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of advanced prostate cancer.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Forteo

## Products Affected

- *teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Fotivda

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## Products Affected

- FOTIVDA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- member has received at least two prior systemic therapies.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Fruzaqla

## Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Gattex

## Products Affected

- **GATTEX 30-VIAL**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of increase in weight from baseline or decrease in intravenous parenteral nutrition requirements from baseline - AND- 1 of the following (1-2): 1) continued dependence on parenteral nutrition/intravenous nutritional support, 2) not receiving parenteral nutrition/intravenous support and experienced therapeutic failure upon trial of discontinuation of parenteral nutrition/intravenous support.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Gavreto

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## Products Affected

- GAVRETO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Gilenya

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## Products Affected

- *fingolimod*

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

# Glatiramer

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## 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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Gleevec

## Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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 aggressive 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 adjuvant 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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# Gleostine

## Products Affected

- *lomustine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# GLP1

## Products Affected

- *liraglutide* ML), 1 MG/DOSE (4 MG/3 ML), 2
- MOUNJARO MG/DOSE (8 MG/3 ML)
- OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3
- 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
Prerequisite Therapy Required	No

# Gomekli

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## Products Affected

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

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

# Growth Hormone

## Products Affected

- **NORDITROPIN FLEXPRO  
SUBCUTANEOUS PEN INJECTOR 10  
MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML  
(10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis, growth chart, member has open epiphyses, 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 <sup>2</sup> . For HIV wasting and cachexia, Concurrent use of antiretroviral therapy -AND- weight loss from baseline of at least 10% in the past 12 months or at least 5% in the past 6 months. For short bowel syndrome, receiving management for short bowel syndrome, including specialized nutritional support -AND- less than 200 cm of functional small bowel.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of growth velocity and member has open epiphyses, 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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Hernexeos

## Products Affected

- **HERNEXEOS**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For non-squamous non-small cell lung cancer (NSCLC), all of the following (1-3): 1) disease is unresectable or metastatic, 2) disease harbors HER2 (ERBB2) tyrosine kinase domain activating mutations, as detected by an FDA-approved test, and 3) member has received at least one prior systemic therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# High-risk meds

## Products Affected

- *amitriptyline*
- *benztropine oral*
- *clomipramine*
- *cyproheptadine oral tablet*
- *doxepin oral capsule*
- *doxepin oral concentrate*
- *doxepin oral tablet*
- *hydroxyzine hcl oral tablet*
- *imipramine hcl*
- *promethazine oral tablet*
- *trimipramine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Automatic approval if less than 65 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Doxepin doses less than or equal to 6 mg per day will receive automatic approval.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

## High-risk meds phenobarbital

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### Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Coverage is not provided for use in sedation/insomnia
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Automatic approval if less than 65 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off Label Uses</b>	Seizure disorders
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Hyruno

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## Products Affected

- **HYRNUO**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For non-squamous non-small cell lung cancer (NSCLC), all of the following (1-3): 1) disease is locally advanced or metastatic, 2) disease harbors HER2 (ERBB2) tyrosine kinase domain activating mutations, as detected by an FDA-approved test, and 3) member has received at least one prior systemic therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Ibrance

## Products Affected

- **IBRANCE**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Ibuprofen

## Products Affected

- **IBTROI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is ROS1-positive.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Iclusig

## Products Affected

- ICLUSIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Treatment of newly-diagnosed chronic phase CML
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Idhifa

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## Products Affected

- **IDHIFA**

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

# IG

## Products Affected

- **GAMMAGARD LIQUID**
- **GAMMAGARD LIQUID ERC INJECTION SOLUTION 10 (100 ML)**
- **GAMMAGARD S-D (IGA)**
- **PRIVIGEN**

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

# Imbruvica

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For chronic graft versus host disease, previous treatment with at least 1 prior systemic therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For suspension, inability to swallow oral tablets or oral capsules is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Imkeldi

## Products Affected

- **IMKELDI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 aggressive 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 adjuvant 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Documentation of an inability to swallow oral tablets is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# Increlex

## Products Affected

- INCRELEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For pediatric patients, reauthorization requires open epiphyses.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Inluriyo

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## Products Affected

- INLURIYO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following (1-3): 1) disease is ER-positive, HER2-negative, 2) disease harbors an ESR1 mutation, as detected by an FDA-approved test, 3) member has experienced disease progression following at least one line of endocrine therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Inlyta

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## Products Affected

- INLYTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Inqovi

## Products Affected

- INQOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Inrebic

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## Products Affected

- **INREBIC**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 $50 \times 10^9/L$
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Baseline platelet count to be provided.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Insulin Supplies

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation the product is being used for the delivery of insulin into the body.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Interferon Alfa

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## Products Affected

- PEGASYS

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

# Interferon Beta

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## 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**

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

# IPF Agents

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 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- chest computing tomography (CT) 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 CT 3. Worsening of respiratory symptoms and increasing extent of fibrotic changes on CT
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.

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

# Iressa

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## Products Affected

- *gefitinib*

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

# Itovebi

## Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Itraconazole

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## Products Affected

- *itraconazole oral capsule*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Onychomycosis: 3 months. All other indications: 3 months initial, 12 months reauth
<b>Other Criteria</b>	Documentation of trial/failure or intolerance of amphotericin b must be provided for approval in patients with aspergillosis.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Ivermectin Oral

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## Products Affected

- *ivermectin oral*

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

# Iwilfin

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## Products Affected

- IWILFIN

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

# Jakafi

## Products Affected

- JAKAFI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 $50 \times 10^9/L$ -OR- documentation of polycythemia vera and inadequate response or intolerance to hydroxyurea -OR- Documentation of steroid refractory acute graft-versus-host disease and prior therapy with at least one systemic corticosteroid -OR- Documentation of chronic graft-versus-host disease with prior failure of at least one systemic therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Baseline platelet count to be provided.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Jascayd

## Products Affected

- JASCAYD

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Diagnosis of idiopathic pulmonary fibrosis -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 25% -AND- 1 of the following (1-3): 1) Concomitant use of a stable dose of Esbriet (pirfenidone) or Ofev (nintedanib). For concomitant Esbriet (pirfenidone) therapy, Jascayd dose will remain 18 mg orally twice daily. 2) Receiving Jascayd as monotherapy and intolerance to Esbriet (pirfenidone) and Ofev (nintedanib), 3) Receiving Jascayd as monotherapy and contraindication to Esbriet (pirfenidone) and Ofev (nintedanib). Diagnosis of progressive pulmonary fibrosis (PPF) -AND- documentation of a chest computed tomography (CT) scan demonstrating at least 10% pulmonary fibrosis -AND- a baseline FVC of at least 45% -AND- a percent predicted DLCO of at least 25% -AND- at least 2 of the following (4-6): 4) Worsening of respiratory symptoms 5) Physiological evidence of disease progression defined as 1 of the following (a or b): a) Decline in FVC of at least 5% (relative from baseline). b) Decline in percent predicted DLCO of at least 10% (relative from baseline). 6) Radiological evidence of disease progression defined as increased extent of fibrotic changes on imaging (e.g., chest computed tomography scan) -AND- One of the following (7-9): 7) Concomitant use of a stable dose of Ofev (nintedanib), 8) Treatment naive to antifibrotic treatment, or 9) Previously discontinued Ofev (nintedanib) with no plans to initiate or resume background PPF treatment.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

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

# Jaypirca

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 relapsed or refractory Chronic Lymphocytic Leukemia/Small Lymphocytic Leukemia, member has previously been treated with a covalent BTK inhibitor.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Joenja

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## Products Affected

- JOENJA

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

# Jynarque

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## Products Affected

- *tolvaptan (polycys kidney dis) oral tablet*
- *tolvaptan (polycys kidney dis) oral tablets, sequential*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of rapidly progressing autosomal dominant polycystic kidney disease defined by one of the following: 1.) Historical decline in eGFR greater than or equal to 3mL/min/1.73 m*2 within a 12 month period, or 2.) Mayo imaging classification of 1C, 1D, or 1E.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, prescriber attestation of slowed decline of kidney function
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Kalydeco

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Kerendia

## Products Affected

- **KERENDIA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	eGFR less than 25 mL/min/1.73 m*2, serum potassium greater than 5.5 mEq/L
<b>Required Medical Information</b>	Documentation of type 2 diabetes mellitus with chronic kidney disease (T2DM+CKD) or heart failure (HF) with left ventricular ejection fraction (LVEF) of greater than or equal to 40% -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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation that signs or symptoms of hyperkalemia are not present.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Kesimpta

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## Products Affected

- **KESIMPTA PEN**

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

# Kineret

## Products Affected

- KINERET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Rheumatoid Arthritis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq and Xeljanz/Xeljanz XR. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Kisqali

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Kisqali Femara

## 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**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- disease is classified as HR-positive, HER2-negative - AND- one of the following (1-2): 1) disease is classified as stage II or stage III early breast cancer at high risk of recurrence and used as adjuvant treatment 2) used as initial endocrine-based therapy for advanced or metastatic breast cancer.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Korlym

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## Products Affected

- *mifepristone oral tablet 300 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of 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, 2) Glucose intolerance
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Koselugo

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## Products Affected

- **KOSELUGO ORAL CAPSULE 10 MG, 25 MG**
- **KOSELUGO ORAL CAPSULE, SPRINKLE 5 MG, 7.5 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- for neurofibromatosis type 1 (NF1), documentation of symptomatic, inoperable plexiform neurofibromas (PN)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For Koselugo granules, 1 of the following is required (1-2): 1) inability to swallow oral capsules, 2) body surface area of less than 0.55 m*2
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Krazati

## Products Affected

- **KRAZATI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Kuvan

## Products Affected

- **JAVYGTOR**
- *sapropterin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Latuda

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Lazcluze

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## Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Lenvima

## Products Affected

- LENVIMA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# Leukine

## Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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]).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Lidoderm

## Products Affected

- *lidocaine topical adhesive patch, medicated 5 %*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off Label Uses</b>	Diabetic peripheral neuropathy
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Litfulo

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## Products Affected

- LITFULO

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

# Livtency

## Products Affected

- LIVTENCITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Diagnosis of CMV prophylaxis.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 12 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Lokelma

## Products Affected

- **LOKELMA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of reduction in serum potassium levels following Lokelma administration and continued treatment for hyperkalemia is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Lonsurf

## Products Affected

- LONSURF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Lorbrena

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of ALK-positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Lotronex

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## Products Affected

- *alosetron oral tablet 0.5 mg, 1 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	For irritable bowel syndrome (IBS): Exclude if male gender
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 weeks initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation that symptoms of IBS continue to persist AND positive clinical response.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Lumakras

## Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Lynparza

## Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>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.</p>
Age Restrictions	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Lyrica

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## Products Affected

- *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg*
- *pregabalin oral solution*

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

# Lytgobi

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## 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)**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Mavyret

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## Products Affected

- MAVYRET ORAL PELLETS IN PACKET
- MAVYRET ORAL TABLET

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

# Megace

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## Products Affected

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

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

# Mekinist

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For Mekinist powder for oral solution, attestation of inability to swallow Mekinist (trametinib) tablets is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Mektovi

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## Products Affected

- MEKTOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Metyrosine

## Products Affected

- *metyrosine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Modeyso

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## Products Affected

- **MODEYSO**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of diffuse midline glioma -AND- disease harbors an H3 K27M mutation -AND- member has experienced progressive disease following prior therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Mulpleta

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## Products Affected

- MULPLETA

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

# Myasthenia Gravis

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## Products Affected

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

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

# Namzaric

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## Products Affected

- *memantine-donepezil*

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

# Nayzilam

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## Products Affected

- NAYZILAM

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

# Nemluvio

## Products Affected

- NEMLUVIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Nerlynx

## Products Affected

- NERLYNX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Nexavar

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## Products Affected

- *sorafenib*

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

# Nexletol

## Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>1. HeFH supported by presence of causal mutation of FH by genetic testing OR untreated LDL-C at least 190mg/dL or untreated LDL-C at least 160mg/dL before 20 yrs 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 at least 70mg OR non-HDL at least 100mg/dL or less than 50% reduction in baseline LDL-C despite use with maximally tolerated statin therapy, or if very high risk, LDL-C at least 55mg/dL or non-HDL at least 85mg/dL -AND- Attestation of combination use with other LDL-C lowering therapies or concomitant LDL-C lowering therapy is not possible -AND- Therapeutic failure to a maximally tolerated statin or documented statin intolerance -AND- Therapeutic failure/intolerance/contraindication to ezetimibe</p> <p>2. ASCVD or attestation of high risk for CVD, -AND- Therapeutic failure to a maximally tolerated statin or documented statin intolerance -AND- Therapeutic failure/intolerance/contraindication to ezetimibe.</p> <p>3. Primary Hyperlipidemia not associated w/ ASCVD or HeFH -AND- LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% reduction in baseline LDL-C despite use with maximally tolerated statin therapy -AND- Attestation of combination use with other LDL-C lowering therapies or concomitant LDL-C lowering therapy is not possible -AND- Therapeutic failure to a maximally tolerated statin or documented statin intolerance -AND- Therapeutic failure/intolerance/contraindication to ezetimibe.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization of ASCVD or High ASCVD Risk, attestation of need for continued therapy is required. For reauthorization associated with all other diagnoses, documentation showing an LDL-C reduction from baseline -AND- 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Ninlaro

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## Products Affected

- NINLARO

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

# Nitisinone

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## Products Affected

- *nitisinone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hereditary tyrosinemia type 1 (HT-1) confirmed by biochemical or genetic testing -AND- dietary restriction of tyrosine and phenylalanine.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Northera

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	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.).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Nubeqa

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## Products Affected

- NUBEQA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of non-metastatic castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer -AND- one of the following (1-2): 1) using in combination with a GnRH analog 2) member has had a bilateral orchiectomy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Nuedexta

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## Products Affected

- NUEDEXTA

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

# Nuplazid

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## Products Affected

- NUPLAZID

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

# Nurtec

## Products Affected

- NURTEC ODT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For Episodic Migraine Prevention, defined as 4-14 migraine days per month, the following criteria will apply (1-2). 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). For acute treatment of migraine with or without aura, trial and failure of one generic triptan or all triptans are contraindicated.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Nuvigil

## Products Affected

- *armodafinil*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Diagnosis of shift work sleep disorder (SWSD) substantiated by excessive sleepiness or insomnia that is temporarily associated with a recurring work schedule that overlaps the usual time for sleep -AND- Symptoms are accompanied by a reduction of total sleep time -AND- Symptoms experienced for at least 3 months -AND- Sleep log or actigraphy monitoring for at least 14 days including both work and free days -AND- Sleep disturbance is not better explained by another current sleep disorder, medical or neurological disorder, mental disorder, medication use, or substance use disorder. Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 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</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	For reauthorization, provider attestation of improvement in daytime sleepiness is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Octreotide

## Products Affected

- *octreotide acetate injection solution*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization of acromegaly, decreased or normalized IGF-1 from baseline
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Odomzo

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## Products Affected

- ODOMZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Ogsiveo

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## Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG

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

# Ojemda

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## Products Affected

- **OJEMDA ORAL SUSPENSION FOR RECONSTITUTION** **MG/WEEK (100 MG X 5), 600 MG/WEEK (100 MG X 6)**
- **OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4), 500**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Ojjaara

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## Products Affected

- OJJAARA

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

# Onfi

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## Products Affected

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

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

# Onureg

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## Products Affected

- ONUREG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Opipza

## Products Affected

- OPIPZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Orencia

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For polyarticular 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.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Rheumatoid Arthritis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Psoriatic Arthritis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, 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, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq/Rinvoq LQ, and Xeljanz/Xeljanz solution. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Orgovyx

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## Products Affected

- **ORGOVYX**

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

# Orkambi

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cystic fibrosis and homozygous F508del mutation
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Orserdu

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following (1-4): 1) member is male or a postmenopausal female 2) disease is ER-positive, HER2-negative 3) disease harbors an ESR1 mutation, as detected by an FDA-approved test 4) member has experienced disease progression on or after an endocrine based regimen.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# 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
- OTEZLA XR
- OTEZLA XR INITIATION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For plaque psoriasis, all of the following (1-2): 1) member is greater than or equal to 18 years of age with mild-to-severe disease -OR- 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 for Otezla or 50 kg for Otezla XR, 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. For psoriatic arthritis, if the member is greater than or equal to 6 years of age and less than 18 years and weight is greater than or equal to 20 kg for Otezla or 50 kg for Otezla XR.
<b>Age Restrictions</b>	Deny if less than 6 years of age for plaque psoriasis or psoriatic arthritis. Deny if less than 18 years of age for Behcet's Disease.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Panretin

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## Products Affected

- PANRETIN

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

# Pemazyre

## Products Affected

- PEMAZYRE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Pheburane

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## Products Affected

- PHEBURANE

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

# Piqray

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## 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)**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Pomalyst

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## Products Affected

- POMALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Posaconazole Tablet

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Preferred Adalimumab

## Products Affected

- **HADLIMA** **SYRINGE KIT 20 MG/0.2 ML, 40**
- **HADLIMA PUSH TOUCH** **MG/0.4 ML**
- **HADLIMA(CF)** • **YUFLYMA(CF)**
- **HADLIMA(CF) PUSH TOUCH** • **YUFLYMA(CF) AI CROHN'S-UC-HS**
- **SIMLANDI(CF) AUTOINJECTOR** • **YUFLYMA(CF) AUTOINJECTOR**
- **SIMLANDI(CF) SUBCUTANEOUS**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 polyarticular 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 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.
<b>Age Restrictions</b>	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 Polyarticular Juvenile Idiopathic Arthritis and Uveitis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	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. These criteria are applicable to Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Preferred Ustekinumab

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 or Ulcerative Colitis, attestation of receiving or currently undergoing a single induction dose of IV ustekinumab within 2 months of initiating therapy with ustekinumab SC.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Crohn's Disease and Ulcerative Colitis. Deny if less than 6 years of age for Plaque Psoriasis and Psoriatic Arthritis.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Must follow recommended dosing guidelines based upon weight. Induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Prenatal Vitamins

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## Products Affected

- **PRENATAL VITAMIN PLUS LOW IRON**

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Required Medical Information</b>	For concomitant use of opiate agonist and substance abuse therapy, documentation of acute pain condition (eg, acute traumatic injury) in which treatment with other agents would cause insufficient pain control or treatment for terminal illness related pain. For concomitant use of an opiate agonist, benzodiazepine, and centrally acting skeletal muscle relaxant, trial/failure of at least 2 other skeletal muscle relaxants (eg, methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, attestations that non-opiate (eg, NSAIDs) and non-benzodiazepine therapies (eg, SSRI, SNRI) have been considered, and attestation of intent to monitor & address concomitant drug-drug interaction adverse events. For concomitant use of opiate agonist and other opiate potentiators (eg, gabapentinoids, sedative-hypnotics), attestation of intent to monitor & address concomitant drug-drug interaction adverse events. For long acting opioid medications, the following apply (1-3): 1)Severe pain requiring daily, around-the-clock, long-term opioid treatment. 2)Not opioid naive. 3)Attestations that non-opiate alternative therapies have been explored (eg, NSAIDs), controlled substance history was reviewed in the state Prescription Drug Monitoring Program (PDMP), counseling on potential adverse effects of opioid analgesics, including risk of misuse, abuse, addiction.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Opiate tx for pain+subs. abuse, approve opiate x 1mo. All other combos and dx approve x 12mo.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# Prevymis Oral Pellets

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## Products Affected

- **PREVYMIS ORAL PELLETS IN PACKET**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis.
<b>Age Restrictions</b>	Deny if less than 6 months of age with HSCT. Deny if less than 12 years of age with kidney transplant.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	7 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Prolia

## Products Affected

- PROLIA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Provigil

## Products Affected

- *modafinil*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Diagnosis of shift work sleep disorder (SWSD) substantiated by excessive sleepiness or insomnia that is temporarily associated with a recurring work schedule that overlaps the usual time for sleep -AND- Symptoms are accompanied by a reduction of total sleep time -AND- Symptoms experienced for at least 3 months -AND- Sleep log or actigraphy monitoring for at least 14 days including both work and free days -AND- Sleep disturbance is not better explained by another current sleep disorder, medical or neurological disorder, mental disorder, medication use, or substance use disorder. Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 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)</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

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

# Pulmonary Arterial Hypertension

## Products Affected

- **ADEMPAS**
- *ambrisentan*
- **OPSUMIT**
- **OPSYNVI**
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*

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

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

# Pulmozyme

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## Products Affected

- PULMOZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis -AND- Used in conjunction with standard therapies for management of cystic fibrosis to improve pulmonary function.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Qinlock

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## Products Affected

- QINLOCK

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

# Quinine

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## Products Affected

- *quinine sulfate*

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

# Qulipta

## Products Affected

- QULIPTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 (1-2). 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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of reduction in migraine frequency
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Ravicti

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## Products Affected

- *glycerol phenylbutyrate*

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

# Repatha

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with another PCSK9 inhibitor or siRNA directed to PCSK9.
<b>Required Medical Information</b>	<p>1.HoFH supported by 1 of the following (a-d): a) bi-allelic causal mutations of FH by genetic testing, b) LDL-C over 560mg/dL, c) LDL-C over 400mg/dL w/ aortic valve disease or xanthomata at less than 20 yrs old, d) LDL-C over 400mg/dL and 1 or both parents w/ clinically diagnosed FH, positive genetic testing for a known LDL-C-raising (LDLR, Apo[b], PCSK9) gene defect, or autosomal-recessive FH AND current LDL-C over 115mg/dL (if 17 yrs or younger) or over 70mg/dL (18 yrs or older) or over 55mg/dL w/ ASCVD or major ASCVD risk factors (18 yrs or older) AND Therapeutic failure to a max tolerated statin or documented statin intolerance. 2.HeFH supported by 1 of the following (a-d): a) causal mutation of FH by genetic testing, b) untreated LDL-C at least 190mg/dL or untreated LDL-C at least 160mg/dL before 20 yrs old, c) physical signs of FH (e.g. xanthomas, xanthelasma), d) diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria w/ score over 8 points, definite on Simon Broome register, or definite on the Make Early Diagnosis to Prevent Early Deaths tool. AND Therapeutic failure to a max tolerated statin or documented statin intolerance AND LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% decrease in baseline LDL-C, or if very high risk, LDL-C at least 55mg/dL or non-HDL-C at least 85mg/dL. 3.Hypercholesterolemia w/ ASCVD or attestation of major CV risk AND LDL-C at least 55mg/dL or non-HDL-C at least 85mg/dL or, if ASCVD, less than 50% decrease in baseline LDL-C AND Therapeutic failure to a max tolerated statin or documented statin intolerance. 4.Primary Hyperlipidemia/Hypercholesterolemia (w/o ASCVD, HeFH, or HoFH) AND LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% decrease in baseline LDL-C AND Therapeutic failure to a max tolerated statin or documented statin intolerance.</p>
<b>Age Restrictions</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization associated with Major Cardiovascular Risk, attestation of need for continued Repatha therapy is required. For reauthorization associated with all other diagnoses, 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Retevmo

## Products Affected

- **RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG**

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

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

# Revlimid

## Products Affected

- *lenalidomide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Documentation of chronic lymphocytic leukemia outside of a controlled clinical trial
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Revuforj

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For relapsed or refractory acute leukemia, member has a lysine methyltransferase 2A gene (KMT2A) translocation, as determined by an FDA-authorized test. For relapsed or refractory acute myeloid leukemia, the member has a susceptible NPM1 mutation -AND- the member has no satisfactory alternative treatment options.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Rexulti

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## Products Affected

- REXULTI ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Rezdiffra

## Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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. Liver biopsy (within the past 3 years) or noninvasive tests (NITs) (performed within the past 6 months) indicating stage F2 or F3 fibrosis -AND- attestation of 1 cardiometabolic risk factor (e.g. obesity, hyperglycemia, hypertriglyceridemia, hyperlipidemia, hypertension) -AND- attestation that member does not have evidence of cirrhosis, hepatic decompensation, or hepatocellular carcinoma -AND- attestation that member's alcohol consumption is not defined as excess alcohol use (greater than 20g/day in females or greater than 30g/day in males)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of continued use in conjunction with diet and exercise -AND- member has experienced improvement or stabilization of fibrosis as demonstrated by NIT -AND- member has not progressed to stage F4 fibrosis -AND- attestation that member does not have evidence of cirrhosis, hepatic decompensation, or hepatocellular carcinoma -AND- attestation that member's alcohol consumption is not defined as excess alcohol use (greater than 20g/day in females or greater than 30g/day in males)
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# Rezlidhia

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## Products Affected

- **REZLIDHIA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA approved test
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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	<p>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 &amp; 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 &amp; failure or intolerance to two nonsteroidal anti-inflammatory drugs (NSAIDs) or contraindication to all. For polyarticular 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.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	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. For ulcerative colitis or Crohns disease, the member has experienced therapeutic failure or intolerance to at least 1 systemic therapy if TNF blockers are not advisable.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Rinvoq LQ

## Products Affected

- RINVOQ LQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For polyarticular 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.
<b>Age Restrictions</b>	For PsA, deny if 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	The member has experienced therapeutic failure or intolerance to at least 1 tumor necrosis factor (TNF) blocker.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Rivfloza

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of all of the following (1-4): 1) diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by one of the following (a or b): a) Genetic testing (i.e., AGXT gene mutation), b) Liver biopsy (i.e., absence or significantly reduced AGT activity), 2) relatively preserved kidney function (e.g., eGFR greater than or equal to 30 mL/min/1.73 m <sup>2</sup> ), 3) at least two elevated urinary oxalate levels greater than 1.5 times the upper reference limit, and 4) The member has not received a liver transplant.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, continued preserved kidney function (e.g., eGFR greater than or equal to 30 mL/min/1.73 m <sup>2</sup> ) -AND- reduction in urinary oxalate levels from baseline -AND- has not received a liver transplant.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Romvimza

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## Products Affected

- ROMVIMZA

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

# Rozlytrek

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Rubraca

## Products Affected

- RUBRACA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 3) member is concurrently receiving a gonadotropin-releasing hormone (GnRH) analog or member has had a bilateral orchiectomy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Rydapt

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## Products Affected

- RYDAPT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Use as single agent induction therapy for AML
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Sabril

## Products Affected

- *vigabatrin*
- **VIGADRONE**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	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
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Samsca

## Products Affected

- *tolvaptan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	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)
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Saphris

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## Products Affected

- *asenapine maleate*

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

# Scemblix

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Secuado

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## Products Affected

- **SECUADO**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- intolerance to 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Siliq

## Products Affected

- SILIQ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For psoriasis, patients must have therapeutic failure or intolerance to 2 preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, and Skyrizi SC. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Sirturo

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## Products Affected

- SIRTURO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of disease improvement -AND- member requires additional antimicrobial therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Skyclarys

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## Products Affected

- SKYCLARYS

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

# Skyrizi

## Products Affected

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

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	Plan Year
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
Prerequisite Therapy Required	Yes

# Sohonos

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## Products Affected

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

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

# Solaraze

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## Products Affected

- *diclofenac sodium topical gel 3 %*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Somavert

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## Products Affected

- SOMAVERT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization of acromegaly, decreased or normalized IGF-1 from baseline
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Sprycel

## Products Affected

- *dasatinib*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Steroidogenesis Inhibitors

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## Products Affected

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- patient is not a candidate for pituitary surgery or surgery has not been curative
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of decrease in urinary free cortisol levels from baseline
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Stivarga

## Products Affected

- STIVARGA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Sutent

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## Products Affected

- *sunitinib malate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Sympazan

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## Products Affected

- SYMPAZAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Deny if less than 2 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Synarel

## Products Affected

- SYNAREL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	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.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Endometriosis: 6 months, CPP: 6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization for CPP, attestation of pubertal development slowing from baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Tabrecta

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## Products Affected

- **TABRECTA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic non-small cell lung cancer with MET exon 14 skipping mutation as detected by an FDA approved test.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Tafinlar

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For Tafinlar tablets for oral suspension, attestation of inability to swallow Tafinlar (dabrafenib) capsules is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Tagrisso

## Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>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.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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

# Talzenna

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## Products Affected

- **TALZENNA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Targretin

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## Products Affected

- *bexarotene oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cutaneous manifestations of cutaneous T-cell lymphoma in patients who are refractory to at least one prior systemic therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Targretin Gel

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## Products Affected

- *bexarotene topical*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cutaneous lesions associated with one (1) of the following stages of cutaneous T-cell lymphoma (CTCL) (1. or 2.): 1) Stage IA or 2) Stage IB - AND- the member has experience therapeutic failure, contraindication, or intolerance to at least one other therapy for CTCL.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Tascenso ODT

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## Products Affected

- TASCENSO ODT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with other disease modifying agents such as teriflunomide, interferons, Copaxone, Tysabri
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Tasigna

## Products Affected

- *nilotinib hcl*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Tasimelteon

## Products Affected

- *tasimelteon*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of increased total nighttime sleep or decreased daytime nap duration for Non-24 Sleep-Wake disorder
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Tazorac

## Products Affected

- *tazarotene topical cream*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Tazverik

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## Products Affected

- TAZVERIK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	For epithelioid sarcoma, deny if less than 16 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Tecfidera

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## Products Affected

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

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

# Tepmetko

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## Products Affected

- **TEPMETKO**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic non-small cell lung cancer with a MET exon 14 skipping alteration
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Testosterone (androgens)

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of primary or secondary hypogonadism in males -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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off Label Uses</b>	Gender Dysphoria, Gender Identity Disorder
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Thalomid

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Use as monotherapy for ENL treatment in the presence of moderate to severe neuritis
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Thrombopoiesis Stimulating Agents

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Platelet count to be provided
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Tibsovo

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## Products Affected

- TIBSOVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Tocilizumab

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Part A covered for Covid-19 in hospitalized patients
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	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
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq and Xeljanz/Xeljanz XR. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq/Rinvoq LQ, and Xeljanz/Xeljanz solution. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Topical Lidocaine

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## Products Affected

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

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

# Tretinoin

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## Products Affected

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

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

# Trikafta

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Trintellix

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## Products Affected

- **TRINTELLIX**

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

# Truqap

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## Products Affected

- TRUQAP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Tukysa

## Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Turalio

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## Products Affected

- TURALIO

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

# Tykerb

## Products Affected

- *lapatinib*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Tymlos

## Products Affected

- TYMLOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Treatment duration greater than 24 months.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Ubrelvy

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of acute treatment of migraine with or without aura -AND- trial and failure of one generic triptan or all triptans are contraindicated
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	Patients must have therapeutic failure, intolerance, or contraindication to Nurtec ODT. For reauthorization, attestation of reduction in migraine symptoms.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Uptravi

## Products Affected

- **UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**      **PACK**
- **UPTRAVI ORAL TABLETS,DOSE**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Trial and failure of Opsumit is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Ustekinumab

## Products Affected

- **STELARA SUBCUTANEOUS SOLUTION**
- **STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- *ustekinumab subcutaneous solution*
- *ustekinumab subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 or Ulcerative Colitis, attestation of receiving or currently undergoing a single induction dose of IV ustekinumab within 2 months of initiating therapy with ustekinumab SC.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Crohn's Disease and Ulcerative Colitis. Deny if less than 6 years of age for Plaque Psoriasis and Psoriatic Arthritis.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For ustekinumab products except Steqeyma and Yesintek, intolerance to both preferred ustekinumab products is required: Steqeyma with NDC starting with 72606 and Yesintek with NDC starting with 83257. 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# Valchlor

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## Products Affected

- VALCHLOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Valtoco

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## Products Affected

- VALTOCO

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

# Vanflyta

## Products Affected

- VANFLYTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Venclexta

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For newly-diagnosed AML, member is using in combination with azacitidine, decitabine, or 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Verquvo

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## Products Affected

- VERQUVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Verzenio

## Products Affected

- VERZENIO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Viibryd

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## Products Affected

- *vilazodone*

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

# Vioice

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## Products Affected

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

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

# Vittrakvi

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Vivjoa

## Products Affected

- VIVJOA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	14 weeks
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Vizimpro

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## Products Affected

- VIZIMPRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Vonjo

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## Products Affected

- VONJO

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

# Voranigo

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 12 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Voriconazole

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## Products Affected

- *voriconazole intravenous*

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

# Vosevi

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## Products Affected

- VOSEVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Votrient

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## Products Affected

- *pazopanib oral tablet 200 mg*

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

# Vraylar

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## Products Affected

- VRAYLAR ORAL CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Vumerity

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## Products Affected

- VUMERITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Welireg

## Products Affected

- WELIREG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Winrevair

## Products Affected

- WINREVAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 -AND- Concomitant use of at least one of the following (1-4): 1) generic endothelin-1 receptor antagonist, 2) phosphodiesterase type 5 inhibitor, 3) soluble guanylate cyclase stimulator, 4) generic prostacyclin agent -AND- Background therapy with PAH-specific therapies will be continued while being treated with Winrevair.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Xalkori

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For metastatic non-small cell lung cancer (NSCLC), disease is ALK-positive as detected by an FDA-approved test or ROS1-positive as detected by an FDA-approved test. 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.
<b>Age Restrictions</b>	Deny if less than 1 year of age or greater than 21 years of age for ALCL.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For crizotinib oral pellets and NSCLC, inability to swallow capsules is required. For crizotinib oral pellets and ALCL / IMT, inability to swallow oral capsules -OR- body surface area less than 1.34 m <sup>2</sup> is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Xcopri

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## Products Affected

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

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

# Xdemvy

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## Products Affected

- XDEMVI

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

# Xeljanz

## Products Affected

- XELJANZ ORAL TABLET
- XELJANZ XR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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). Xeljanz immediate release for polyarticular 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).
<b>Age Restrictions</b>	Deny if less than 18 years of age for rheumatoid arthritis, ulcerative colitis, ankylosing spondylitis. For Xeljanz XR, deny if less than 18 years of age for psoriatic arthritis. For Xeljanz regular release tablet, deny if less than 2 years of age for polyarticular juvenile idiopathic arthritis and psoriatic arthritis.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# Xeljanz Solution

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## Products Affected

- XELJANZ ORAL SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. Documentation of polyarticular 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.
<b>Age Restrictions</b>	Deny if less than 2 years of age for polyarticular juvenile idiopathic arthritis and psoriatic arthritis.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	The member has experienced therapeutic failure or intolerance to at least 1 tumor necrosis factor (TNF) blocker.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Xenazine

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## Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

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

# Xermelo

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## Products Affected

- XERMELO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of carcinoid syndrome diarrhea AND used in combination with a somatostatin analog AND trial and failure of somatostatin analog monotherapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Xgeva

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## Products Affected

- XGEVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Xifaxan

## Products Affected

- XIFAXAN ORAL TABLET 550 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Hepatic encephalopathy: 1 year. IBS-D: 14 days.
<b>Other Criteria</b>	No more than three courses of rifaximin for the treatment of IBS-D will be approved per lifetime.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Xolair

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>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 12mos or at least 1 asthma exacerbation requiring hospitalization in past 12mos, 8) 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, 9) will continue treatment with a medium- or high-dose ICS and at least 1 add'l asthma controller medication w/ or w/o OCS -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.</p>
Age Restrictions	
Prescriber Restrictions	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Xolremdi

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## Products Affected

- XOLREMDI

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

# Xospata

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## Products Affected

- XOSPATA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- member is FLT3 mutation-positive.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Xtandi

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Xyrem

## Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) - AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. If the member has a diagnosis of cataplexy provision of baseline number of cataplexy episodes is required.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>If 18 years or older and no diagnosis of cataplexy, trial and failure, intolerance, or contraindication to generic modafinil -AND- a generic CNS stimulant indicated for use in narcolepsy (e.g. methylphenidate, amphetamine salts) is required. For reauthorization, attestation supporting improvement in symptoms of narcolepsy and cataplexy (if applicable) is required.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# Yonsa

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## Products Affected

- YONSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- using in combination with methylprednisolone.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Yorvipath

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of hypoparathyroidism -AND- albumin-corrected serum calcium greater than or equal to 7.8 mg/dL -AND- trial and failure of an active form of vitamin D (e.g. calcitriol, alfacalcidol).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of normalization or improvement in total serum calcium from baseline is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Zavesca

## Products Affected

- *miglustat*
- YARGESA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 <sup>3</sup> -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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Attestation enzyme replacement therapy (e.g. Cerezyme, Elelyso, or VPRIV) is not a therapeutic option
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Zavzpret

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## Products Affected

- ZAVZPRET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of reduction in migraine symptoms.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Zejula

## Products Affected

- ZEJULA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 -AND- disease is associated with homologous recombination deficiency-positive status, defined by at least one of the following (1 or 2): 1) a deleterious or suspected deleterious BRCA mutation or 2) genomic instability. 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Zelboraf

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## Products Affected

- ZELBORAF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Wild-type BRAF melanoma
<b>Required Medical Information</b>	Documentation of diagnosis. For unresectable or metastatic melanoma, member has a BRAF V600E mutation. For Erdheim-Chester Disease, member has a BRAF V600 mutation.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Zelsuvmi

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## Products Affected

- ZELSUVMI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of molluscum contagiosum
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 weeks
<b>Other Criteria</b>	For reauthorization, attestation that the member has previously experienced complete or partial clearance of molluscum contagiosum lesions with Zelsuvmi -AND- additional course of therapy is required for recurrence of molluscum contagiosum
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Zeposia

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use of Zeposia and other disease modifying agents such as interferons, Copaxone, Tysabri.
<b>Required Medical Information</b>	Documentation of diagnosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Ulcerative Colitis: Plan Year, Multiple Sclerosis: 24 months
<b>Other Criteria</b>	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, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Zokinvy

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## Products Affected

- ZOKINVY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- BSA of at least 0.39 m <sup>2</sup> . For Hutchinson-Gilford Progeria Syndrome (HGPS), a mutation in the LMNA gene is required. For Processing-Deficient Progeroid Lamionpathy (PL), 1 of the following is required (1-3): 1) heterozygous LMNA mutation and progerin-like protein accumulation, 2) homozygous ZMPSTE24 mutations, or 3) compound heterozygous ZMPSTE24 mutations.
<b>Age Restrictions</b>	Deny if less than 12 months of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Zolinza

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## Products Affected

- ZOLINZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Zonisade

## Products Affected

- ZONISADE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Zoryve 0.15 Cream

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## Products Affected

- ZORYVE TOPICAL CREAM 0.15 %

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of all of the following (1-3). 1) Documentation of mild to moderate atopic dermatitis -AND- 2) therapeutic failure, contraindication or intolerance to one generic formulary topical corticosteroid -OR- documentation of facial or anogenital involvement -AND- 3) therapeutic failure, contraindication or intolerance to topical generic tacrolimus or topical generic pimecrolimus.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# Ztalmy

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## Products Affected

- ZTALMY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of seizures associated with CDKL5 deficiency confirmed by genetic testing.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Zurzuvaе

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of postpartum depression -AND- attestation of symptom onset began during the third trimester of pregnancy or up to 4 weeks post-delivery -AND- less than or equal to 12 months postpartum.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Zydelig

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## Products Affected

- ZYDELIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	First line treatment. Combination use with benadmustine and/or rituximab for the treatment of FL.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# Zykadia

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## Products Affected

- ZYKADIA

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

# Zytiga

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## Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*
- **ABIRTEGA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- using in combination with prednisone.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No



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**Section:**  
**Step Therapy**

# Entresto Tablet

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## Products Affected

- ENTRESTO 24 MG-26 MG TABLET
- ENTRESTO 49 MG-51 MG TABLET
- ENTRESTO 97 MG-103 MG TABLET

## Details

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<b>Criteria</b>	Require a 1 month trial of generic sacubitril/valsartan tablets (Step 1 drug) in the last 90 days
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# GnRH Agonists

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## 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

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<b>Criteria</b>	Require a trial of Leuprolide 22.5mg (Step 1 drug) in the last 180 days when being utilized for the same medically accepted indication
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# Herpetic Keratitis

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## Products Affected

- ZIRGAN 0.15 % EYE GEL

## Details

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<b>Criteria</b>	Require a 1 month trial of generic trifluridine eye drops (Step 1 drug) in the last 90 days
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# Pulmonary Antiinflammatory

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## 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

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<b>Criteria</b>	Require a 1 month trial of Qvar and Asmanex/Asmanex HFA (Step 1 drugs) in the last 180 days
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# Rho Kinase Inhibitors

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## Products Affected

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

## Details

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<b>Criteria</b>	Require a 1 month trial of one preferred glaucoma drug (Step 1 drug) in the last 120 days
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# Rytary

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## 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

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<b>Criteria</b>	Require a trial of generic carbidopa/levodopa product (Step 1 drug) in the last 90 days
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**ELIGARD 30 MG (4 MONTH)  
SUBCUTANEOUS SYRINGE..... 2**

**ELIGARD 45 MG (6 MONTH)  
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**ELIGARD 7.5 MG (1 MONTH)  
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**ENTRESTO 49 MG-51 MG TABLET ..... 1**

**ENTRESTO 97 MG-103 MG TABLET ..... 1**

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*fluticasone propionate 110 mcg/actuation  
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*fluticasone propionate 220 mcg/actuation  
hfa aerosol inhaler..... 4*

*fluticasone propionate 250 mcg/actuation  
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**RYTARY 48.75 MG-195 MG  
CAPSULE,EXTENDED RELEASE..... 6**

**RYTARY 61.25 MG-245 MG  
CAPSULE,EXTENDED RELEASE..... 6**

**TRELSTAR 11.25 MG IM  
SUSPENSION..... 2**

**TRELSTAR 22.5 MG IM SUSPENSION.. 2**

**TRELSTAR 3.75 MG IM SUSPENSION.. 2**

**ZIRGAN 0.15 % EYE GEL..... 3**