

## **Medicare Part D: 5 Tier Closed Performance Formulary 2024**

Please click here.

### **For Medicare Part D: Prior Authorization Criteria**

Please click here.

### **For Medicare Part D: Step Therapy Criteria**

Please click here.

For more recent information or other questions, please contact:

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

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).

### **Notice: Oral Antivirals for COVID-19 Coverage**

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

Formulary ID: 24017 Version: 18

Updated: 10/2024

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

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

When it refers to “plan” or “our plan,” it means 2024 Freedom Blue PPO, Security Blue HMO- POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, or Together Blue HMO.

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

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

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

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

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

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

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

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

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

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

Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, or Together Blue HMO Formulary?”

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

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

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

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

## **Medical Condition**

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

## **Alphabetical Listing**

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

## **What are generic drugs?**

Our plan 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 cost less than brand name drugs.

## **Are there any restrictions on my coverage?**

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

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug we will cover. For example, our plan provides 31 tablets, per 31 days, per prescription for 100mg losartan. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan 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 Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, or Together Blue HMO Formulary?” on page 5 for information about how to request an exception.

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

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

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

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

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

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

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan 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.

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

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

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

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

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

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

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

## **For more information**

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

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

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

## **Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, or Together Blue HMO 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 at the end of this document.

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

The information in the Requirements/Limits column tells you if 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	
<b>ABELCET</b>	T4	PA-BvD
<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>	T3	
<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	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>amoxicillin-pot clavulanate oral tablet, chewable 400-57 mg</i>	T2	
<i>amphotericin b</i>	T4	PA-BvD
<i>amphotericin b liposome</i>	T5	PA-BvD
<i>ampicillin oral capsule 500 mg</i>	T2	
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	T4	
<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 packet</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)
<i>casprofungin intravenous recon soln 50 mg</i>	T5	
<i>casprofungin intravenous recon soln 70 mg</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 injection 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	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<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>COMPLERA</b>	T5	
<i>dapsone oral</i>	T3	
<i>daptomycin intravenous recon soln 350 mg</i>	T5	
<i>daptomycin intravenous recon soln 500 mg</i>	T4	
<i>darunavir</i>	T5	
<b>DELSTRIGO</b>	T5	QL (31 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>DESCOVY</b>	T5	QL (31 EA per 31 days)
<i>dicloxacillin</i>	T2	
<b>DIFICID ORAL TABLET</b>	T5	QL (20 EA per 10 days)
<b>DOVATO</b>	T5	QL (31 EA per 31 days)
<b>DOXY-100</b>	T4	
<i>doxycycline hyclate oral capsule</i>	T2	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	T2	
<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>E.E.S. 400 ORAL TABLET</b>	T4	
<b>EDURANT</b>	T5	
<i>efavirenz</i>	T4	
<i>efavirenz-emtricitabin-tenofovir</i>	T5	
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate</i>	T5	QL (31 EA per 31 days)
<i>emtricitabine</i>	T3	
<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	T5	
<i>emtricitabine-tenofovir (tdf) oral tablet 200-300 mg</i>	T4	
<b>EMTRIVA ORAL SOLUTION</b>	T3	
<b>EMVERM</b>	T5	
<i>entecavir</i>	T4	
<b>EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG</b>	T5	PA; QL (28 EA per 28 days)
<b>EPCLUSA ORAL PELLETS IN PACKET 200-50 MG</b>	T5	PA; QL (56 EA per 28 days)
<b>EPCLUSA ORAL TABLET</b>	T5	PA; QL (28 EA per 28 days)
<i>ertapenem</i>	T4	
<b>ERY-TAB ORAL TABLET, DELAYED RELEASE (DR/EC) 250 MG, 333 MG</b>	T4	
<i>erythromycin ethylsuccinate oral tablet</i>	T4	
<i>erythromycin oral tablet</i>	T2	
<i>ethambutol</i>	T2	
<i>etravirine</i>	T5	
<b>EVOTAZ</b>	T5	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>famciclovir</i>	T3	
<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	
<b>FUZEON SUBCUTANEOUS RECON SOLN</b>	T5	
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	T2	
<i>gentamicin injection solution 40 mg/ml</i>	T4	
<b>GENVOYA</b>	T5	
<i>griseofulvin microsize</i>	T4	
<i>griseofulvin ultramicrosize</i>	T4	
<b>HARVONI ORAL PELLETS IN PACKET</b>	T5	PA; QL (28 EA per 28 days)
<b>HARVONI ORAL TABLET 90-400 MG</b>	T5	PA; QL (28 EA per 28 days)
<i>hydroxychloroquine oral tablet 200 mg</i>	T2	QL (93 EA per 31 days)
<i>imipenem-cilastatin</i>	T4	
<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</i>	T4	PA
<i>ivermectin oral</i>	T3	PA
<b>JULUCA</b>	T5	
<i>ketoconazole oral</i>	T2	
<b>KITABIS PAK</b>	T4	PA
<b>LAGEVRIO (EUA)</b>	T3	QL (360 EA per 365 days)
<i>lamivudine</i>	T2	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lamivudine-zidovudine</i>	T2	
<i>ledipasvir-sofosbuvir</i>	T5	PA; QL (28 EA per 28 days)
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	T2	
<i>levofloxacin oral solution</i>	T4	
<i>levofloxacin oral tablet</i>	T2	
<i>linezolid in dextrose 5%</i>	T4	
<i>linezolid oral tablet</i>	T4	
<i>lopinavir-ritonavir oral solution</i>	T4	
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	T3	
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	T4	
<i>maraviroc oral tablet 150 mg</i>	T5	
<i>maraviroc oral tablet 300 mg</i>	T4	
<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)
<i>mefloquine</i>	T2	
<i>meropenem intravenous recon soln 1 gram, 500 mg</i>	T4	
<i>methenamine hippurate</i>	T4	
<i>metronidazole in nacl (iso-os)</i>	T2	
<i>metronidazole oral tablet</i>	T2	
<i>micafungin intravenous recon soln 100 mg</i>	T4	
<i>micafungin intravenous recon soln 50 mg</i>	T5	
<i>minocycline oral capsule</i>	T2	
<i>minocycline oral tablet</i>	T2	
<i>moxifloxacin oral</i>	T3	
<i>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>	T4	
<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)

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>NORVIR ORAL POWDER IN PACKET</b>	T4	
<i>nystatin oral</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	
<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 in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml</i>	T4	
<i>oxacillin injection recon soln 1 gram</i>	T2	
<i>oxacillin injection recon soln 2 gram</i>	T4	
<b>PAXLOVID ORAL TABLETS,DOSE PACK 150-100 MG</b>	T3	QL (180 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)
<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</b>	T5	QL (31 EA per 31 days)
<b>PREZCOBIX</b>	T5	
<b>PREZISTA ORAL SUSPENSION</b>	T5	
<b>PREZISTA ORAL TABLET 150 MG, 75 MG</b>	T5	
<b>PRIFTIN</b>	T4	
<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	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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 intravenous</i>	T5	
<i>rifampin oral</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>SELZENTRY ORAL TABLET 25 MG</b>	T4	
<b>SELZENTRY ORAL TABLET 75 MG</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	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	T1	
<b>SUNLENCA ORAL</b>	T5	
<b>SYMTUZA</b>	T5	QL (31 EA per 31 days)
<b>TEFLARO INTRAVENOUS RECON SOLN 400 MG</b>	T4	
<b>TEFLARO INTRAVENOUS RECON SOLN 600 MG</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>	T5	
<b>TIVICAY ORAL TABLET 10 MG</b>	T4	
<b>TIVICAY ORAL TABLET 25 MG, 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	
<b>TRECTOR</b>	T4	

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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>trimethoprim</i>	T2	
<b>TRIUMEQ</b>	T5	
<b>TRIUMEQ PD</b>	T5	QL (186 EA per 31 days)
<b>TRIZIVIR</b>	T5	
<b>TYBOST</b>	T3	
<i>valacyclovir</i>	T2	
<i>valganciclovir oral recon soln</i>	T5	
<i>valganciclovir oral tablet</i>	T3	
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg</i>	T4	
<i>vancomycin oral capsule 125 mg</i>	T4	PA; QL (124 EA per 31 days)
<i>vancomycin oral capsule 250 mg</i>	T4	PA; QL (248 EA per 31 days)
<i>vancomycin oral recon soln 50 mg/ml</i>	T4	
<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 suspension for reconstitution</i>	T5	
<i>voriconazole oral tablet</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>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>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	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>AUGTYRO</b>	T5	PA-NS; QL (248 EA per 31 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</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>CABOMETYX</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>CALQUENCE</b>	T5	PA-NS; QL (62 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)
<i>cyclophosphamide oral</i>	T3	PA-BvD
<i>cyclosporine modified oral capsule</i>	T2	PA-BvD
<i>cyclosporine modified oral solution</i>	T4	PA-BvD
<i>cyclosporine oral capsule</i>	T2	PA-BvD
<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>DROXIA</b>	T4	
<b>ELIGARD</b>	T4	
<b>ELIGARD (3 MONTH)</b>	T4	
<b>ELIGARD (4 MONTH)</b>	T4	
<b>ELIGARD (6 MONTH)</b>	T4	

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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ENVARBUS XR</b>	T4	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)
<i>everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 7.5 mg</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg, 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>everolimus (immunosuppressive)</i>	T5	PA-BvD
<i>exemestane</i>	T4	
<b>FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG</b>	T5	
<b>FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG</b>	T4	
<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>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</b>	T2	PA-BvD
<b>GILOTRIF</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>GLEOSTINE ORAL CAPSULE 10 MG, 40 MG</b>	T4	PA-NS
<b>GLEOSTINE ORAL CAPSULE 100 MG</b>	T5	PA-NS
<i>hydroxyurea</i>	T2	
<b>IBRANCE</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>ICLUSIG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>IDHIFA ORAL TABLET 100 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>IDHIFA ORAL TABLET 50 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<i>imatinib oral tablet 100 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>imatinib oral tablet 400 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<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)

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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG</b>	T5	PA-NS; QL (31 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>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 200 MG/DAY(200 MG X 1)-2.5 MG</b>	T5	PA-NS; QL (49 EA per 28 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>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>KLISYRI</b>	T5	PA
<b>KOSELUGO ORAL CAPSULE 10 MG</b>	T5	PA; QL (279 EA per 31 days)
<b>KOSELUGO ORAL CAPSULE 25 MG</b>	T5	PA; QL (124 EA per 31 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)
<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 (3 month)</i>	T4	ST
<i>leuprolide subcutaneous kit</i>	T3	
<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</b>	T5	PA-NS; QL (124 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>LUMAKRAS ORAL TABLET 320 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>LUPRON DEPOT</b>	T5	ST
<b>LUPRON DEPOT (3 MONTH)</b>	T5	ST
<b>LUPRON DEPOT (4 MONTH)</b>	T5	ST
<b>LUPRON DEPOT (6 MONTH)</b>	T5	ST
<b>LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG</b>	T5	PA
<b>LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)</b>	T5	PA
<b>LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT</b>	T5	PA
<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>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</i>	T2	
<b>MESNEX ORAL</b>	T4	
<i>methotrexate sodium</i>	T2	PA-BvD
<i>methotrexate sodium (pf) injection solution</i>	T2	PA-BvD
<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

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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>mycophenolate sodium</i>	T4	PA-BvD
<b>NERLYNX</b>	T5	PA-NS; QL (186 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 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	T4	PA
<i>octreotide acetate injection solution 500 mcg/ml</i>	T5	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>OGSIVEO ORAL TABLET 50 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>OJEMDA ORAL SUSPENSION FOR RECONSTITUTION</b>	T5	PA-NS; QL (96 ML per 28 days)
<b>OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)</b>	T5	PA-NS; QL (20 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</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>PURIXAN</b>	T5	
<b>QINLOCK</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>RETEVMO ORAL CAPSULE 40 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>RETEVMO ORAL CAPSULE 80 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>REZLIDHIA</b>	T5	PA-NS; QL (62 EA per 31 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)

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>SANDIMMUNE ORAL SOLUTION</b>	T3	PA-BvD
<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 (310 EA per 31 days)
<b>SIGNIFOR</b>	T5	PA
<i>sirolimus oral solution</i>	T5	PA-BvD
<i>sirolimus oral tablet</i>	T4	PA-BvD
<b>SOLTAMOX</b>	T5	
<i>sorafenib</i>	T5	PA-NS; QL (124 EA per 31 days)
<b>SPRYCEL</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>STIVARGA</b>	T5	PA-NS; QL (84 EA per 28 days)
<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>TAGRISO</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>TASIGNA</b>	T5	PA-NS; QL (124 EA per 31 days)
<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, 150 MG, 50 MG</b>	T5	PA-NS; QL (28 EA per 28 days)
<b>THALOMID ORAL CAPSULE 200 MG</b>	T5	PA-NS; QL (56 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</b>	T4	ST
<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)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>TUKYSA ORAL TABLET 50 MG</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>TURALIO ORAL CAPSULE 125 MG</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>	T4	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>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>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 (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)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
<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)
<b>AJOVY AUTOINJECTOR</b>	T3	PA; QL (1.5 ML per 28 days)
<b>AJOVY SYRINGE</b>	T3	PA; QL (1.5 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>apomorphine</i>	T5	PA; QL (60 ML per 30 days)
<b>APTIOM ORAL TABLET 200 MG</b>	T5	QL (186 EA per 31 days)
<b>APTIOM ORAL TABLET 400 MG</b>	T5	QL (93 EA per 31 days)
<b>APTIOM ORAL TABLET 600 MG, 800 MG</b>	T5	QL (62 EA per 31 days)
<i>aripiprazole oral solution</i>	T4	PA-NS
<i>aripiprazole oral tablet</i>	T3	PA-NS
<i>aripiprazole oral tablet, disintegrating</i>	T4	PA-NS
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
<i>asenapine maleate</i>	T4	PA-NS; QL (62 EA per 31 days)
<i>atomoxetine oral capsule 10 mg, 25 mg, 40 mg</i>	T4	QL (62 EA per 31 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	T4	QL (31 EA per 31 days)
<i>atomoxetine oral capsule 18 mg</i>	T4	QL (124 EA per 31 days)
<b>AUVELITY</b>	T4	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)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>benztropine oral</i>	T2	PA
<b>BRIVIACT ORAL SOLUTION</b>	T5	QL (620 ML per 31 days)
<b>BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 75 MG</b>	T5	QL (62 EA per 31 days)
<b>BRIVIACT ORAL TABLET 50 MG</b>	T4	QL (62 EA per 31 days)
<i>bromocriptine</i>	T4	
<i>buprenorphine</i>	T4	PA; QL (4 EA per 28 days)
<i>buprenorphine hcl sublingual tablet 2 mg</i>	T3	QL (93 EA per 31 days)
<i>buprenorphine hcl sublingual tablet 8 mg</i>	T3	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 12-3 mg, 4-1 mg, 8-2 mg</i>	T2	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>buprenorphine-naloxone sublingual tablet</i>	T4	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet</i>	T2	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	T2	QL (31 EA per 31 days)
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	T2	QL (62 EA per 31 days)
<i>buspirone</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</i>	T2	
<i>carbidopa-levodopa</i>	T2	
<i>carbidopa-levodopa-entacapone</i>	T4	
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	T2	ST; QL (62 EA per 31 days)
<i>celecoxib oral capsule 400 mg</i>	T3	ST; QL (62 EA per 31 days)
<i>chlorpromazine oral</i>	T4	
<i>citalopram oral solution</i>	T3	
<i>citalopram oral tablet</i>	T1	
<i>clobazam oral suspension</i>	T4	PA-NS; QL (496 ML per 31 days)
<i>clobazam oral tablet</i>	T3	PA-NS; QL (62 EA per 31 days)
<i>clomipramine</i>	T4	PA-NS
<i>clonazepam oral tablet 0.5 mg</i>	T2	PA-NS; QL (93 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
<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>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	
<b>DAYBUE</b>	T5	PA; QL (3600 ML per 30 days)
<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>	T2	QL (31 EA per 31 days)
<i>dexmethylphenidate oral tablet 10 mg</i>	T2	QL (62 EA per 31 days)
<i>dexmethylphenidate oral tablet 2.5 mg, 5 mg</i>	T2	QL (93 EA per 31 days)
<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr</i>	T4	QL (31 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	T2	QL (62 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dextroamphetamine-amphetamine oral tablet 20 mg</i>	T2	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 epolamine</i>	T4	PA; QL (62 EA per 31 days)
<i>diclofenac potassium oral tablet 50 mg</i>	T2	
<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>	T4	PA; QL (8 ML per 31 days)
<b>DILANTIN</b>	T4	
<b>DILANTIN EXTENDED</b>	T4	
<b>DILANTIN INFATABS</b>	T4	
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg (14)- 240 mg (46)</i>	T5	PA; QL (120 EA per 365 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 240 mg</i>	T5	PA; QL (62 EA per 31 days)
<i>divalproex oral capsule, delayed rel sprinkle</i>	T2	
<i>divalproex oral tablet extended release 24 hr 250 mg</i>	T2	
<i>divalproex oral tablet extended release 24 hr 500 mg</i>	T3	
<i>divalproex oral tablet, delayed release (dr/ec)</i>	T2	
<i>donepezil oral tablet 10 mg, 5 mg</i>	T1	
<i>donepezil oral tablet 23 mg</i>	T3	QL (31 EA per 31 days)
<i>donepezil oral tablet, disintegrating</i>	T2	
<i>doxepin oral capsule</i>	T2	PA-NS
<i>doxepin oral concentrate</i>	T2	PA-NS
<i>doxepin oral tablet</i>	T3	PA

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
<b>ENDOCET</b>	T3	PA; QL (372 EA per 31 days)
<i>entacapone</i>	T3	
<b>EPIDIOLEX</b>	T5	PA-NS
<b>EPITOL</b>	T2	
<b>EPRONTIA</b>	T4	PA-NS; QL (496 ML per 31 days)
<i>ergotamine-caffeine</i>	T3	PA
<i>escitalopram oxalate oral solution</i>	T4	QL (620 ML per 31 days)
<i>escitalopram oxalate oral tablet 10 mg</i>	T2	QL (45 EA per 30 days)
<i>escitalopram oxalate oral tablet 20 mg, 5 mg</i>	T2	QL (30 EA per 30 days)
<i>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>EVRYSDI</b>	T5	PA; QL (240 ML per 31 days)
<b>FANAPT ORAL TABLET 1 MG</b>	T4	QL (62 EA per 31 days)
<b>FANAPT ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG</b>	T5	QL (62 EA per 31 days)
<b>FANAPT ORAL TABLETS,DOSE PACK</b>	T4	QL (16 EA per 365 days)
<i>felbamate oral suspension</i>	T5	
<i>felbamate oral tablet</i>	T4	
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg</i>	T5	PA; QL (40 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 1,600 mcg</i>	T5	PA; QL (30 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	T5	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr</i>	T4	PA; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr</i>	T4	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 25 mcg/hr</i>	T2	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 50 mcg/hr</i>	T2	PA; QL (17 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 75 mcg/hr</i>	T4	PA; QL (12 EA per 30 days)
<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)
<b>FIRDAPSE</b>	T5	PA; QL (248 EA per 31 days)
<b>FLECTOR</b>	T4	PA; QL (62 EA per 31 days)
<i>fluoxetine (pmdd)</i>	T2	
<i>fluoxetine oral capsule</i>	T1	
<i>fluoxetine oral solution</i>	T3	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	T2	
<i>fluphenazine decanoate</i>	T3	
<i>fluphenazine hcl injection</i>	T4	
<i>fluphenazine hcl oral concentrate</i>	T4	
<i>fluphenazine hcl oral tablet</i>	T2	
<i>flurbiprofen oral tablet 100 mg</i>	T2	
<i>fluvoxamine oral capsule,extended release 24hr</i>	T4	
<i>fluvoxamine oral tablet</i>	T2	
<b>FYCOMPA ORAL SUSPENSION</b>	T5	QL (744 ML per 31 days)
<b>FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG</b>	T5	QL (31 EA per 31 days)
<b>FYCOMPA ORAL TABLET 2 MG</b>	T4	QL (31 EA per 31 days)
<i>gabapentin oral capsule 100 mg, 400 mg</i>	T2	PA-NS; QL (270 EA per 30 days)

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>gabapentin oral capsule 300 mg</i>	T2	PA-NS; QL (360 EA per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	T4	PA-NS; QL (2160 ML per 30 days)
<i>gabapentin oral tablet 600 mg</i>	T2	PA-NS; QL (180 EA per 30 days)
<i>gabapentin oral tablet 800 mg</i>	T2	PA-NS; QL (120 EA per 30 days)
<i>galantamine</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	
<b>HETLIOZ</b>	T5	PA; QL (31 EA per 31 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>hydromorphone oral liquid</i>	T4	PA; QL (1550 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 (186 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>INGREZZA INITIATION PK(TARDIV)</b>	T5	PA; QL (56 EA per 365 days)
<b>INGREZZA ORAL CAPSULE 40 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>INGREZZA ORAL CAPSULE 60 MG, 80 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML</b>	T5	QL (3.5 ML per 180 days)
<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)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<b>LIBERVANT</b>	T5	PA-NS; QL (10 EA per 30 days)
<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	
<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	
<b>LUCEMYRA</b>	T5	
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>lurasidone oral tablet 80 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<b>MARPLAN</b>	T4	
<b>MAVENCLAD (10 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MAVENCLAD (4 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (5 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (6 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (7 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (8 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (9 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<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 oral tablets, dose pack</i>	T4	
<i>methadone oral solution 10 mg/5 ml</i>	T2	PA; QL (1033 ML per 31 days)
<i>methadone oral solution 5 mg/5 ml</i>	T2	PA; QL (2066 ML per 31 days)
<i>methadone oral tablet 10 mg</i>	T2	PA; QL (206 EA per 31 days)
<i>methadone oral tablet 5 mg</i>	T2	PA; QL (248 EA per 31 days)
<i>methsuximide</i>	T4	
<i>methylphenidate 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>naloxone nasal</i>	T3	
<i>naltrexone</i>	T2	
<b>NAMZARIC</b>	T4	PA
<i>naproxen oral suspension</i>	T2	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
<i>nefazodone</i>	T4	
<b>NEUPRO</b>	T4	
<i>nortriptyline</i>	T2	
<b>NOURIANZ</b>	T5	PA; QL (31 EA per 31 days)
<b>NUEDEXTA</b>	T3	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)
<i>oxcarbazepine oral suspension</i>	T4	
<i>oxcarbazepine oral tablet</i>	T2	
<i>oxycodone oral capsule</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral concentrate</i>	T4	PA; QL (180 ML per 31 days)
<i>oxycodone oral solution</i>	T2	PA; QL (4133 ML per 31 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral tablet 30 mg</i>	T3	PA; QL (138 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg</i>	T3	PA; QL (372 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	T4	QL (31 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	T4	QL (62 EA per 31 days)
<i>paroxetine hcl oral suspension</i>	T4	
<i>paroxetine hcl oral tablet</i>	T1	
<i>perphenazine</i>	T4	
<b>PERSERIS</b>	T5	QL (1 EA per 28 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>phenelzine</i>	T2	
<i>phenobarbital</i>	T2	PA-NS
<i>phenytoin oral suspension 125 mg/5 ml</i>	T2	
<i>phenytoin oral tablet, chewable</i>	T2	
<i>phenytoin sodium extended</i>	T2	
<i>pimozide</i>	T4	
<i>piroxicam</i>	T2	
<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>	T4	
<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</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>RADICAVA ORS STARTER KIT SUSP</b>	T5	PA; QL (70 ML per 28 days)
<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)
<b>REYVOW ORAL TABLET 100 MG</b>	T4	QL (8 EA per 28 days)
<b>REYVOW ORAL TABLET 50 MG</b>	T4	QL (4 EA per 28 days)
<i>risperidone microspheres intramuscular suspension, extended rel recon 12.5 mg/2 ml, 25 mg/2 ml, 37.5 mg/2 ml</i>	T4	QL (2 EA per 28 days)
<i>risperidone microspheres intramuscular suspension, extended rel recon 50 mg/2 ml</i>	T5	QL (2 EA per 28 days)
<i>risperidone oral solution</i>	T2	QL (496 ML per 31 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T2	QL (31 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
<i>rizatriptan oral tablet,disintegrating 5 mg</i>	T2	QL (24 EA per 28 days)
<i>ropinirole oral tablet</i>	T2	
<b>ROWEEPRA ORAL TABLET 500 MG</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</b>	T4	
<b>SUBVENITE</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 cartridge 6 mg/0.5 ml</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	T4	QL (6 ML per 28 days)

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>SUNOSI</b>	T4	PA; QL (31 EA per 31 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)
<b>TEGRETOL ORAL TABLET</b>	T4	
<b>TEGRETOL XR</b>	T4	
<i>teriflunomide</i>	T5	PA; QL (31 EA per 31 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>tetrabenazine oral tablet 25 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>thioridazine</i>	T2	
<i>thiothixene</i>	T3	
<i>tiagabine</i>	T4	
<i>tizanidine oral tablet</i>	T2	
<i>topiramate oral capsule, sprinkle</i>	T2	
<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</i>	T3	PA-NS
<b>TRINTELLIX</b>	T3	
<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 NASAL SPRAY, NON-AEROSOL 10 MG/SPRAY (0.1 ML), 5 MG/SPRAY (0.1 ML)</b>	T4	PA-NS; QL (10 EA per 30 days)
<b>VALTOCO NASAL SPRAY, NON-AEROSOL 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2)</b>	T5	PA-NS; QL (10 EA per 30 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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
<b>VIGPODER</b>	T5	PA-NS
<i>vilazodone</i>	T3	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 ORAL TABLET 250MG/DAY(150 MG X1-100MG X1)</b>	T4	PA-NS
<b>XCOPRI MAINTENANCE PACK ORAL TABLET 350 MG/DAY (200 MG X1-150MG X1)</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
<b>XYREM</b>	T5	PA; QL (540 ML per 30 days)
<i>zaleplon oral capsule 10 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>zaleplon oral capsule 5 mg</i>	T2	PA; QL (93 EA per 31 days)
<b>ZAVZPRET</b>	T5	PA; QL (8 EA per 30 days)
<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 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)

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ziprasidone mesylate</i>	T3	
<i>zolpidem oral tablet</i>	T4	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 SUBLINGUAL TABLET 0.7-0.18 MG, 2.9-0.71 MG, 8.6-2.1 MG</b>	T3	QL (62 EA per 31 days)
<b>ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG</b>	T3	QL (93 EA per 31 days)
<b>ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 5.7-1.4 MG</b>	T3	QL (31 EA per 31 days)
<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>ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG</b>	T5	QL (2 EA per 28 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>	T3	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	
<i>benazepril</i>	T1	
<i>benazepril-hydrochlorothiazide</i>	T1	
<i>bisoprolol fumarate</i>	T2	
<i>bisoprolol-hydrochlorothiazide</i>	T1	
<b>BRILINTA</b>	T3	
<i>bumetanide oral</i>	T2	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>CABLIVI INJECTION KIT</b>	T5	PA; QL (31 EA per 31 days)
<b>CAMZYOS</b>	T5	PA; QL (31 EA per 31 days)
<i>candesartan</i>	T1	
<i>candesartan-hydrochlorothiazid</i>	T1	
<i>captopril</i>	T1	
<b>CARTIA XT</b>	T2	
<i>carvedilol</i>	T1	
<i>carvedilol phosphate</i>	T4	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>cholestyramine (with sugar) oral powder in packet</i>	T2	
<b>CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET</b>	T2	
<i>cilostazol</i>	T2	
<i>clonidine</i>	T3	
<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>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	
<b>DOPTELET (10 TAB PACK)</b>	T5	PA
<b>DOPTELET (15 TAB PACK)</b>	T5	PA
<b>DOPTELET (30 TAB PACK)</b>	T5	PA
<i>doxazosin</i>	T2	
<b>ELIQUIS DVT-PE TREAT 30D START</b>	T3	QL (74 EA per 30 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>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>	T3	QL (186 EA per 31 days)
<b>ENTRESTO ORAL TABLET 49-51 MG</b>	T3	QL (93 EA per 31 days)
<b>ENTRESTO ORAL TABLET 97-103 MG</b>	T3	QL (62 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	
<b>FILSPARI</b>	T5	PA; QL (31 EA per 31 days)
<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	
<b>FUROSCIX</b>	T5	PA; QL (8 EA per 30 days)
<i>furosemide injection solution</i>	T2	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	T2	
<i>furosemide oral tablet</i>	T1	
<i>gemfibrozil</i>	T1	
<i>heparin (porcine) injection solution</i>	T3	
<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)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>irbesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<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>JUXTAPID</b>	T5	PA
<b>KERENDIA</b>	T4	PA; QL (31 EA per 31 days)
<i>labetalol oral</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</i>	T1	
<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)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nicardipine oral</i>	T4	
<i>nifedipine oral tablet extended release</i>	T2	
<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>	T2	QL (31 EA per 31 days)
<i>olmesartan oral tablet 5 mg</i>	T2	QL (93 EA per 31 days)
<i>olmesartan-amlodipin-hcthiazid</i>	T3	
<i>olmesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<i>omega-3 acid ethyl esters</i>	T3	QL (124 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG</b>	T4	PA; QL (93 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG</b>	T5	PA; QL (186 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG</b>	T5	PA; QL (521 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG</b>	T5	PA; QL (261 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</i>	T3	
<i>pravastatin</i>	T1	
<i>prazosin</i>	T2	
<b>PREVALITE ORAL POWDER IN PACKET</b>	T4	
<b>PROMACTA ORAL POWDER IN PACKET 12.5 MG</b>	T5	PA; QL (372 EA per 31 days)
<b>PROMACTA ORAL POWDER IN PACKET 25 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>PROMACTA ORAL TABLET 12.5 MG, 25 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>PROMACTA ORAL TABLET 50 MG, 75 MG</b>	T5	PA; QL (62 EA per 31 days)
<i>propafenone oral capsule, extended release 12 hr</i>	T4	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>quinidine sulfate oral tablet</i>	T2	
<i>ramipril</i>	T1	
<i>ranolazine</i>	T4	QL (62 EA per 31 days)
<b>REPATHA PUSHTRONEX</b>	T3	PA; QL (7 ML per 28 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>simvastatin</i>	T1	
<b>SORINE ORAL TABLET 120 MG, 160 MG</b>	T2	
<b>SOTALOL AF</b>	T2	
<i>sotalol oral</i>	T2	
<i>spironolactone oral tablet</i>	T1	
<i>spironolacton-hydrochlorothiaz</i>	T2	
<i>telmisartan</i>	T2	
<i>telmisartan-amlodipine</i>	T4	
<i>telmisartan-hydrochlorothiazid</i>	T2	
<i>terazosin</i>	T1	
<b>TIADYLT ER</b>	T2	
<i>timolol maleate oral</i>	T3	
<i>toremide 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>	T2	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	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
<b>VYNDAMAX</b>	T5	PA; QL (31 EA per 31 days)
<b>VYNDAQEL</b>	T5	PA; QL (124 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>ACCUTANE ORAL CAPSULE 10 MG</b>	T2	
<b>ACCUTANE ORAL CAPSULE 20 MG, 40 MG</b>	T4	
<i>acitretin</i>	T4	PA
<i>acyclovir topical ointment</i>	T3	QL (30 GM per 30 days)
<b>ADBRY SUBCUTANEOUS SYRINGE</b>	T5	PA; QL (4 ML per 28 days)
<b>ALA-CORT TOPICAL CREAM 1 %</b>	T1	
<b>ALA-CORT TOPICAL CREAM 2.5 %</b>	T1	QL (30 GM per 28 days)
<i>alclometasone</i>	T3	
<i>ammonium lactate</i>	T2	
<b>AMNESTEEM</b>	T4	
<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)

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>calcipotriene topical ointment</i>	T3	QL (60 GM per 28 days)
<i>calcitriol topical</i>	T4	ST
<b>CIBINQO</b>	T5	PA; QL (31 EA per 31 days)
<i>ciclopirox topical cream</i>	T2	QL (90 GM per 28 days)
<i>ciclopirox topical gel</i>	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 gel, once daily</i>	T2	QL (75 ML 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>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>CROTAN</b>	T4	
<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 100 MG/0.67 ML</b>	T5	PA; QL (1.34 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	

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>erythromycin with ethanol topical gel</i>	T2	QL (60 GM per 28 days)
<i>erythromycin with ethanol topical solution</i>	T2	QL (60 ML per 28 days)
<i>erythromycin-benzoyl peroxide</i>	T4	
<b>FILSUEZ</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 butyrate topical lotion</i>	T4	QL (118 ML 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>isotretinoin</i>	T4	
<i>ketoconazole topical cream</i>	T2	QL (60 GM per 28 days)
<i>ketoconazole topical shampoo</i>	T2	QL (120 ML per 28 days)
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	T2	PA; QL (50 ML per 28 days)
<i>lidocaine topical adhesive patch,medicated 5 %</i>	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	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<b>REGRANEX</b>	T5	PA
<b>SANTYL</b>	T4	QL (180 GM per 30 days)
<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 150 MG/ML</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)
<i>sulfacetamide sodium (acne)</i>	T2	
<b>SULFAMYLON TOPICAL CREAM</b>	T3	
<i>tacrolimus topical</i>	T4	QL (100 GM per 28 days)
<b>TALTZ AUTOINJECTOR</b>	T5	PA; QL (1 ML per 28 days)
<b>TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML</b>	T5	PA; QL (1 ML per 28 days)
<i>tazarotene topical cream 0.1 %</i>	T4	PA; QL (60 GM per 28 days)
<i>tazarotene topical gel</i>	T4	PA; QL (100 GM per 28 days)
<b>TAZORAC TOPICAL CREAM 0.05 %</b>	T4	PA; QL (60 GM per 28 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tretinoin topical cream</i>	T2	PA; QL (45 GM per 28 days)
<i>tretinoin topical gel</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	
<i>triamcinolone acetonide topical ointment 0.05 %</i>	T4	
<b>TRIDERM TOPICAL CREAM</b>	T4	
<b>VALCHLOR</b>	T5	PA-NS
<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
<i>cevimeline</i>	T4	
<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>deferiprone</i>	T5	PA
<i>dextrose 10 % in water (d10w)</i>	T2	
<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	T2	
<i>disulfiram</i>	T3	
<i>droxidopa oral capsule 100 mg</i>	T5	PA; QL (465 EA per 31 days)
<i>droxidopa oral capsule 200 mg, 300 mg</i>	T5	PA; QL (186 EA per 31 days)
<b>DUVYZAT</b>	T5	PA; QL (420 ML per 35 days)
<b>FABHALTA</b>	T5	PA; QL (62 EA per 31 days)
<b>INCRELEX</b>	T5	PA
<b>JOENJA</b>	T5	PA; QL (60 EA per 30 days)
<b>KIONEX (WITH SORBITOL)</b>	T2	
<i>levocarnitine (with sugar)</i>	T4	PA-BvD

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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</b>	T4	
<b>NICOTROL NS</b>	T5	
<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>PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG</b>	T5	PA; QL (56 EA per 28 days)
<b>RAVICTI</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>	T4	
<i>sevelamer carbonate oral powder in packet</i>	T4	
<i>sevelamer carbonate oral tablet</i>	T3	
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	T2	
<i>sodium chloride irrigation</i>	T2	
<i>sodium phenylbutyrate</i>	T5	PA
<i>sodium polystyrene sulfonate oral powder</i>	T2	
<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 oral tablet</i>	T4	QL (60 EA per 30 days)
<i>varenicline oral tablets,dose pack</i>	T4	QL (106 EA per 365 days)
<b>XURIDEN</b>	T5	PA; QL (124 EA per 31 days)
<b>ZOKINVY</b>	T5	PA
<b>Ear, Nose / Throat Medications</b>		
<i>acetic acid otic (ear)</i>	T2	
<i>azelastine nasal spray,non-aerosol 137 mcg (0.1 %)</i>	T2	QL (30 ML per 25 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>chlorhexidine gluconate mucous membrane</i>	T1	
<b>CIPRO HC</b>	T4	
<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	
<b>BAQSIMI</b>	T3	
<b>BASAGLAR KWIKPEN U-100 INSULIN</b>	T4	
<b>BASAGLAR TEMPO PEN(U-100)INSLN</b>	T4	
<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>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)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>FIASP FLEXTOUCH U-100 INSULIN</b>	T3	
<b>FIASP PENFILL U-100 INSULIN</b>	T3	
<b>FIASP U-100 INSULIN</b>	T3	
<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 TEMPO PEN(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 asp prt-insulin aspart</i>	T3	
<i>insulin aspart u-100</i>	T3	
<i>insulin lispro</i>	T3	
<i>insulin lispro protamin-lispro</i>	T3	
<b>INVOKAMET</b>	T3	QL (62 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>INVOKAMET XR</b>	T3	QL (62 EA per 31 days)
<b>INVOKANA ORAL TABLET 100 MG</b>	T3	QL (62 EA per 31 days)
<b>INVOKANA ORAL TABLET 300 MG</b>	T3	QL (31 EA per 31 days)
<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>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	
<b>LEVEMIR FLEXPEN</b>	T3	
<b>LEVEMIR 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	
<i>liothyronine oral</i>	T2	
<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)

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MYALEPT</b>	T5	PA
<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 INSULIN</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>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	PA; QL (248 EA per 31 days)
<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>SYMLINPEN 120</b>	T5	QL (10.8 ML per 28 days)
<b>SYMLINPEN 60</b>	T5	QL (6 ML per 28 days)
<b>SYNAREL</b>	T5	PA
<b>SYNJARDY</b>	T3	QL (62 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>	T3	PA
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)</i>	T3	PA
<i>tolvaptan</i>	T5	PA
<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>TRESIBA FLEXTOUCH U-100</b>	T3	
<b>TRESIBA FLEXTOUCH U-200</b>	T3	
<b>TRESIBA U-100 INSULIN</b>	T3	
<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>VICTOZA 3-PAK</b>	T3	PA; QL (9 ML per 30 days)
<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>ZEGALOGUE AUTOINJECTOR</b>	T3	
<b>ZEGALOGUE SYRINGE</b>	T3	
<b>Gastroenterology</b>		
<i>alosetron oral tablet 0.5 mg</i>	T5	PA; QL (93 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>alosetron oral tablet 1 mg</i>	T5	PA; QL (62 EA per 31 days)
<i>aprepitant</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>CHOLBAM</b>	T5	PA
<b>CIMZIA POWDER FOR RECONST</b>	T5	PA; QL (2 EA per 28 days)
<b>CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)</b>	T5	PA; QL (2 EA per 28 days)
<b>CLENPIQ</b>	T4	
<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</i>	T2	
<i>diphenoxylate-atropine oral liquid</i>	T4	
<i>diphenoxylate-atropine oral tablet</i>	T2	
<i>dronabinol</i>	T4	PA-BvD
<b>ENULOSE</b>	T2	
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec)</i>	T2	QL (31 EA per 31 days)
<i>famotidine oral suspension for reconstitution</i>	T2	
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
<b>GATTEX 30-VIAL</b>	T5	PA
<b>GAVILYTE-C</b>	T2	
<b>GAVILYTE-G</b>	T2	
<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>hydrocortisone-pramoxine rectal cream 1-1 %</i>	T4	
<b>IBSRELA</b>	T5	PA; QL (62 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lactulose oral solution 10 gram/15 ml</i>	T2	
<b>LINZESS</b>	T3	QL (31 EA per 31 days)
<i>loperamide oral capsule</i>	T2	
<i>lubiprostone</i>	T3	QL (62 EA per 31 days)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	T2	
<i>mesalamine oral capsule (with del rel tablets)</i>	T3	QL (186 EA per 31 days)
<i>mesalamine oral capsule, extended release</i>	T4	QL (248 EA per 31 days)
<i>mesalamine oral capsule, extended release 24hr</i>	T4	QL (124 EA per 31 days)
<i>mesalamine oral tablet, delayed release (dr/ec) 1.2 gram</i>	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	
<b>OCALIVA</b>	T5	PA; QL (31 EA per 31 days)
<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>	T2	
<i>peg3350-sod sul-nacl-kcl-asb-c</i>	T4	
<i>peg-electrolyte soln</i>	T2	
<i>prochlorperazine</i>	T4	
<i>prochlorperazine maleate</i>	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)
<b>RECTIV</b>	T4	
<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>	T3	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>SUCRAID</b>	T5	PA
<i>sucralfate</i>	T2	
<i>sulfasalazine</i>	T2	
<i>ursodiol oral capsule 300 mg</i>	T4	
<i>ursodiol oral tablet</i>	T3	
<b>VIBERZI</b>	T5	PA; QL (62 EA per 31 days)
<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 (2 EA per 365 days)
<b>ACTHIB (PF)</b>	T3	
<b>ACTIMMUNE</b>	T5	PA
<b>ADACEL(TDAP ADOLESN/ADULT)(PF)</b>	T3	
<b>ARCALYST</b>	T5	PA
<b>AREXVY (PF)</b>	T3	QL (2 EA per 365 days)
<b>AVONEX INTRAMUSCULAR PEN INJECTOR KIT</b>	T5	PA; QL (4 EA per 28 days)
<b>AVONEX INTRAMUSCULAR SYRINGE KIT</b>	T5	PA; QL (4 EA per 28 days)
<i>bcg vaccine, live (pf)</i>	T4	
<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>BIVIGAM</b>	T5	PA
<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>FULPHILA</b>	T5	
<b>GAMMAGARD LIQUID</b>	T5	PA
<b>GAMMAGARD S-D (IGA &lt; 1 MCG/ML)</b>	T5	PA
<b>GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)</b>	T5	PA

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>GAMMAPLEX</b>	T5	PA
<b>GAMMAPLEX (WITH SORBITOL)</b>	T5	PA
<b>GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)</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>IXCHIQ (PF)</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>MENACTRA (PF) INTRAMUSCULAR SOLUTION</b>	T3	
<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>NEULASTA</b>	T5	
<b>NIVESTYM</b>	T5	
<b>NORDITROPIN FLEXPPO</b>	T5	PA
<b>OCTAGAM</b>	T5	PA
<b>PANZYGA</b>	T5	PA
<b>PEDIARIX (PF)</b>	T3	PA-BvD
<b>PEDVAX HIB (PF)</b>	T3	
<b>PEGASYS</b>	T5	PA
<b>PENBRAYA (PF)</b>	T3	
<b>PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU -10 MCG/0.5ML</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>PREHEVBRIO (PF)</b>	T3	PA-BvD

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PRIORIX (PF)</b>	T3	
<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</b>	T3	
<b>ROTATEQ VACCINE</b>	T3	
<b>SHINGRIX (PF)</b>	T3	QL (2 EA per 999 days)
<b>TDVAX</b>	T3	
<b>TENIVAC (PF)</b>	T3	
<i>tetanus, diphtheria tox ped(pf)</i>	T4	
<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>XOLREMDI</b>	T5	PA; QL (124 EA per 31 days)
<b>YF-VAX (PF)</b>	T3	
<b>ZARXIO</b>	T5	
<b>ZIEXTENZO</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	
<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)

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>adalimumab-adaz</i>	T5	PA; QL (0.8 ML per 28 days)
<i>adalimumab-adbm subcutaneous pen injector kit 40 mg/0.4 ml</i>	T5	PA; QL (2 EA per 28 days)
<i>adalimumab-adbm subcutaneous pen injector kit 40 mg/0.8 ml</i>	T5	PA; QL (1.6 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 10 mg/0.2 ml</i>	T5	PA; QL (0.4 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 20 mg/0.4 ml</i>	T5	PA; QL (0.8 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 40 mg/0.4 ml</i>	T5	PA; QL (2 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 40 mg/0.8 ml</i>	T5	PA; QL (1.6 EA per 28 days)
<b>ADALIMUMAB-ADBM(CF) PEN CROHNS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML</b>	T5	PA; QL (12 EA per 365 days)
<b>ADALIMUMAB-ADBM(CF) PEN CROHNS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML</b>	T5	PA; QL (9.6 EA per 365 days)
<b>ADALIMUMAB-ADBM(CF) PEN PS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML</b>	T5	PA; QL (8 EA per 365 days)
<b>ADALIMUMAB-ADBM(CF) PEN PS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML</b>	T5	PA; QL (6.4 EA per 365 days)
<i>alendronate oral tablet 10 mg, 35 mg, 70 mg</i>	T1	
<i>allopurinol oral tablet 100 mg, 300 mg</i>	T1	
<b>BENLYSTA SUBCUTANEOUS</b>	T5	PA; QL (4 ML per 28 days)
<i>colchicine oral capsule</i>	T3	QL (62 EA per 31 days)
<b>CYLTEZO(CF)</b>	T5	PA; QL (2 EA per 28 days)
<b>CYLTEZO(CF) PEN</b>	T5	PA; QL (2 EA per 28 days)
<b>CYLTEZO(CF) PEN CROHN'S-UC-HS</b>	T5	PA; QL (12 EA per 365 days)
<b>CYLTEZO(CF) PEN PSORIASIS-UV</b>	T5	PA; QL (8 EA per 365 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)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML ( 105MG/1.17MLX2)</b>	T5	PA; QL (2.34 ML per 28 days)
<b>HUMIRA PEN</b>	T5	PA; QL (2 EA per 28 days)
<b>HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML</b>	T5	PA; QL (2 EA per 28 days)
<b>HUMIRA(CF)</b>	T5	PA; QL (2 EA per 28 days)
<b>HUMIRA(CF) PEN</b>	T5	PA; QL (2 EA per 28 days)
<b>HUMIRA(CF) PEN CROHNS-UC-HS</b>	T5	PA; QL (3 EA per 28 days)
<b>HUMIRA(CF) PEN PEDIATRIC UC</b>	T5	PA; QL (4 EA per 28 days)
<b>HUMIRA(CF) PEN PSOR-UV-ADOL HS</b>	T5	PA; QL (3 EA per 28 days)
<b>HYRIMOZ PEN CROHN'S-UC STARTER</b>	T5	PA; QL (4.8 ML per 365 days)
<b>HYRIMOZ PEN PSORIASIS STARTER</b>	T5	PA; QL (3.2 ML per 365 days)
<b>HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML</b>	T5	PA; QL (4.8 ML per 365 days)
<b>HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML-40 MG/0.4 ML</b>	T5	PA; QL (2.4 ML per 365 days)
<b>HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML</b>	T5	PA; QL (0.8 ML per 28 days)
<b>HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 80 MG/0.8 ML</b>	T5	PA; QL (1.6 ML per 28 days)
<b>HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML</b>	T5	PA; QL (0.2 ML per 28 days)
<b>HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML</b>	T5	PA; QL (0.4 ML per 28 days)
<b>HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML</b>	T5	PA; QL (0.8 ML per 28 days)
<i>ibandronate oral</i>	T2	
<b>KEVZARA</b>	T5	PA; QL (2.28 ML per 28 days)
<b>KINERET</b>	T5	PA; QL (18.76 ML per 28 days)
<i>leflunomide</i>	T3	
<b>MITIGARE</b>	T3	QL (62 EA per 31 days)
<b>OLUMIANT</b>	T5	PA; QL (31 EA per 31 days)
<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)

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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>OTEZLA ORAL TABLET 30 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)</b>	T5	PA; QL (55 EA per 28 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>RIDAURA</b>	T5	
<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	
<i>risedronate oral tablet,delayed release (dr/ec)</i>	T4	
<b>SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML</b>	T5	PA; QL (1 ML per 28 days)
<b>SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 28 days)
<b>SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML</b>	T5	PA; QL (1 ML per 28 days)
<b>SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 28 days)
<i>teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)</i>	T5	PA; QL (2.48 ML per 28 days)
<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>Obstetrics / Gynecology</b>		
<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>BALZIVA (28)</b>	T2	
<b>BLISOVI FE 1.5/30 (28)</b>	T2	
<b>BRIELLYN</b>	T2	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>	T4	
<i>desog-e.estradiol/e.estradiol</i>	T2	
<i>desogestrel-ethinyl estradiol</i>	T2	
<b>DOLISHALE</b>	T2	
<i>drospirenone-ethinyl estradiol</i>	T2	
<b>ENPRESSE</b>	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	
<i>estradiol-norethindrone acet</i>	T2	
<i>ethynodiol diac-eth estradiol</i>	T2	
<i>etonogestrel-ethinyl estradiol</i>	T4	
<b>HAILEY 24 FE</b>	T2	
<b>HALOETTE</b>	T4	
<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	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>KELNOR 1/50 (28)</b>	T2	
<b>KURVELO (28)</b>	T2	
<b>LESSINA</b>	T2	
<b>LEVONEST (28)</b>	T2	
<i>levonorgestrel-ethinyl estrad</i>	T2	
<i>levonorg-eth estrad triphasic</i>	T2	
<b>LEVORA-28</b>	T2	
<b>LILETTA</b>	T4	
<b>LORYNA (28)</b>	T2	
<b>LOW-OGESTREL (28)</b>	T2	
<b>LUTERA (28)</b>	T2	
<b>LYLEQ</b>	T2	
<b>LYZA</b>	T2	
<b>MARLISSA (28)</b>	T2	
<i>medroxyprogesterone</i>	T2	
<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	
<i>noreth-ethinyl estradiol-iron</i>	T2	
<i>norethindrone (contraceptive)</i>	T2	
<i>norethindrone acetate</i>	T2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	T3	
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	T2	
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	T2	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>norgestimate-ethinyl estradiol oral tablet</i> <i>0.18/0.215/0.25 mg-35 mcg (28), 0.25-35 mg-mcg</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>NYMYO</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-NYMYO</b>	T2	
<b>TRI-SPRINTEC (28)</b>	T2	
<b>TRIVORA (28)</b>	T2	
<b>TRI-VYLIBRA</b>	T2	
<b>TURQOZ (28)</b>	T2	
<b>VANDAZOLE</b>	T3	
<b>VELIVET TRIPHASIC REGIMEN (28)</b>	T2	
<b>VESTURA (28)</b>	T2	
<b>VIENVA</b>	T2	
<b>VYFEMLA (28)</b>	T2	
<b>VYLIBRA</b>	T2	
<b>YUVAFEM</b>	T4	
<b>ZOVIA 1-35 (28)</b>	T2	
<b>Ophthalmology</b>		
<i>acetazolamide</i>	T3	
<b>ALOMIDE</b>	T4	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>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	
<b>CILOXAN OPHTHALMIC (EYE) OINTMENT</b>	T4	
<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	
<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	
<b>ILEVRO</b>	T3	
<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>	T1	

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>levofloxacin 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	
<b>NATACYN</b>	T4	
<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	
<b>NEO-POLYCIN</b>	T2	
<b>NEO-POLYCIN HC</b>	T2	
<i>ofloxacin ophthalmic (eye)</i>	T2	
<b>OXERVATE</b>	T5	PA; QL (112 ML per 56 days)
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T3	
<b>POLYCIN</b>	T2	
<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>SIMBRINZA</b>	T4	
<i>sulfacetamide sodium ophthalmic (eye)</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	
<b>TOBRADEX OPHTHALMIC (EYE) OINTMENT</b>	T3	
<b>TOBRADEX ST</b>	T3	
<i>tobramycin ophthalmic (eye)</i>	T1	
<i>tobramycin-dexamethasone</i>	T3	
<b>TOBREX OPHTHALMIC (EYE) OINTMENT</b>	T4	
<i>travoprost</i>	T3	
<i>trifluridine</i>	T3	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>XDEM VY</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)
<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	
<b>ALYQ</b>	T5	PA; QL (62 EA per 31 days)
<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>BERINERT INTRAVENOUS KIT</b>	T5	PA
<i>bosentan</i>	T5	PA; QL (62 EA per 31 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)
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	T3	PA-BvD
<i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i>	T4	PA-BvD
<i>budesonide-formoterol</i>	T3	QL (10.2 GM per 30 days)
<b>CINRYZE</b>	T5	PA; QL (20 EA per 28 days)
<b>COMBIVENT RESPIMAT</b>	T3	QL (4 GM per 30 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cromolyn inhalation</i>	T5	PA-BvD
<i>cyproheptadine</i>	T2	PA
<i>desloratadine oral tablet</i>	T2	QL (31 EA per 31 days)
<i>epinephrine injection auto-injector</i>	T3	
<b>FASENRA PEN</b>	T5	PA; QL (1 ML per 56 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 56 days)
<i>flunisolide</i>	T3	QL (50 ML per 25 days)
<i>fluticasone propionate inhalation blister with device</i>	T3	QL (60 EA per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation</i>	T3	QL (12 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	T3	QL (24 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation</i>	T3	QL (10.6 GM per 30 days)
<i>fluticasone propionate nasal</i>	T1	QL (16 GM per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated</i>	T3	QL (1 EA per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	T3	QL (60 EA per 30 days)
<b>HAEGARDA</b>	T5	PA
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	T2	PA
<i>hydroxyzine hcl oral tablet</i>	T2	PA
<i>icatibant</i>	T5	PA; QL (18 ML per 30 days)
<i>ipratropium bromide inhalation</i>	T2	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
<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>	T2	PA-BvD
<i>levalbuterol tartrate</i>	T3	QL (30 GM per 30 days)
<i>levocetirizine oral solution</i>	T3	QL (310 ML per 31 days)
<i>levocetirizine oral tablet</i>	T1	QL (31 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>NUCALA SUBCUTANEOUS AUTO-INJECTOR</b>	T5	PA; QL (3 ML per 28 days)
<b>NUCALA SUBCUTANEOUS RECON SOLN</b>	T5	PA; QL (3 EA per 28 days)
<b>NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML</b>	T5	PA; QL (3 ML per 28 days)
<b>NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML</b>	T5	PA; QL (0.4 ML per 28 days)
<b>OFEV</b>	T5	PA; QL (62 EA per 31 days)
<b>OPSUMIT</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)
<b>ORLADEYO</b>	T5	PA; QL (31 EA per 31 days)
<i>pirfenidone oral capsule</i>	T5	PA; QL (279 EA per 31 days)
<i>pirfenidone oral tablet</i>	T5	PA; QL (93 EA per 31 days)
<i>promethazine oral 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 suspension for reconstitution</i>	T5	PA; QL (784 ML per 31 days)
<i>sildenafil (pulm.hypertension) oral tablet</i>	T3	PA; QL (372 EA per 31 days)
<b>SPIRIVA RESPIMAT</b>	T3	QL (4 GM per 30 days)
<b>SPIRIVA WITH HANDIHALER</b>	T3	QL (30 EA 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)
<b>SYMDEKO</b>	T5	PA; QL (56 EA per 28 days)
<i>tadalafil (pulm. hypertension)</i>	T5	PA; QL (62 EA per 31 days)
<b>TADLIQ</b>	T5	PA; QL (310 ML per 31 days)
<b>TAKHZYRO SUBCUTANEOUS SOLUTION</b>	T5	PA; QL (4 ML per 28 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML</b>	T5	PA; QL (2 ML per 28 days)
<b>TAKHZYRO SUBCUTANEOUS SYRINGE 300 MG/2 ML (150 MG/ML)</b>	T5	PA; QL (4 ML per 28 days)
<i>terbutaline oral</i>	T4	
<b>THEO-24</b>	T4	
<i>theophylline oral solution</i>	T2	
<i>theophylline oral tablet extended release 12 hr</i>	T2	
<i>theophylline oral tablet extended release 24 hr</i>	T2	
<i>tiotropium bromide</i>	T3	QL (30 EA per 30 days)
<b>TRACLEER ORAL TABLET FOR SUSPENSION</b>	T5	PA; QL (124 EA per 31 days)
<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>TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 32 MCG, 32-48 MCG, 48 MCG, 64 MCG</b>	T5	PA
<b>TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16(112)-32(112) -48(28) MCG</b>	T5	PA; QL (504 EA per 365 days)
<b>VENTOLIN HFA</b>	T3	QL (36 GM per 30 days)
<b>WIXELA INHUB</b>	T3	QL (60 EA per 30 days)
<b>XOLAIR</b>	T5	PA
<i>zafirlukast oral tablet 10 mg</i>	T4	QL (93 EA per 31 days)
<i>zafirlukast oral tablet 20 mg</i>	T4	QL (62 EA per 31 days)
<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>CIALIS ORAL TABLET 2.5 MG</b>	T4	PA; QL (62 EA per 31 days)
<b>CIALIS ORAL TABLET 5 MG</b>	T4	PA; QL (31 EA per 31 days)
<b>CYSTAGON</b>	T4	
<i>darifenacin</i>	T4	QL (31 EA per 31 days)
<i>dutasteride</i>	T2	QL (31 EA per 31 days)
<i>dutasteride-tamsulosin</i>	T3	QL (31 EA per 31 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ELMIRON</b>	T4	
<i>finasteride oral tablet 5 mg</i>	T2	
<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 capsule,extended release 24hr</i>	T3	QL (31 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) oral capsule</i>	T2	
<i>calcium acetate(phosphat bind) oral tablet</i>	T3	
<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 %, 30 %</b>	T4	PA-BvD
<b>ISOLYTE S PH 7.4</b>	T3	PA-BvD
<b>ISOLYTE-P IN 5 % DEXTROSE</b>	T4	PA-BvD

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>KLOR-CON</b>	T3	
<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	
<b>TRAVASOL 10 %</b>	T3	PA-BvD
<b>TROPHAMINE 10 %</b>	T4	PA-BvD

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



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<b>PERIOGARD</b> .....	45	<i>pregabalin</i> .....	29	<i>ramipril</i> .....	38
<i>permethrin</i> .....	42	<b>PREHEVBRIO (PF)</b> .....	53	<i>ranolazine</i> .....	38
<i>perphenazine</i> .....	28	<b>PREMARIN</b> .....	60	<i>rasagiline</i> .....	29
<b>PERSERIS</b> .....	28	<b>PRENATAL VITAMIN</b>		<b>RAVICTI</b> .....	44
<b>PHEBURANE</b> .....	44	<b>PLUS LOW IRON</b> .....	68	<b>RECLIPSEN (28)</b> .....	60
<i>phenelzine</i> .....	29	<b>PREVALITE</b> .....	37	<b>RECOMBIVAX HB (PF)</b> .....	54
<i>phenobarbital</i> .....	29	<b>PREVYMIS</b> .....	9	<b>RECORLEV</b> .....	48
<i>phenytoin</i> .....	29	<b>PREZCOBIX</b> .....	9	<b>RECTIV</b> .....	51
<i>phenytoin sodium extended</i> .....	29	<b>PREZISTA</b> .....	9	<b>REGANEX</b> .....	42
<b>PIFELTRO</b> .....	9	<b>PRIFTIN</b> .....	9	<b>RELENZA DISKHALER</b> .....	9
<i>pilocarpine hcl</i> .....	44, 62	<i>primaquine</i> .....	9	<i>repaglinide</i> .....	48
<i>pimozide</i> .....	29	<i>primidone</i> .....	29	<b>REPATHA PUSHTRONEX</b> ... 38	
<b>PIMTREA (28)</b> .....	60	<b>PRIORIX (PF)</b> .....	54	<b>REPATHA SURECLICK</b> ..... 38	
<i>pindolol</i> .....	37	<b>PRIVIGEN</b> .....	54	<b>REPATHA SYRINGE</b> ..... 38	
<i>pioglitazone</i> .....	48	<i>probenecid</i> .....	57	<b>RESTASIS</b> .....	62
<i>pioglitazone-metformin</i> .....	48	<i>probenecid-colchicine</i> .....	57	<b>RESTASIS MULTIDOSE</b> ..... 62	
<i>piperacillin-tazobactam</i> .....	9	<i>prochlorperazine</i> .....	51	<b>RETACRIT</b> .....	54
<b>PIQRAY</b> .....	16	<i>prochlorperazine maleate</i> .....	51	<b>RETEVMO</b> .....	16
<i>pirfenidone</i> .....	65	<b>PROCRT</b> .....	54	<b>REVCovi</b> .....	44
<i>piroxicam</i> .....	29	<b>PROCTOSOL HC</b> .....	51	<b>REXULTI</b> .....	29
<i>pitavastatin calcium</i> .....	37	<b>PROCTOZONE-HC</b> .....	51	<b>REYATAZ</b> .....	10
<b>PLEGRIDY</b> .....	53	<b>PROGRAF</b> .....	16	<b>REYVOW</b> .....	29
<b>PLENAMINE</b> .....	68	<b>PROLASTIN-C</b> .....	44	<b>REZDIFFRA</b> .....	44
<i>podofilox</i> .....	42	<b>PROLIA</b> .....	57	<b>REZLIDHIA</b> .....	16
<b>POLYCN</b> .....	62	<b>PROMACTA</b> .....	37	<i>ribavirin</i> .....	10
<i>polymyxin b sulf-trimethoprim</i> ....	62	<i>promethazine</i> .....	65	<b>RIDAURA</b> .....	57
<b>POMALYST</b> .....	16	<i>propafenone</i> .....	37, 38	<i>rifabutin</i> .....	10
<b>PORTIA 28</b> .....	60	<i>propranolol</i> .....	38	<i>rifampin</i> .....	10
<i>posaconazole</i> .....	9	<i>propylthiouracil</i> .....	48	<i>riluzole</i> .....	44
<i>potassium chlorid-d5-</i>		<b>PROQUAD (PF)</b> .....	54	<i>rimantadine</i> .....	10
<i>0.45%nacl</i> .....	68	<b>PROSOL 20 %</b> .....	68	<b>RINVOQ</b> .....	57
<i>potassium chloride</i> .....	68	<i>protriptyline</i> .....	29	<i>risedronate</i> .....	44, 57
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<i>potassium chloride in 5 % dex</i> .... 68		<b>PURIXAN</b> .....	16	<i>risperidone microspheres</i> .....	29
<i>potassium chloride in lr-d5</i> ..... 68		<i>pyrazinamide</i> .....	9	<i>ritonavir</i> .....	10
<i>potassium chloride in water</i> ..... 68		<i>pyridostigmine bromide</i> .....	29	<i>rivastigmine</i> .....	30
<i>potassium chloride-0.45 % nacl</i> . 68		<i>pyrimethamine</i> .....	9	<i>rivastigmine tartrate</i> .....	30
<i>potassium chloride-d5-</i>		<b>PYRUKYND</b> .....	44	<b>RIVFLOZA</b> .....	67
<i>0.2%nacl</i> .....	68	<b>QINLOCK</b> .....	16	<i>rizatriptan</i> .....	30
<i>potassium chloride-d5-</i>		<b>QUADRACEL (PF)</b> .....	54	<i>roflumilast</i> .....	65
<i>0.9%nacl</i> .....	68	<i>quetiapine</i> .....	29	<i>ropinirole</i> .....	30

<i>rosuvastatin</i> .....	38	<b>SOMAVERT</b> .....	48	<i>tadalafil (pulm. hypertension)</i> ....	65
<b>ROTARIX</b> .....	54	<i>sorafenib</i> .....	17	<b>TADLIQ</b> .....	65
<b>ROTATEQ VACCINE</b> .....	54	<b>SORINE</b> .....	38	<b>TAFINLAR</b> .....	17
<b>ROWEEPR</b> A.....	30	<i>sotalol</i> .....	38	<b>TAGRISO</b> .....	17
<b>ROZLYTREK</b> .....	16	<b>SOTALOL AF</b> .....	38	<b>TAKHZYRO</b> .....	65, 66
<b>RUBRACA</b> .....	17	<b>SPIRIVA RESPIMAT</b> .....	65	<b>TALTZ AUTOINJECTOR</b> .....	42
<i>rufinamide</i> .....	30	<b>SPIRIVA WITH</b>		<b>TALTZ SYRINGE</b> .....	42
<b>RUKOBIA</b> .....	10	<b>HANDIHALER</b> .....	65	<b>TALZENNA</b> .....	17
<b>RYBELSUS</b> .....	48	<i>spironolactone</i> .....	38	<i>tamoxifen</i> .....	17
<b>RYDAPT</b> .....	17	<i>spironolacton-hydrochlorothiaz.</i>	38	<i>tamsulosin</i> .....	67
<b>RYTARY</b> .....	30	<b>SPRINTEC (28)</b> .....	60	<b>TASCENSO ODT</b> .....	31
<b>SAJAZIR</b> .....	65	<b>SPRITAM</b> .....	30	<b>TASIGNA</b> .....	17
<b>SANDIMMUNE</b> .....	17	<b>SPRYCEL</b> .....	17	<i>tasimelteon</i> .....	31
<b>SANTYL</b> .....	42	<b>SPS (WITH SORBITOL)</b> .....	44	<i>tazarotene</i> .....	42
<i>sapropterin</i> .....	48	<b>SRONYX</b> .....	60	<b>TAZORAC</b> .....	42
<b>SCEMBLIX</b> .....	17	<b>SSD</b> .....	42	<b>TAZVERIK</b> .....	17
<i>scopolamine base</i> .....	51	<b>STELARA</b> .....	42	<b>TDVAX</b> .....	54
<b>SECUADO</b> .....	30	<b>STIOLTO RESPIMAT</b> .....	65	<b>TEFLARO</b> .....	10
<i>selegiline hcl</i> .....	30	<b>STIVARGA</b> .....	17	<b>TEGRETOL</b> .....	31
<i>selenium sulfide</i> .....	42	<i>streptomycin</i> .....	10	<b>TEGRETOL XR</b> .....	31
<b>SELZENTRY</b> .....	10	<b>STRIBILD</b> .....	10	<i>telmisartan</i> .....	38
<b>SEREVENT DISKUS</b> .....	65	<b>STRIVERDI RESPIMAT</b> .....	65	<i>telmisartan-amlodipine</i> .....	38
<i>sertraline</i> .....	30	<b>SUBVENITE</b> .....	30	<i>telmisartan-hydrochlorothiazid.</i>	38
<b>SETLAKIN</b> .....	60	<b>SUCRAID</b> .....	52	<b>TENIVAC (PF)</b> .....	54
<i>sevelamer carbonate</i> .....	44	<i>sucralfate</i> .....	52	<i>tenofovir disoproxil fumarate</i> .....	10
<b>SHINGRIX (PF)</b> .....	54	<i>sulfacetamide sodium</i> .....	62	<b>TEPMETKO</b> .....	17
<b>SIGNIFOR</b> .....	17	<i>sulfacetamide sodium (acne)</i> .....	42	<i>terazosin</i> .....	38
<i>sildenafil (pulm.hypertension)</i> ....	65	<i>sulfacetamide-prednisolone</i> .....	62	<i>terbinafine hcl</i> .....	10
<b>SILIQ</b> .....	42	<i>sulfadiazine</i> .....	10	<i>terbutaline</i> .....	66
<i>silodosin</i> .....	67	<i>sulfamethoxazole-trimethoprim.</i>	10	<i>terconazole</i> .....	60
<i>silver sulfadiazine</i> .....	42	<b>SULFAMYLON</b> .....	42	<i>teriflunomide</i> .....	31
<b>SIMBRINZA</b> .....	62	<i>sulfasalazine</i> .....	52	<i>teriparatide</i> .....	57
<b>SIMPONI</b> .....	57	<i>sulindac</i> .....	30	<i>testosterone</i> .....	49
<i>simvastatin</i> .....	38	<i>sumatriptan</i> .....	30	<i>testosterone cypionate</i> .....	49
<i>sirolimus</i> .....	17	<i>sumatriptan succinate</i> .....	30, 31	<i>testosterone enanthate</i> .....	49
<b>SIRTURO</b> .....	10	<i>sunitinib malate</i> .....	17	<i>tetanus,diphtheria tox ped(pf)</i> ....	54
<b>SKYCLARYS</b> .....	30	<b>SUNLENCA</b> .....	10	<i>tetrabenazine</i> .....	31
<b>SKYRIZI</b> .....	42, 51	<b>SUNOSI</b> .....	31	<i>tetracycline</i> .....	10
<i>sodium chloride</i> .....	44	<b>SYEDA</b> .....	60	<b>THALOMID</b> .....	17
<i>sodium chloride 0.45 %</i> .....	68	<b>SYMDEKO</b> .....	65	<b>THEO-24</b> .....	66
<i>sodium chloride 0.9 %</i> .....	44	<b>SYMLINPEN 120</b> .....	48	<i>theophylline</i> .....	66
<i>sodium chloride 3 % hypertonic</i> .....	68	<b>SYMLINPEN 60</b> .....	48	<i>thioridazine</i> .....	31
<i>sodium chloride 5 % hypertonic</i> .....	68	<b>SYMPAZAN</b> .....	31	<i>thiothixene</i> .....	31
<i>sodium oxybate</i> .....	30	<b>SYMTUZA</b> .....	10	<b>TIADYLT ER</b> .....	38
<i>sodium phenylbutyrate</i> .....	44	<b>SYNAREL</b> .....	48	<i>tiagabine</i> .....	31
<i>sodium polystyrene sulfonate</i> .....	44	<b>SYNJARDY</b> .....	48	<b>TIBSOVO</b> .....	17
<i>sodium,potassium,mag sulfates.</i>	51	<b>SYNJARDY XR</b> .....	49	<b>TICOVAC</b> .....	54
<i>sofosbuvir-velpatasvir</i> .....	10	<b>SYNTHROID</b> .....	49	<i>tigecycline</i> .....	10
<b>SOHONOS</b> .....	44	<b>TABLOID</b> .....	17	<i>timolol maleate</i> .....	38, 62
<i>solifenacin</i> .....	67	<b>TABRECTA</b> .....	17	<i>tiotropium bromide</i> .....	66
<b>SOLIQUA 100/33</b> .....	48	<i>tacrolimus</i> .....	17, 42	<b>TIVICAY</b> .....	10
<b>SOLTAMOX</b> .....	17	<i>tadalafil</i> .....	67	<b>TIVICAY PD</b> .....	10

<i>tizanidine</i> .....	31	<b>TRI-SPRINTEC (28)</b> .....	60	<b>VIENVA</b> .....	60
<b>TOBI PODHALER</b> .....	10	<b>TRIUMEQ</b> .....	11	<i>vigabatrin</i> .....	32
<b>TOBRADEX</b> .....	62	<b>TRIUMEQ PD</b> .....	11	<b>VIGADRONE</b> .....	32
<b>TOBRADEX ST</b> .....	62	<b>TRIVORA (28)</b> .....	60	<b>VIGPODER</b> .....	32
<i>tobramycin</i> .....	10, 62	<b>TRI-VYLIBRA</b> .....	60	<b>VIJOICE</b> .....	18
<i>tobramycin in 0.225 % nacl</i> .....	10	<b>TRIZIVIR</b> .....	11	<i>vilazodone</i> .....	32
<i>tobramycin sulfate</i> .....	10	<b>TROPHAMINE 10 %</b> .....	68	<b>VIRACEPT</b> .....	11
<i>tobramycin-dexamethasone</i> .....	62	<i>trospium</i> .....	67	<b>VIREAD</b> .....	11
<b>TOBREX</b> .....	62	<b>TRULICITY</b> .....	49	<b>VITRAKVI</b> .....	18
<i>tolterodine</i> .....	67	<b>TRUMENBA</b> .....	54	<b>VIVITROL</b> .....	32
<i>tolvaptan</i> .....	49	<b>TRUQAP</b> .....	17	<b>VIVJOA</b> .....	11
<i>topiramate</i> .....	31	<b>TUKYSA</b> .....	17, 18	<b>VIZIMPRO</b> .....	18
<i>toremifene</i> .....	17	<b>TURALIO</b> .....	18	<b>VONJO</b> .....	18
<i>torse mide</i> .....	38	<b>TURQOZ (28)</b> .....	60	<i>voriconazole</i> .....	11
<b>TOUJEO MAX U-300</b>		<b>TWINRIX (PF)</b> .....	54	<b>VOSEVI</b> .....	11
<b>SOLOSTAR</b> .....	49	<b>TYBOST</b> .....	11	<b>VOWST</b> .....	52
<b>TOUJEO SOLOSTAR U-300</b>		<b>TYMLOS</b> .....	57	<b>VRAYLAR</b> .....	32
<b>INSULIN</b> .....	49	<b>TYPHIM VI</b> .....	54	<b>VUMERITY</b> .....	32
<b>TRACLEER</b> .....	66	<b>TYVASO DPI</b> .....	66	<b>VYFEMLA (28)</b> .....	60
<b>TRADJENTA</b> .....	49	<b>UBRELVY</b> .....	31	<b>VYLIBRA</b> .....	60
<i>tramadol</i> .....	31	<b>UNITHROID</b> .....	49	<b>VYNDAMAX</b> .....	39
<i>tramadol-acetaminophen</i> .....	31	<b>UPTRAVI</b> .....	38	<b>VYNDAQEL</b> .....	39
<i>trandolapril</i> .....	38	<i>ursodiol</i> .....	52	<i>warfarin</i> .....	39
<i>tranexamic acid</i> .....	60	<i>valacyclovir</i> .....	11	<b>WELIREG</b> .....	18
<i>tranylcypromine</i> .....	31	<b>VALCHLOR</b> .....	43	<b>WIXELA INHUB</b> .....	66
<b>TRAVASOL 10 %</b> .....	68	<i>valganciclovir</i> .....	11	<b>XALKORI</b> .....	18
<i>travoprost</i> .....	62	<i>valproic acid</i> .....	31	<b>XARELTO</b> .....	39
<i>trazodone</i> .....	31	<i>valproic acid (as sodium salt)</i> .....	31	<b>XARELTO DVT-PE TREAT</b>	
<b>TRECTOR</b> .....	10	<i>valsartan</i> .....	38	<b>30D START</b> .....	39
<b>TRELEGY ELLIPTA</b> .....	66	<i>valsartan-hydrochlorothiazide</i> .....	38	<b>XATMEP</b> .....	18
<b>TRELSTAR</b> .....	17	<b>VALTOCO</b> .....	31	<b>XCOPRI</b> .....	32
<b>TRESIBA FLEXTOUCH U-</b>		<i>vancomycin</i> .....	11	<b>XCOPRI MAINTENANCE</b>	
<b>100</b> .....	49	<b>VANDAZOLE</b> .....	60	<b>PACK</b> .....	32
<b>TRESIBA FLEXTOUCH U-</b>		<b>VANFLYTA</b> .....	18	<b>XCOPRI TITRATION PACK</b>	32
<b>200</b> .....	49	<b>VAQTA (PF)</b> .....	54	<b>XDEMVY</b> .....	63
<b>TRESIBA U-100 INSULIN</b> .....	49	<i>varenicline</i> .....	44	<b>XELJANZ</b> .....	57
<i>tretinoin</i> .....	43	<b>VARIVAX (PF)</b> .....	54	<b>XELJANZ XR</b> .....	57
<i>tretinoin (antineoplastic)</i> .....	17	<b>VELIVET TRIPHASIC</b>		<b>XERMELo</b> .....	18
<i>triamcinolone acetonide</i> .....	43, 45	<b>REGIMEN (28)</b> .....	60	<b>XGEVA</b> .....	18
<i>triamterene-hydrochlorothiazid</i> .....	38	<b>VEMLIDY</b> .....	11	<b>XIFAXAN</b> .....	11
<b>TRIDERM</b> .....	43	<b>VENCLEXTA</b> .....	18	<b>XIGDUO XR</b> .....	49
<i>trientine</i> .....	44	<b>VENCLEXTA STARTING</b>		<b>XIIDRA</b> .....	63
<b>TRI-ESTARYLLA</b> .....	60	<b>PACK</b> .....	18	<b>XOFLUZA</b> .....	11
<i>trifluoperazine</i> .....	31	<i>venlafaxine</i> .....	32	<b>XOLAIR</b> .....	66
<i>trifluridine</i> .....	62	<b>VENTOLIN HFA</b> .....	66	<b>XOLREMDI</b> .....	54
<b>TRIJARDY XR</b> .....	49	<i>verapamil</i> .....	38, 39	<b>XOSPATA</b> .....	18
<b>TRIKAFTA</b> .....	66	<b>VERQUVO</b> .....	39	<b>XPOVIO</b> .....	18
<i>trimethoprim</i> .....	11	<b>VERSACLOZ</b> .....	32	<b>XTANDI</b> .....	18
<b>TRI-MILI</b> .....	60	<b>VERZENIO</b> .....	18	<b>XULTOPHY 100/3.6</b> .....	49
<i>trimipramine</i> .....	31	<b>VESTURA (28)</b> .....	60	<b>XURIDEN</b> .....	44
<b>TRINTELLIX</b> .....	31	<b>VIBERZI</b> .....	52	<b>XYREM</b> .....	32
<b>TRI-NYMYO</b> .....	60	<b>VICTOZA 3-PAK</b> .....	49	<b>YARGESA</b> .....	49

<b>YF-VAX (PF)</b> .....	54
<b>YONSA</b> .....	18
<b>YUVAFEM</b> .....	60
<i>zafirlukast</i> .....	66
<i>zaleplon</i> .....	32
<b>ZARXIO</b> .....	54
<b>ZAVZPRET</b> .....	32
<b>ZEGALOGUE</b>	
<b>AUTOINJECTOR</b> .....	49
<b>ZEGALOGUE SYRINGE</b> .....	49
<b>ZEJULA</b> .....	19
<b>ZELBORAF</b> .....	19
<b>ZENPEP</b> .....	52
<b>ZEPOSIA</b> .....	32
<b>ZEPOSIA STARTER KIT</b>	
<b>(28-DAY)</b> .....	32
<b>ZEPOSIA STARTER PACK</b>	
<b>(7-DAY)</b> .....	32
<i>zidovudine</i> .....	11
<b>ZIEXTENZO</b> .....	54
<b>ZILBRYSQ</b> .....	32
<i>ziprasidone hcl</i> .....	32
<i>ziprasidone mesylate</i> .....	33
<b>ZIRGAN</b> .....	63
<b>ZOKINVY</b> .....	44
<b>ZOLINZA</b> .....	19
<i>zolpidem</i> .....	33
<b>ZONISADE</b> .....	33
<i>zonisamide</i> .....	33
<b>ZOVIA 1-35 (28)</b> .....	60
<b>ZTALMY</b> .....	33
<b>ZUBSOLV</b> .....	33
<b>ZURZUVAE</b> .....	33
<b>ZYDELIG</b> .....	19
<b>ZYKADIA</b> .....	19
<b>ZYPREXA RELPREVV</b> .....	33

# 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

# Actemra

## 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>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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



# Adbry

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## Products Affected

- **ADBRY SUBCUTANEOUS SYRINGE**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe atopic dermatitis, documentation of one of the following (1 or 2): 1) trial & failure or intolerance to at least one topical corticosteroid or one topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus) -OR- 2) severe atopic dermatitis and the member is incapable of applying topical therapies due to the extent of body surface area involvement or severe atopic dermatitis and topical therapies are contraindicated due to severely damaged skin.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For Atopic Dermatitis, patients must have a trial/failure, intolerance, or contraindication to both preferred products: 1) Dupixent and 2) If 18 years or older, Rinvoq. For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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

# Afinitor

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## Products Affected

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

<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, if applicable to diagnosis: 1) HR mutation status and HER2 mutation status 2) Alternatives tried/failed 3) Concomitant therapy 4) Candidacy for surgical 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

# 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 (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes.
<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 migraine frequency
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Ajovy

## Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

PA Criteria	Criteria Details
<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 (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes.
<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 migraine frequency
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# 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- All of the following, if applicable to diagnosis: 1) BRCA mutations, 2) Comcomitant therapy with prednisone, 3) Concomitant therapy with a gonadotropin-releasing hormone analog or a bilateral orchiectomy.
<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

# 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 -AND- One of the following (1 or 2): 1) metastatic disease, or 2) will be used as adjuvant treatment following tumor resection of node positive or greater than or equal to 4 cm tumor(s).
<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



# 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

# 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
<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

# 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>	3 months initial authorization, 12 months reauthorization
<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

# Apokyn

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## Products Affected

- *apomorphine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Parkinson's disease -AND- for use in acute, intermittent treatment of hypomobility off episodes -AND- experiencing off episodes despite the use of oral carbidopa/levodopa -AND- Therapeutic failure, intolerance, or contraindication to one of the following generic products: pramipexole, ropinirole, entacapone, selegiline or rasagiline
<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

# 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

## ATTR-CM drugs

### Products Affected

- VYNDAMAX
- VYNDAQEL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitantly with transthyretin-lowering agents
<b>Required Medical Information</b>	Documentation of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) with amyloid deposits on cardiac biopsy or scintigraphy with heart contralateral greater than 1.5 (Grade III) -AND- Cardiac involvement supported by cardiac magnetic resonance, echocardiography or serum cardiac biomarker (e.g. B-type natriuretic peptide, cardiac troponin) - AND- Primary (light chain) amyloidosis has been ruled out by immunohistochemistry, mass spectrometry or scintigraphy.
<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

# Atypical Antipsychotics

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## Products Affected

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

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). For Rexulti used 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

# 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



# Augtyro

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## Products Affected

- AUGTYRO

<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

# 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

# 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 diagnosis -AND- all of the following, if applicable to diagnosis: 1) PDGFRA exon 18 mutation status 2) platelet count greater than or equal to 50 x 10 <sup>9</sup> /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

# 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

# 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>	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

# 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

# Benlysta

## Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of active systemic lupus erythematosus (SLE) -AND- documentation of positive anti-nuclear antibody (ANA) titer (greater than or equal to 1:80) or anti-double-stranded DNA antibody (anti-dsDNA) greater than or equal to 30IU/mL -AND- member will continue to receive concomitant standard of care treatment with use of at least one of the following (alone or in combination): 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate) -OR- Documentation of active lupus nephritis -AND- documentation of positive ANA titer (greater than or equal to 1:80) or anti-dsDNA greater than or equal to 30 IU/mL -AND- member will continue to receive concomitant standard of care treatment which includes corticosteroids (e.g. prednisone) with at least one of the following: 1.) mycophenolate for induction followed by mycophenolate for maintenance 2.) cyclophosphamide for induction followed by azathioprine for maintenance
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<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>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

# Berinert

## Products Affected

- **BERINERT INTRAVENOUS KIT**

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>	<p>For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type I &amp; II with the following (1-4): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. 4) Documentation of member's weight. For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type III with the following (5-9): 5) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 6) Documentation of family history of HAE or FXII mutation 7) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 8) Medications known to cause angioedema have been evaluated and discontinued. 9) Documentation of member's weight.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For 18 years of age or older, therapeutic failure, intolerance or contraindication to icatibant.

<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

# 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

# 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

# Braftovi

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## Products Affected

- BRAFTOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Use in wild-type BRAF melanoma or wild-type BRAF CRC
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) BRAF V600E or V600K mutation status 2) alternatives tried/failed 3) concomitant therapy
<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

# Brukinsa

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## Products Affected

- BRUKINSA

<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



# 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

# Cablivi

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## Products Affected

- CABLIVI INJECTION KIT

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

# Cabometyx

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## Products Affected

- CABOMETYX

<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, if applicable to diagnosis: 1) alternatives tried/failed 2) attestation of first line use 3) concomitant therapy 4) radioactive iodine refractory status
<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

# Calquence

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## Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- if applicable to diagnosis, alternatives tried/failed
<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

# Camzyos

## Products Affected

- CAMZYOS

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

# 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>	Documentation of diagnosis -AND- therapeutic failure, intolerance, or contraindication to one other generic atypical antipsychotic (e.g. quetiapine).
<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

# 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>	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



# 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

# 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

# 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

## CF drugs

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### Products Affected

- **KITABIS PAK**
- **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

# Cholbam

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## Products Affected

- CHOLBAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of bile acid synthesis disorders due to single enzyme defects (e.g. AKR1D1, CTX, CYP7A1) -OR- documentation of use as adjunctive therapy for peroxisomal disorders (PDs), including Zellweger spectrum disorders, in patients who exhibit manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption.
<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

# Cialis

## Products Affected

- **CIALIS ORAL TABLET 2.5 MG, 5 MG**
- *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>	For brand Cialis, trial and failure of generic tadalafil is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Cibinqo

## Products Affected

- CIBINQO

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

# Cimzia

## Products Affected

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

PA Criteria	Criteria Details
<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. leflunomide). For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to two nonsteroidal anti-inflammatory drugs (NSAIDs). For moderate to severe psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months



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

# 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>	For the prophylactic treatment of abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type I & II with the following (1-3): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. For the prophylactic treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type III with the following (4-7): 4) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 5) Documentation of family history of HAE or FXII mutation 6) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 7) Medications known to cause angioedema have been evaluated and discontinued.
<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

# 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

# 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- if applicable to diagnosis, alternatives tried/failed
<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

# Corlanor

## Products Affected

- **CORLANOR ORAL SOLUTION**
- *ivabradine oral tablet 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- All of the following: 1) Normal sinus rhythm, 2) Left ventricular ejection fraction less than or equal to 35 percent, when applicable, 3) Resting heart rate greater than or equal to 70 beats per minute, 4) In patients greater than or equal to 18 years of age, concurrent use of, therapeutic failure, intolerance to the maximum tolerated dose of at least 1 beta-blocker recommended for heart failure (i.e. bisoprolol, carvedilol, metoprolol succinate), or contraindication to beta-blocker use.
<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

# 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). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs.
<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>	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. 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

# Cotellic

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## 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, if applicable to diagnosis: 1) BRAF V600E or V600K mutation status 2) Concomitant 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



# 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

# 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

# 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>	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

# Daybue

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## Products Affected

- DAYBUE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Rett syndrome confirmed by all of the following (1 thru 4): 1) Partial or complete loss of acquired purposeful hand skills, 2) Partial or complete loss of acquired spoken language, 3) Gait abnormalities: impaired or absence of ability, 4) Stereotypic hand movements such as hand wringing/squeezing, clapping/tapping, mouthing, and washing/rubbing automatisms
<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

# 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

# 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

# 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

# Doptelet

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## Products Affected

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

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



# Dupixent

## Products Affected

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

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

<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 reauthorization, attestation of positive clinical response to therapy, for atopic dermatitis -OR- attestation of decreased rescue medication or oral corticosteroid use, decreased frequency of severe asthma exacerbation, increased pulmonary function from baseline (e.g. FEV1) or reduction in reported asthma related symptoms, for asthma -OR- attestation of decrease in nasal polyp score or reduction in nasal congestion/obstruction severity score, for CRSwNP -OR- attestation of histological remission (less than 15 eos/hpf) on esophageal biopsy or reduced severity or frequency of clinical symptoms of esophageal dysfunction, for EoE -OR- attestation of reduction in itch or number of nodules or lesions from baseline, for prurigo nodularis
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# 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

# 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>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis 1) Epidermal growth factor receptor (EGFR) mutations, including exon 19 deletions, exon 21 (L858R) substitution mutations or exon 20 insertion mutations 2) Alternatives tried/failed 3) Concomitant therapy 4) Line of therapy in which medication will be used
<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

# 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 (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes. For episodic cluster headaches, characterized by severe or very severe unilateral orbital, supraorbital, and/or temporal pain lasting 15 to 180 minutes when left untreated -AND- Attack frequency of at least one attack every other day during the cluster period.
<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 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>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Enbrel

## Products Affected

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

PA Criteria	Criteria Details
<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 juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
<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 Juvenile Idiopathic Arthritis and Psoriatic Arthritis or Less than 4 years of age for Plaque Psoriasis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Epclusa

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## Products Affected

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



# 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>	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

# Eprontia

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## Products Affected

- EPRONTIA

<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

# 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 or intolerance to a generic triptan -OR- documentation of use to prevent a vascular headache -AND- therapeutic failure or intolerance to generic prophylactic migraine medication
<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

# 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>	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

# 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

# Evenity

## Products Affected

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

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

# Evrysdi

## Products Affected

- EVRYSDI

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

# Fabhalta

## Products Affected

- FABHALTA

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

# Fasenra

## Products Affected

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

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

# Fecal Microbiota Products

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## Products Affected

- VOWST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a recent diagnosis of recurrent <i>Clostridioides difficile</i> infection (CDI) -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed.
<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

# Ferriprox

## Products Affected

- *deferiprone*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of transfusional iron overload due to thalassemia syndromes, sickle cell disease and other anemias -AND- transfusion history of greater than or equal to 100 mL/kg of packed red blood cells (i.e. at least 20 units of packed red blood cells for a 40 kg person or more in individuals weighing more than 40 kg) -AND- history of serum ferritin consistently greater than 1,000 mcg/L or liver iron concentration (LIC) greater than or equal to 7 iron per gram of liver dry weight (mg Fe/g dw)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial authorization requires trial and failure of deferasirox (generic Exjade) and reauthorization requires failure of generic deferasirox (generic Exjade) if not previously trialed. For reauthorization, continued requirement for regular blood transfusions -AND- serum ferritin level greater than or equal to 500mcg/L or LIC greater than or equal to 3 mg Fe/g dw
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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 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

# Filspari

## Products Affected

- FILSPARI

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

# 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>	Deny if less than 6 months of age
<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



# 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

# 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) type I & II with the following (1-3): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type III with the following (4-7): 4) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 5) Documentation of family history of HAE or FXII mutation 6) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 7) Medications known to cause angioedema have been evaluated and discontinued.
<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

# Firdapse

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## Products Affected

- **FIRDAPSE**

<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 of positive clinical response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Flector

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## Products Affected

- *diclofenac epolamine*
- **FLECTOR**

<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 (1,2 or 3): 1) trial/failure, intolerance, or contraindication to 2 oral generic NSAIDs one of which must be diclofenac 2) hypersensitivity to oral NSAIDs 3) history or high risk for adverse gastrointestinal effects associated with oral NSAID use.
<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

# Forteo

## Products Affected

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

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

# 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- if applicable to diagnosis, previous therapies tried/failed
<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

# Fruzaqla

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## Products Affected

- FRUZAQLA ORAL CAPSULE 1 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>	
<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



# Furoscix

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## Products Affected

- **FUROSCIX**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of heart failure classified as NYHA Class II/III - AND- chronic heart failure medication regimen includes an oral loop diuretic (e.g. furosemide, bumetanide, torsemide) -AND- treatment with oral diuretics will replace the use of Furoscix as soon as practical.
<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

# Gabapentin

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators
<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

# Gattex

## Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
<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 if age 18 and older, dependence on parenteral nutrition or intravenous nutritional support for at least 12 months AND requiring parenteral nutrition at least 3 times per week -OR- Documentation of SBS having less than 200 cm of functional small bowel AND age 1 to 17 years of age AND Dependence on parenteral nutrition AND weight of at least 10 kg.
<b>Age Restrictions</b>	Deny if less than 1 year of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, continued dependence on parenteral nutrition/intravenous nutritional support -AND- attestation of increase in weight from baseline or decrease in intravenous parenteral nutrition requirements from baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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 -AND- all of the following, if applicable to diagnosis 1) RET mutant or fusion status 2) Radioactive iodine-refractory (if radioactive iodine is appropriate)
<b>Age Restrictions</b>	Deny if less than 18 years of age for NSCLC or less than 12 years of age for thyroid cancer
<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

# 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

# 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

# Gleevec

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## Products Affected

- *imatinib oral tablet 100 mg, 400 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, if applicable to diagnosis 1) Alternatives tried 2) Concomitant therapy 3) mutation status, if applicable to 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

# Gleostine

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## Products Affected

- GLEOSTINE

<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, if applicable to diagnosis: 1) Prior surgical procedures and/or radiotherapeutic procedures 2) Concomitant therapy 3) Alternatives tried/failed
<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



# GLP1

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Obesity or use for weight loss
<b>Required Medical Information</b>	Documentation of diabetes mellitus type 2
<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

# Growth Hormone

## Products Affected

- **NORDITROPIN FLEXPRO**

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

# Haegarda

## Products Affected

- HAEGARDA

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

# Harvoni

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## Products Affected

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

<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

# Hetlioz

## Products Affected

- HETLIOZ

PA Criteria	Criteria Details
<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 -OR- Documented diagnosis of Smith-Magenis Syndrome as confirmed by chromosome analysis -AND- patient is experiencing nighttime sleep disturbances (e.g. difficulty falling asleep, shortened sleep cycles, inability to enter REM sleep, or frequent awaking during the night and early in the morning)
<b>Age Restrictions</b>	Deny if less than 16 years of age for nighttime sleep disturbances in Smith-Magenis Syndrome or deny if less than 18 years of age for Non-24 Hour Sleep-Wake Disorder
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of increased total nighttime sleep or decreased daytime nap duration for Non-24 Sleep-Wake disorder -OR- attestation of positive clinical response to therapy with minimal side effects for Smith-Magenis Syndrome
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# High-risk meds

## Products Affected

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

PA Criteria	Criteria Details
<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

# High-risk meds phenobarbital

## 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



# Homozygous FH

## Products Affected

- JUXTAPID

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

# Humira

## Products Affected

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

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<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 Juvenile Idiopathic Arthritis and Uveitis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<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. Please Note for New Starts Only: Covered preferred adalimumab products include Humira with NDC starting 00074, Cyltezo with NDC starting 00597, Hyrimoz with NDC starting 61314, adalimumab-adaz with NDC starting 61314, and adalimumab-adbm with NDC starting 00597.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Ibrance

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## 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.
<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

# Ibsrela

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## Products Affected

- **IBSRELA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of irritable bowel syndrome with constipation -AND- failure or intolerance to Linzess -AND- if member is female, failure or intolerance to lubiprostone.
<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

# 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

# Idhifa

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## Products Affected

- **IDHIFA 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 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>	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

# IG

## Products Affected

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

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



<b>PA Criteria</b>	<b>Criteria Details</b>
<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, Inflammatory Myopathies, Polymyositis, Bone Marrow Transplant, Pediatric HIV, Guillain-Barre syndrome, Autoimmune Mucocutaneous Blistering Diseases
<b>Part B Prerequisite</b>	No

# 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 -AND- all of the following, if applicable to diagnosis: 1) 17p deletion status 2) Alternatives tried/failed 3) concomitant therapy. For suspension, members must also have an inability to swallow oral tablets or oral capsules.
<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

# 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) If female, bone age less than or equal to 14 years. If male, bone age less than or equal to 16. - OR- Documentation of diagnosis of growth hormone deficiency caused by gene deletion and all of the following: 1) Growth velocity at least 2 standard deviations below the age-appropriate mean or height at least 2.25 standard deviations below the age-appropriate mean. 2) Subnormal response (less than 10 ng/mL) to two (2) of the following standard growth hormone stimulation tests: arginine, clonidine, glucagon, insulin, levodopa, propranolol. 3) Development of neutralizing antibodies to growth hormone product(s). 4) If female, bone age of less than or equal to 14 years. If male, bone age less than or equal to 16.
<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, attestation of growth velocity and bone age, as applicable to meet standard continuation of therapy guidelines
<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

# Ingrezza

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## Products Affected

- **INGREZZA INITIATION PK(TARDIV)**
- **INGREZZA ORAL CAPSULE 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 tardive dyskinesia -OR- documentation of chorea associated with Huntington's 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

# 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 diagnosis -AND- all of the following, if applicable to diagnosis: 1) Alternatives tried/failed 2) Concomitant therapy 3) Line of 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

# 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 de novo or secondary myelodysplastic syndrome -AND- One of the following (1 or 2): 1) French American-British MDS subtypes of refractory anemia, refractory anemia with ringed sideroblasts or refractory anemia with excess blasts. 2) International Prognostic Scoring System group of intermediate-1, intermediate-2 or high-risk.
<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

# 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, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis per an accepted risk stratification tool for myelofibrosis (e.g., International Prognostic Scoring System [IPSS]) -AND- If a new start, baseline platelet count of greater than $50 \times 10^9/L$
<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>	Baseline platelet count to be provided.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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

# 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

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

# Interleukin-1b Blockers

## Products Affected

- ARCALYST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For Deficiency of Interleukin-1 Receptor Antagonist (DIRA), documentation of need for maintenance of remission. For Recurrent Pericarditis (RP), documentation of trial/failure or intolerance to one, or contraindication to all of the following: oral nonsteroidal anti-inflammatory drug (NSAID), systemic corticosteroid, or colchicine.
<b>Age Restrictions</b>	Deny if less than 12 years of age for Recurrent Pericarditis and Cryopyrin-Associated Periodic Syndromes
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For DIRA: patient must weigh 10kg or more
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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 high-resolution chest computed tomography (CT) scan demonstrating greater than or equal to 10% pulmonary fibrosis. For Ofev only, documentation of chronic fibrosing interstitial lung disease with progressive phenotype -AND- high resolution chest computing tomography (HRCT) scan demonstrating greater than 10% fibrosing disease -AND- baseline forced vital capacity (FVC) of at least 45% and a percent predicted diffusing capacity of the lungs of carbon monoxide (DLCO) of at least 30% -AND- disease progression in previous 24 months shown by one of the following : 1. Relative decline in FVC greater than or equal to 10% predicted 2. Relative decline in FVC greater than or equal to 5% but less than 10% predicted and either worsening of respiratory symptoms or increased extent of fibrotic changes on HRCT 3. Worsening of respiratory symptoms and increasing extent of fibrotic changes on HRCT
<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

# 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

# Itraconazole

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## Products Affected

- *itraconazole*

<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

# 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



# 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

# Jakafi

## Products Affected

- JAKAFI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis per an accepted risk stratification tool for myelofibrosis (e.g., International Prognostic Scoring System [IPSS]) and if a new start, baseline platelet count of greater than $50 \times 10^9/L$ -OR- documentation of polycythemia vera and inadequate response or intolerance to hydroxyurea -OR- Documentation of steroid refractory acute graft-versus-host disease and prior therapy with at least one systemic corticosteroid -OR- Documentation of chronic graft-versus-host disease with prior failure of at least one systemic therapy.
<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

# 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 -AND- if applicable to diagnosis, alternatives tried/failed
<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

# 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

# Kalydeco

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## 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

# Kerendia

## Products Affected

- **KERENDIA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	eGFR less than or equal to 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 - 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

# 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

# Kevzara

## Products Affected

- KEVZARA

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

# Kineret

## Products Affected

- KINERET

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

# Kisqali

## Products Affected

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

PA Criteria	Criteria Details
<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) 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.
<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

# Klisyri

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## Products Affected

- **KLISYRI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of actinic keratosis of the face or scalp -AND- Therapeutic failure or intolerance to 1 of the following 1) generic topical imiquimod 5% cream 2) generic fluorouracil 5% topical cream 3) generic fluorouracil topical solution
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	For reauthorization, attestation that the member has previously experienced complete or partial clearance of actinic keratosis lesions with Klisyri -AND- additional course of therapy is required for recurrence of actinic keratosis -AND- member is restarting therapy at least 60 days after cessation of an initial Klisyri 5-day course.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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 hyperglycemia secondary to hypercortisolism in patients with endogenous Cushing's syndrome -AND- Patient is not a candidate for surgery or where surgery has failed -AND- one of the following (1 or 2): 1) Diagnosis of diabetes with trial and failure, intolerance, or contraindication to one previous therapy for Type 2 Diabetes (e.g. metformin, sulfonylureas, insulin) or using in addition to a therapy for Type 2 diabetes. 2) Glucose intolerance
<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

# Koselugo

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## Products Affected

- **KOSELUGO ORAL CAPSULE 10 MG,  
25 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>	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

# Krazati

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## 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- member is using Krazati as a single agent. Documentation of locally advanced or metastatic colorectal cancer -AND- disease is KRAS G12C-mutated as determined by an FDA-approved test -AND- member using using Krazati in combination with cetuximab -AND- member has received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy.
<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

# 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



# 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

# Lenvima

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## Products Affected

- LENVIMA

<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 if applicable to diagnosis: 1) Radioactive iodine refractory status 2) Microsatellite instability-high status or mismatch repair deficient status 3) Alternatives tried/failed or attestation of first line use 4) Concomitant therapy
<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

# 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

# Libervant

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## Products Affected

- **LIBERVANT**

<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>	Deny if less than 2 years of age or greater than 5 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

# 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) -AND- trial and failure of 1 other agent used to treat PHN (e.g. gabapentin), inability to swallow oral medication or unable to take an oral medication due to potential adverse events (e.g. sedation) -OR- documentation of diabetic peripheral neuropathy (DPN) -AND- trial and failure of one other agent used to treat DPN (e.g. duloxetine), inability to swallow oral medication or unable to take an oral medication due to potential adverse events (e.g. sedation)
<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

# 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>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# 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

# Lonsurf

## Products Affected

- LONSURF

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



# Lorbrena

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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)
<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

# 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

# Lumakras

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## Products Affected

- **LUMAKRAS ORAL TABLET 120 MG,  
320 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, if applicable to diagnosis 1) KRAS G12C mutation status, as detected by an FDA-approved test 2) Alternatives tried
<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

# Lupron Depot Ped

## Products Affected

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

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

# Lynparza

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## Products Affected

- LYNPARZA

<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, if applicable to diagnosis: 1) BRCA mutations 2) Genomic instability status 3) Homologous recombinant repair gene mutations 4) HER2 status 5) Alternatives tried/failed 6) Concomitant therapy
<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

# Lyrica

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of DPN and trial/failure or intolerance to duloxetine -OR- PHN and trial/failure or intolerance to gabapentin -OR- Partial-onset seizures and trial/failure or intolerance to two AEDS -OR- Neuropathic pain associated with spinal cord injury -OR- Documentation to support a diagnosis of fibromyalgia and trial/failure or intolerance to duloxetine. When using pregabalin products concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators.
<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

# 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, if applicable to diagnosis: 1) FGFR2 fusion or other rearrangement 2) Previous therapies tried/failed
<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

# Mavenclad

## Products Affected

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

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



# 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

# 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

# Mekinist

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## Products Affected

- **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>	Documentation of diagnosis -AND- all of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
<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

# Mekinist Suspension

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## Products Affected

- MEKINIST ORAL RECON SOLN

<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) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Attestation of inability to swallow Mekinist tablets is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# 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 -AND- all of the following, if applicable to diagnosis: 1) BRAF mutation status 2) Concomitant 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

# 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

# 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

# Myalept

## Products Affected

- MYALEPT

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



# 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

# Namzarin

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## Products Affected

- NAMZARIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis and trial/failure of 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

# 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>	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

# Nerlynx

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## Products Affected

- **NERLYNX**

<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) HER2 mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to 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

# 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

# Nexletol

## Products Affected

- NEXLETOL
- NEXLIZET

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

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

# 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



# 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

# Northera

## Products Affected

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

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

# Nourianz

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## Products Affected

- NOURIANZ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Parkinson's disease experiencing off episodes -AND- Used as adjunct to levodopa/carbidopa -AND- trial/failure, contraindication or intolerance to one of the following generic products: ropinirole, pramipexole, entacapone, selegiline, or rasagiline
<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

# 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>	Documentation of diagnosis -AND- all of the following if applicable to diagnosis: 1. Concomitant therapy 2. History of 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

# Nucala

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Documentation of diagnosis of severe asthma evidenced by pretreatment FEV1 less than 80 percent predicted in adults or FEV1 less than 90 percent predicted in adolescents or FEV1 reversibility of at least 12% after albuterol administration -AND- 1.) A history of 2 or more exacerbations in the previous year or inadequate symptom control with inhaled corticosteroid in combination with 3 months of controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline), unless intolerant of or contraindication to all agents -AND- 2 or 3. 2) Greater than or equal to 150 cells/uL screening within 6 weeks of dosing. 3) Greater than or equal to 300 cells/uL within 12 months of screening. -OR- Documentation of eosinophilic granulomatosis with polyangiitis (EGPA) in patients who have a history of relapsing or refractory disease and will be receiving concomitant glucocorticoid treatment with or without immunosuppressive therapy -OR- Documentation of hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause for greater than or equal to 6 months -AND- At least 2 HES flares (HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy) within the past 12 months -AND- Stable on HES therapy for at least 4 weeks (chronic or episodic oral corticosteroids, immunosuppressive or cytotoxic therapy) -OR- Documentation of chronic rhinosinusitis with nasal polyps (CRSwNP) and trial/failure, contraindication, or intolerance to an intranasal corticosteroid.</p>
<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 Severe Asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of severe asthma exacerbation, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For EGPA reauthorization, attestation of one of the following is required (5-8): 5) reduction in frequency and/or severity of relapses, 6) reduction or discontinuation of corticosteroids and/or immunosuppressant, 7) disease remission, or 8) reduction in severity or frequency of EGPA-related symptoms. For HES reauthorization, attestation of one of the following is required (9-10): 9) reduction in frequency of HES flares, or 10) maintenance or reduction in background HES therapy requirements. For CRSwNP reauthorization, attestation of one of the following is required (11-12): 11) decrease in nasal polyp score, or 12) reduction in nasal congestion/obstruction severity score.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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

# 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



# Nurtec

## Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
<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 (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes. For acute treatment of migraine with or without aura, trial and failure of one generic triptan.
<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 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

# 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 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography as established in accordance with ICSD or DSM V criteria acceptable for all indications</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, provider attestation of improvement in daytime sleepiness is required.

<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

# Ocaliva

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## Products Affected

- OCALIVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Compensated cirrhosis with evidence of portal hypertension
<b>Required Medical Information</b>	Documentation of primary biliary cholangitis -AND- trial and failure, contraindication, or intolerance to ursodiol monotherapy -AND- will use concomitantly with ursodiol unless contraindicated or intolerant.
<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

# Octreotide

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## 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

# 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>	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

# Ogsiveo

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## Products Affected

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

# Ojemda

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## Products Affected

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

<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



# 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

# Olumiant

## Products Affected

- OLUMIANT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Part A covered for Covid-19 in hospitalized patients
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severely active rheumatoid arthritis an inadequate response or intolerance to at least one non-biologic DMARD (e.g., methotrexate, leflunomide). For severe alopecia areata, inadequate response or intolerance to an intralesional corticosteroid or high potency topical corticosteroid, or contraindication to all.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Rheumatoid Arthritis and Alopecia Areata
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR, with at least 1 being a tumor necrosis factor blocker.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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

# 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>	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

# Orencia

## Products Affected

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

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

# 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

# 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



# Orladeyo

## Products Affected

- ORLADEYO

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

# 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, if applicable to diagnosis: 1) ER mutation status, HER2 mutation status, and ESR1 mutation status 2) Alternatives tried/failed
<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

# OTEZLA

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For plaque psoriasis, all of the following (1-2): 1) if the member is greater than or equal to 6 years of age and less than 18 years, weight is greater than or equal to 20 kg and member has moderate-to-severe disease -AND- 2) inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For oral ulcers associated with Behcet's Disease, inadequate response or intolerance to one systemic therapy colchicine for prevention of recurrent oral ulcers
<b>Age Restrictions</b>	Deny if less than 6 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

# Oxervate

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## Products Affected

- **OXERVATE**

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

# 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

# Pemazyre

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## Products Affected

- PEMAZYRE

<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, if applicable to diagnosis: 1) FGFR2 fusion or other rearrangement as detected by an FDA-approved test 2) Attestation of previous treatment in alignment with FDA indication
<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

# 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- therapeutic failure or 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



# 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

# Pomalyst

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## Products Affected

- POMALYST

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

# Posaconazole Tablets

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<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

# 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

# Prescription Drug Combo

## Products Affected

- acetaminophen-codeine oral solution 120-12 mg/5 ml
- acetaminophen-codeine oral tablet
- alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg
- buprenorphine
- clonazepam oral tablet 0.5 mg, 1 mg, 2 mg
- clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg
- clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg
- **DIAZEPAM INTENSOL**
- diazepam oral solution 5 mg/5 ml (1 mg/ml)
- diazepam oral tablet
- **ENDOCET**
- fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr
- hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg
- hydromorphone oral liquid
- hydromorphone oral tablet
- **LORAZEPAM INTENSOL**
- lorazepam oral tablet 0.5 mg, 1 mg, 2 mg
- methadone oral solution 10 mg/5 ml, 5 mg/5 ml
- methadone oral tablet 10 mg, 5 mg
- morphine concentrate oral solution
- morphine oral 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 solution
- oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg
- oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg
- 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>	<p>For concomitant use of an opiate agonist and substance abuse therapy, documentation that the member has an acute pain condition (e.g. acute traumatic injury) in which treatment with other agents would cause insufficient pain control or if the member requires treatment for pain related to a terminal illness. For concomitant use of an opiate agonist, benzodiazepine, and a centrally acting skeletal muscle relaxant, documentation that the member has tried/failed at least 2 other skeletal muscle relaxants (e.g. methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients AND attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For concomitant use of an opiate agonist and other opiate potentiators (e.g. gabapentinoids, sedative-hypnotics) attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For long acting (e.g. extended release) opioid medications, the following apply (1-5). 1)Pain is severe enough to require daily, around-the-clock, long-term opioid treatment. 2)Patient is not opioid naive. 3)Attestation that non-opiate alternative therapies have been explored (e.g. NSAIDs). 4)Attestation that controlled substance Rx history has been reviewed in the state Prescription Drug Monitoring Program. 5)Attestation of counseling on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Opiate tx for pain+subs. abuse, app. opiate x 1mo. All other combos and dx approve x 12mo.
<b>Other Criteria</b>	<p>Opiate agonists will receive automatic approval if no recent claims for a substance abuse therapy (e.g. buprenorphine-naloxone) OR a benzodiazepine (e.g. triazolam, alprazolam) OR a benzodiazepine with a centrally acting skeletal muscle relaxant (e.g., carisoprodol) OR a gabapentinoid OR a sedative-hypnotic. Benzodiazepines (e.g. triazolam, alprazolam) will receive automatic approval if no recent claims for an opiate agonist (e.g. oxycodone, hydrocodone, oxymorphone) or an opiate agonist with a centrally acting skeletal muscle relaxant (e.g. carisoprodol). Sedative-hypnotics (e.g. zolpidem) will receive automatic approval if no recent claims for an opiate agonist. Infusible opiate agonists will be covered under Part B when administered via infusion pump.</p>
<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

# 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



# 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 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography as established in accordance with ICSD or DSM V criteria acceptable for all indications. Diagnosis of fatigue associated with Multiple Sclerosis (MS)</p>
<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

# Pulmonary Arterial Hypertension

## Products Affected

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

PA Criteria	Criteria Details
<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 bosentan and sildenafil in pediatric individuals, an exception to RHC will be allowed when the risk of RHC outweighs the benefit -AND- prescriber attests alternative studies have been completed (i.e. CT, MRI or specified test ruling out other causes of pulmonary hypertension). For Adempas, additional diagnosis of CTEPH as documented by right heart catheterization and V/Q scan substantiating mPAP greater than 20 mmHg at rest and PWP less than or equal to 15 mmHg and documented presence of occlusive thrombi within the pulmonary arteries will be approved.
<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 brand Tadliq, trial and failure of generic tadalafil or Alyq -OR- Inability to swallow tablets is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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

# Pyrukynd

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hemolytic anemia with pyruvate kinase deficiency, as supported by one of the following (1-2): 1) mutations in the PKLR gene, 2) reduced activity of the pyruvate kinase enzyme.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 weeks initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of increase in hemoglobin level from baseline -OR- decrease in transfusion burden from baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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

# 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



# 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 (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes.
<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 migraine frequency
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Radicava ORS

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## Products Affected

- **RADICAVA ORS STARTER KIT SUSP**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of amyotrophic lateral sclerosis (ALS)
<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

# Ravicti

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## Products Affected

- RAVICTI

<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

# Recorlev

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## Products Affected

- **RECORLEV**

<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 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 mean urine free cortisol (mUFC) less than starting baseline value.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Regranex

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## Products Affected

- REGRANEX

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

# Repatha

## Products Affected

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

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

# Retevmo

## Products Affected

- **RETEVMO ORAL CAPSULE 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



# Revlimid

## Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
<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 -OR- diagnosis of marginal zone lymphoma in combination with a rituximab product after previous treatment.
<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 Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Rezdiffra

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## Products Affected

- REZDIFFRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<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. Diagnosis of NASH confirmed by a liver biopsy or non-invasive tests (NITs) performed within the previous 6 months indicating F2 or F3 fibrosis - AND- member does not have any evidence of cirrhosis, hepatic decompensation, or hepatocellular carcinoma.
<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 stabilization of fibrosis as demonstrated by NIT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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

# Rinvoq

## Products Affected

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

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) or all non-biologic DMARDs are contraindicated. For moderate to severe refractory atopic dermatitis whose disease is not adequately controlled with other systemic drug products, documentation of one of the following (1 or 2): 1) trial & failure, or intolerance to at least one topical corticosteroid -OR- topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus) 2) The member has severe atopic dermatitis and is incapable of applying topical therapies due to the extent of body surface area involvement or topical therapies are contraindicated due to severely damaged skin. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For Non-radiographic Axial Spondyloarthritis, trial & failure or intolerance to two nonsteroidal anti-inflammatory drugs (NSAIDs) or contraindication to all. For juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or all non-biologic DMARDs are contraindicated or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<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.

<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

# 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 (1-3): 1) genetically confirmed diagnosis of primary hyperoxaluria type 1 (PH1), 2) relatively preserved kidney function (e.g., eGFR greater than or equal to 30 mL/min/1.73 m <sup>2</sup> ), and 3) at least two elevated urinary oxalate levels greater than 1.5 times the upper reference limit.
<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- a reduction in urinary oxalate levels from baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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

# Rubraca

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## Products Affected

- RUBRACA

<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) BRCA mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
<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



# 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 -AND- All of the following, if applicable to diagnosis: 1) FLT3 mutations 2) Concomitant 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

# Sabril

## Products Affected

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

<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

# Samsca

## Products Affected

- *tolvaptan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<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

# 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

# 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 (1-2): 1) member has experienced therapeutic intolerance or failure to at least 2 prior kinase inhibitors 2) 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

# 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- trial and failure of generic asenapine sublingual tablets -AND- trial/failure or intolerance to 1 of the following or all are contraindicated (1-3): 1) olanzapine, 2) quetiapine, 3) risperidone.
<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

# Signifor

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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 Cushing's disease AND patient is not a candidate for pituitary surgery or surgery has not been curative
<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 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

# Siliq

## Products Affected

- SILIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<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>	12 months
<b>Other Criteria</b>	For psoriasis, patients must have therapeutic failure or intolerance to 2 preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Cosentyx, Taltz, Otezla, Stelara SC, Enbrel, and Skyrizi SC. For psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# Simponi

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## Products Affected

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

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

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

# 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 extensively drug resistant tuberculosis, pre-extensively drug-resistant tuberculosis, treatment-intolerant tuberculosis, or nonresponsive multidrug-resistant tuberculosis -AND- Therapeutic failure, contraindication, or intolerance to 1 of the following: isoniazid, rifampin, rifabutin, or rifapentine -AND- Used in combination with at least 3 other drugs for tuberculosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 weeks
<b>Other Criteria</b>	For reauthorization, additional therapy required due to doses of the regimen being missed for safety reasons
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</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

# Skyrizi

## Products Affected

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

PA Criteria	Criteria Details
<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. For Crohns disease, attestation of clinical response or remission following IV administration of Skyrizi within 3 months of initiating therapy with Skyrizi SC. For moderate to severe ulcerative colitis, attestation of clinical response or remission following IV administration of Skyrizi within 3 months of initiating therapy with Skyrizi SC.
<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 induction therapy, doses above plan quantity limit will be approved when 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

# 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

# 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>	Deny if less than 18 years of age
<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

# 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



# Sprycel

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## Products Affected

- SPRYCEL

<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, if applicable to diagnosis: 1) Philadelphia Chromosome status (e.g. positive) 2) Alternatives tried/failed 3) Concomitant 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

# Stelara

## Products Affected

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

<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, attestation of clinical response or remission following single induction dose of IV Stelara within 2 months of initiating therapy with Stelara SC. For Ulcerative colitis, attestation of clinical response or remission following single induction dose of IV Stelara within 2 months of initiating therapy with Stelara SC
<b>Age Restrictions</b>	Deny if less than 18 years of age for Crohn's Disease and Ulcerative Colitis or less than 6 years of age for Plaque Psoriasis and Psoriatic Arthritis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<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

# Stivarga

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## Products Affected

- STIVARGA

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

# Sucraid

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## Products Affected

- SUCRAID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of congenital-sucrase-isomaltase deficiency (CSID) supported by one of the following (1 or 2): 1) small bowel biopsy with disaccharidase assay showing absent or reduced sucrase activity, reduced or normal isomaltase activity, reduced maltase activity, and reduced or normal lactase activity. 2) sucrase deficiency evidenced by sucrose breath hydrogen test or carbon-sucrose breath test.
<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

# Sunosi

## Products Affected

- SUNOSI

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. 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>Other Criteria</b>	<p>For narcolepsy and OSAHS, documentation of trial and failure, contraindication or intolerance to modafinil and armodafinil. For reauthorization, provider attestation of improvement in daytime sleepiness is required.</p>
<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

# 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 -AND- all of the following, if applicable to diagnosis: 1) disease progression on or intolerance to imatinib mesylate 2) high risk of recurrent RCC following nephrectomy
<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

# Symdeko

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## Products Affected

- SYMDEKO

<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 either the homozygous F508del mutation or another mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to tezacaftor/ivacaftor based on clinical and/or in vitro assay (e.g. E56K, R117C, A455E)
<b>Age Restrictions</b>	Deny if less than 6 years of age
<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



# 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

# Synarel

## Products Affected

- SYNAREL

<b>PA Criteria</b>	<b>Criteria Details</b>
<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

# 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>	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

# Tafinlar for Suspension

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## Products Affected

- **TAFINLAR ORAL TABLET FOR SUSPENSION**

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

# Tagrisso

## Products Affected

- TAGRISSO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of non-small cell lung cancer (NSCLC) and one of the following (1-4): 1) Adjuvant therapy after tumor resection -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, 2) Locally advanced disease -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations -AND- used in combination with pemetrexed and platinum-based chemotherapy, 3) Metastatic disease -AND- using as first-line therapy -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations -AND- used with or without combination therapy of pemetrexed and platinum-based chemotherapy, 4) Metastatic disease -AND- using as first-line therapy -AND- disease harbors EGFR T790M mutations -AND- has progressed on or after EGFR TKI therapy.
<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

# Takhzyro

## Products Affected

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

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

# Taltz

## Products Affected

- **TALTZ AUTOINJECTOR**
- **TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/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 plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Psoriatic Arthritis, Ankylosing Spondylitis and non-radiographic axial spondyloarthritis or less than 6 years of age for Plaque Psoriasis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For induction therapy, doses above plan quantity limit will be approved when 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



# 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>	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

# Targretin

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## Products Affected

- *bexarotene oral*
- *bexarotene topical*

<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>	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

# 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

# Tasigna

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## Products Affected

- TASIGNA

<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, if applicable to diagnosis: 1) Philadelphia Chromosome status (e.g. positive) 2) Alternatives tried/failed
<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

# 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>	3 months initial authorization, 12 months reauthorization
<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

# Tazorac

## Products Affected

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

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

# 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

# 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



# 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>	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

# Testosterone (androgens)

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of primary or secondary hypogonadism in males with testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, radiation or toxic damage -OR- documentation of primary or secondary hypogonadism in males with multiple symptoms of hypogonadism including at least one of the following specific symptoms: height loss due to vertebral fractures, low trauma fractures, low bone density, incomplete or delayed sexual development, breast discomfort, loss of axillar and/or pubic body hair, hot flushes -OR- documentation of HIV infection in men with weight loss -OR- documentation of chronic steroid treatment in men. In all previously noted indications, members must also have documented low total testosterone level below the normal range for the laboratory -OR- a total testosterone level near the lower limit of the normal range with a low free testosterone level which is less than normal based upon the laboratory reference range -OR- the member is not producing any testosterone. Additional approvable indications include female patients with metastatic breast cancer (testosterone enanthate only), primary or secondary hypogonadism in males with testicular failure due to double orchidectomy, and delayed puberty in males (testosterone enanthate only).
<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>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	HIV Wasting
<b>Part B Prerequisite</b>	No

# Thalomid

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## Products Affected

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

# Thrombopoiesis Stimulating Agents

## Products Affected

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

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

# 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- all of the following, if applicable to diagnosis: 1) IDH1 mutation status, 2) alternatives tried/failed, 3) comorbidity that precludes use of intensive induction chemotherapy (i.e. age greater than or equal to 75 years, severe cardiac or pulmonary comorbidity, reduced renal function, hepatic impairment, or physician attestation) 4) Concomitant therapy.
<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

# Topical Lidocaine

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## Products Affected

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

<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

# Transmucosal Fentanyl Citrate

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## Products Affected

- *fentanyl citrate buccal lozenge on a handle*  
1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg,  
600 mcg, 800 mcg

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



# Tretinoin

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## Products Affected

- *tretinoin*

<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, sulfacetamide, erythromycin)
<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

# 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

# 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

# Tukysa

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## Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 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, if applicable to diagnosis: 1) HER2 mutations 2) RAS genetic status 3) Alternatives tried/failed 4) Concomitant 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

# Turalio

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## Products Affected

- TURALIO ORAL CAPSULE 125 MG

<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>	Deny if less than 18 years of age
<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

# Tykerb

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## Products Affected

- *lapatinib*

<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, if applicable to diagnosis: 1) HER2 mutations 2) Alternatives tried/failed 3) Concomitant 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

# 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

# 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.
<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>	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



# 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

# 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>	Deny if less than 6 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

# Vancomycin

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## Products Affected

- *vancomycin oral capsule 125 mg, 250 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>	
<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

# Vanflyta

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## Products Affected

- VANFLYTA

<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, if applicable to diagnosis: 1) Induction, consolidation, or maintenance therapy 2) FLT3 ITD mutation status, as detected by an FDA-approved test 3) Concomitant therapy
<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

# Venclexta

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## 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 and concomitant therapy, if applicable to diagnosis. For newly-diagnosed AML, age greater than or equal to 75 years or presence of at least one comorbidity that precludes use of intensive induction chemotherapy (i.e. severe cardiac or pulmonary comorbidity, reduced renal function, hepatic impairment, or physician attestation) is required.
<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

# 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

# Verzenio

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## Products Affected

- VERZENIO

<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 mutation status and HER2 mutation status 2) Alternatives tried/failed 3) Concomitant therapy, if applicable to 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

# Viberzi

## Products Affected

- **VIBERZI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Severe (Child-Pugh C) hepatic impairment
<b>Required Medical Information</b>	Documentation of diarrhea predominant, irritable bowel syndrome (IBS-D) -AND- trial/failure or intolerance to one of the following medications for IBS-D or documentation of contraindication to all: antidiarrheal (e.g., loperamide), antispasmodic (e.g., dicyclomine, hyoscyamine), tricyclic antidepressant (e.g., amitriptyline, nortriptyline).
<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



# 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

# Vittrakvi

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<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

# Vivjoa

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## 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).
<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

# 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 (1 or 2): 1. Epidermal growth factor (EGFR) exon 19 deletions - OR- 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

# 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

# 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

# Vosevi

## 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 all regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
<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

# Votrient

## Products Affected

- *pazopanib*

<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>	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



# 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>	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

# 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

# Welireg

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## 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, 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

# 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 or ROS1-positive. For relapsed or refractory anaplastic large cell lymphoma (ALCL), disease is ALK-positive. For unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT), disease is ALK-positive.
<b>Age Restrictions</b>	Deny if less than 18 years of age for NSCLC. Deny if less than 1 year of age or greater than 21 years of age for ALCL.
<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

# 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

# Xdemvy

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## Products Affected

- XDEMVIY

<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

# Xeljanz

## Products Affected

- XELJANZ ORAL TABLET
- XELJANZ XR

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

# Xeljanz Solution

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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 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
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<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



# 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

# 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

# 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

# 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

# Xolair

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Documentation of chronic idiopathic urticaria with trial/failure or intolerance of a second-generation non-sedating H1 antihistamine at the maximum recommended doses (e.g., cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine) -OR- Documentation of moderate to severe persistent asthma in patients with a positive skin test or in vitro reactivity to a perennial aeroallergen -AND- Baseline IgE titer greater than or equal to 30 IU/mL -AND- symptoms that are inadequately controlled despite a 3 month trial of both 1. and 2. 1) medium-dose inhaled corticosteroid or systemic steroid 2) a long-acting beta-agonist or leukotriene antagonist - AND- patient is currently on a long-acting beta2-agonist, leukotriene modifier, or theophylline -OR- Documentation of chronic rhinosinusitis with nasal polyps -AND- will use concomitantly with nasal corticosteroid maintenance treatment -OR- Documentation of IgE mediated food allergy confirmed by skin prick test or food-specific antibodies -AND- previous allergic reaction to food -AND- using for the reduction of allergic reactions (type 1), including anaphylaxis -AND- used in conjunction with food allergen avoidance -AND- member has a documented prescription for epinephrine.</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, attestation of decreased rescue medication or oral corticosteroid use, decreased frequency of asthma exacerbations, increased pulmonary function from baseline (e.g. FEV1), or reduction in reported asthma related symptoms in treatment of asthma -OR- improved symptoms in treatment of CIU -OR- reduction in nasal polyp score or nasal congestion/obstruction severity score in treatment of nasal polyps -OR- member requires continuation of therapy and will continue food allergen avoidance in IgE-mediated food allergy
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# 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

# 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- FLT3 mutations, if applicable to 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



# Xpovio

## Products Affected

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

PA Criteria	Criteria Details
<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 relapse or refractory multiple myeloma after receiving 1 prior multiple myeloma therapy -OR- Documentation of relapsing or refractory diffuse large B-cell lymphoma with failure, intolerance or contraindication to at least 2 lines of systemic therapy
<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

# 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 -AND- one of the following (1 or 2): 1) Concomitant GnRH analog, 2) The member has had a bilateral orchiectomy, if applicable to 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

# Xuriden

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## Products Affected

- XURIDEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hereditary orotic aciduria
<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

# Xyrem

## Products Affected

- *sodium oxybate*
- **XYREM**

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 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>Part B Prerequisite</b>	No

# 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- all of the following: 1) Alternatives tried/failed 2) Concomitant therapy
<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

# 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

# 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

# Zejula

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## 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. 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



# Zelboraf

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## Products Affected

- TAFINLAR ORAL CAPSULE
- 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 -AND- both of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed and concomitant therapy, if applicable to diagnosis (e.g. diagnosis of V600K metastatic melanoma and drug regimen of Zelboraf and Cotellic)
<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

# Zeposia

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<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. For moderate to severe active ulcerative colitis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Ulcerative Colitis: 12 months, 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 Humira, Xeljanz/Xeljanz XR and Stelara SC.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# 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 Hutchinson-Gilford Progeria Syndrome with mutation of the LMNA gene and BSA of 0.39 square meters or above -OR- Documentation of processing-deficient Progeroid Laminopathies with BSA of 0.39 square meters or above -AND- one of the following (1 or 2): 1) Heterozygous LMNA mutation and progerin-like protein accumulation 2.) Homozygous ZMPSTE24 mutations or compound heterozygous ZMPSTE23 mutations
<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

# 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>	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

# Zonisade

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## 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 (1-3): 1) generic carbamazepine suspension/chewable tablet/extended-release capsule, 2) generic lacosamide solution, 3) generic oxcarbazepine suspension.
<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

# 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 -AND- therapeutic failure or intolerance to 2 previous antiepileptic 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

# 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 moderate to severe postpartum depression -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

# 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 diagnosis -AND- all of the following, if applicable to diagnosis: 1) Alternatives tried/failed 2) Concomitant therapy 3) Candidacy for use of rituximab alone
<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



# 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

# Zytiga

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## Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- concomitant therapy
<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



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<i>(40 mg/ml), 625 mg/5 ml (125 mg/ml)</i> .....	169	<b>OGSIVEO ORAL TABLET 100 MG,</b>	
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<i>metirosine</i> .....	173	<b>OPSUMIT</b> .....	226
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<i>morphine concentrate oral solution</i> .....	220	<b>87.5 MG/0.7 ML</b> .....	204
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<i>mg/5 ml (4 mg/ml)</i> .....	220	<b>EXTENDED RELEASE 0.125 MG, 0.25</b>	
<i>morphine oral tablet</i> .....	220	<b>MG, 1 MG, 2.5 MG, 5 MG</b> .....	226
<i>morphine oral tablet extended release 100</i>		<b>ORGOVYX</b> .....	206
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<b>MULPLETA</b> .....	174	<b>ORKAMBI ORAL TABLET</b> .....	207
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<b>NAYZILAM</b> .....	178	<b>86 MG</b> .....	210
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<b>NEXLETOL</b> .....	181	<b>OTEZLA STARTER ORAL</b>	
<b>NEXLIZET</b> .....	181	<b>TABLETS,DOSE PACK 10 MG (4)-20</b>	
<b>NINLARO</b> .....	183	<b>MG (4)-30 MG (47)</b> .....	211
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<b>NORDITROPIN FLEXPRO</b> .....	105	<i>oxycodone oral capsule</i> .....	220
<b>NOURIANZ</b> .....	186	<i>oxycodone oral concentrate</i> .....	220
<b>NUBEQA</b> .....	187	<i>oxycodone oral solution</i> .....	220
<b>NUCALA SUBCUTANEOUS AUTO-</b>		<i>oxycodone oral tablet 10 mg, 15 mg, 20</i>	
<b>INJECTOR</b> .....	188	<i>mg, 30 mg, 5 mg</i> .....	220
<b>NUCALA SUBCUTANEOUS RECON</b>		<i>oxycodone-acetaminophen oral tablet 10-</i>	
<b>SOLN</b> .....	188	<i>325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	
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<b>NUDEXTA</b> .....	190		
<b>NUPLAZID</b> .....	191		



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<b>PANRETIN</b> .....	213	<b>RAVICTI</b> .....	234
<b>PANZYGA</b> .....	119	<b>RECORLEV</b> .....	235
<i>pazopanib</i> .....	319	<b>REGRANEX</b> .....	236
<b>PEGASYS</b> .....	128	<b>REPATHA PUSHTRONEX</b> .....	237
<b>PEMAZYRE</b> .....	214	<b>REPATHA SURECLICK</b> .....	237
<b>PHEBURANE</b> .....	215	<b>REPATHA SYRINGE</b> .....	237
<i>phenobarbital</i> .....	111	<b>RETEVMO ORAL CAPSULE 40 MG, 80 MG</b> .....	239
<b>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> .....	216	<b>REXULTI ORAL TABLET</b> .....	17
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<i>pirfenidone oral tablet</i> .....	131	<b>REZLIDHIA</b> .....	242
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<b>PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML</b> .....	129	<b>RIVFLOZA SUBCUTANEOUS SOLUTION</b> .....	245
<b>POMALYST</b> .....	217	<b>RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML, 160 MG/ML</b> .....	245
<i>posaconazole oral tablet, delayed release (dr/ec)</i> .....	218	<b>ROZLYTREK ORAL CAPSULE 100 MG, 200 MG</b> .....	246
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i> .....	165	<b>ROZLYTREK ORAL PELLETS IN PACKET</b> .....	246
<i>pregabalin oral solution</i> .....	165	<b>RUBRACA</b> .....	247
<b>PRENATAL VITAMIN PLUS LOW IRON</b> .....	219	<i>rufinamide</i> .....	24
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<b>PROLIA</b> .....	223	<b>SAJAZIR</b> .....	89
<b>PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG</b> .....	292	<i>sapropterin</i> .....	151
<b>PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG</b> .....	292	<b>SCSEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG</b> .....	252
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<b>PULMOZYME</b> .....	228	<b>SIGNIFOR</b> .....	254
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<b>QINLOCK</b> .....	230	<b>SILIQ</b> .....	255
<i>quinine sulfate</i> .....	231	<b>SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML</b> .....	256
<b>QULIPTA</b> .....	232	<b>SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML</b>	256
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<b>SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)</b> .....	260	<i>tazarotene topical gel</i> .....	285
<i>sodium oxybate</i> .....	339	<b>TAZORAC TOPICAL CREAM 0.05 %</b>	285
<i>sodium phenylbutyrate</i> .....	33	<b>TAZVERIK</b> .....	286
<i>sofosbuvir-velpatasvir</i> .....	71	<b>TEPMETKO</b> .....	288
<b>SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG</b> .....	261	<i>teriflunomide</i> .....	18
<b>SOMAVERT</b> .....	263	<i>teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)</i> .....	93
<i>sorafenib</i> .....	180	<i>testosterone cypionate</i> .....	289
<b>SPRYCEL</b> .....	264	<i>testosterone enanthate</i> .....	289
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<b>STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML</b> ..	265	<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)</i> .....	289
<b>STIVARGA</b> .....	266	<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i> ...328	
<b>SUCRAID</b> .....	267	<b>THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG</b> .....	291
<i>sunitinib malate</i> .....	270	<b>TIBSOVO</b> .....	293
<b>SUNOSI</b> .....	268	<b>TOBI PODHALER</b> .....	43
<b>SYMDEKO</b> .....	271	<i>tobramycin in 0.225 % nacl</i> .....	43
<b>SYMPAZAN</b> .....	272	<i>tobramycin inhalation</i> .....	43
<b>SYNAREL</b> .....	273	<i>tolvaptan</i> .....	250
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<i>tadalafil (pulm. hypertension)</i> .....	226	<i>tramadol oral tablet 50 mg</i> .....	220
<i>tadalafil oral tablet 2.5 mg, 5 mg</i> .....	45	<i>tramadol-acetaminophen</i> .....	220
<b>TADLIQ</b> .....	226	<i>tretinoin</i> .....	296
<b>TAFINLAR ORAL CAPSULE</b> .....	344	<b>TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL</b> .....	297
<b>TAFINLAR ORAL TABLET FOR SUSPENSION</b> .....	275	<b>TRIKAFTA ORAL TABLETS, SEQUENTIAL</b> .....	297
<b>TAGRISO</b> .....	276	<i>trimipramine</i> .....	110
<b>TAKHZYRO SUBCUTANEOUS SOLUTION</b> .....	277	<b>TRULICITY</b> .....	104
<b>TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML (150 MG/ML)</b> .....	277	<b>TRUQAP</b> .....	298
<b>TALTZ AUTOINJECTOR</b> .....	279	<b>TUKYSA ORAL TABLET 150 MG, 50 MG</b> .....	299
<b>TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML</b> .....	279	<b>TURALIO ORAL CAPSULE 125 MG</b> ..	300
<b>TALZENNA</b> .....	280	<b>TYMLOS</b> .....	302
<b>TASCENSO ODT</b> .....	282	<b>TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 32-48 MCG, 48 MCG, 64 MCG</b> ...226	
<b>TASIGNA</b> .....	283	<b>UBRELVY ORAL TABLET 100 MG, 50 MG</b> .....	303

<b>UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG</b> .....	226	<b>XELJANZ ORAL SOLUTION</b> .....	327
<b>UPTRAVI ORAL TABLETS,DOSE PACK</b> .....	226	<b>XELJANZ ORAL TABLET</b> .....	326
<b>VALCHLOR</b> .....	304	<b>XELJANZ XR</b> .....	326
<b>VALTOCO</b> .....	305	<b>XERMELO</b> .....	329
<i>vancomycin oral capsule 125 mg, 250 mg.</i>	306	<b>XGEVA</b> .....	330
<b>VANFLYTA</b> .....	307	<b>XIFAXAN ORAL TABLET 550 MG</b> .....	331
<b>VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG</b> .....	308	<b>XOLAIR</b> .....	332
<b>VENCLEXTA STARTING PACK</b> .....	308	<b>XOLREMDI</b> .....	334
<b>VERQUVO</b> .....	309	<b>XOSPATA</b> .....	335
<b>VERZENIO</b> .....	310	<b>XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)</b> .....	336
<b>VIBERZI</b> .....	311	<b>XTANDI ORAL CAPSULE</b> .....	337
<b>VICTOZA 3-PAK</b> .....	104	<b>XTANDI ORAL TABLET 40 MG, 80 MG</b> .....	337
<i>vigabatrin</i> .....	249	<b>XURIDEN</b> .....	338
<b>VIGADRONE</b> .....	249	<b>XYREM</b> .....	339
<b>VIGPODER</b> .....	249	<b>YARGESA</b> .....	341
<b>VIJOICE ORAL GRANULES IN PACKET</b> .....	312	<b>YONSA</b> .....	340
<b>VIJOICE ORAL TABLET 125 MG, 250 MG/DAY (200 MG X1-50 MG X1), 50 MG</b> .....	312	<i>zaleplon oral capsule 10 mg, 5 mg</i> .....	220
<b>VITRAKVI ORAL CAPSULE 100 MG, 25 MG</b> .....	313	<b>ZAVZPRET</b> .....	342
<b>VITRAKVI ORAL SOLUTION</b> .....	313	<b>ZEJULA ORAL TABLET</b> .....	343
<b>VIVJOA</b> .....	314	<b>ZELBORAF</b> .....	344
<b>VIZIMPRO</b> .....	315	<b>ZEPOSIA</b> .....	345
<b>VONJO</b> .....	316	<b>ZEPOSIA STARTER KIT (28-DAY)</b> .....	345
<i>voriconazole intravenous</i> .....	317	<b>ZEPOSIA STARTER PACK (7-DAY)</b> .....	345
<b>VOSEVI</b> .....	318	<b>ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML, 23 MG/0.574 ML, 32.4 MG/0.81 ML</b> .....	176
<b>VOWST</b> .....	83	<b>ZOKINVY</b> .....	346
<b>VRAYLAR ORAL CAPSULE</b> .....	320	<b>ZOLINZA</b> .....	347
<b>VUMERITY</b> .....	321	<i>zolpidem oral tablet</i> .....	220
<b>VYNDAMAX</b> .....	16	<b>ZONISADE</b> .....	348
<b>VYNDAQEL</b> .....	16	<b>ZTALMY</b> .....	349
<b>WELIREG</b> .....	322	<b>ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG</b> .....	350
<b>XALKORI ORAL CAPSULE</b> .....	323	<b>ZYDELIG</b> .....	351
<b>XALKORI ORAL PELLETT 150 MG, 20 MG, 50 MG</b> .....	323	<b>ZYKADIA</b> .....	352
<b>XCOPRI</b> .....	324		
<b>XCOPRI MAINTENANCE PACK</b> .....	324		
<b>XCOPRI TITRATION PACK</b> .....	324		
<b>XDEMVI</b> .....	325		

# Celecoxib

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## Products Affected

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

## Details

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

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## Products Affected

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

## Details

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

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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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# 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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# Topical Psoriasis

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## Products Affected

- *calcitriol 3 mcg/gram topical ointment*

## Details

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

*calcitriol 3 mcg/gram topical ointment*..... 5  
*celecoxib 100 mg capsule* ..... 1  
*celecoxib 200 mg capsule* ..... 1  
*celecoxib 400 mg capsule* ..... 1  
*celecoxib 50 mg capsule* ..... 1  
*leuprolide 22.5 mg (3 month)  
intramuscular suspension*..... 2  
**LUPRON DEPOT 11.25 MG (3  
MONTH) INTRAMUSCULAR  
SYRINGE KIT** .....2  
**LUPRON DEPOT 22.5 MG (3 MONTH)  
INTRAMUSCULAR SYRINGE KIT** .....2  
**LUPRON DEPOT 3.75 MG  
INTRAMUSCULAR SYRINGE KIT** .....2  
**LUPRON DEPOT 30 MG (4 MONTH)  
INTRAMUSCULAR SYRINGE KIT** .....2  
**LUPRON DEPOT 45 MG (6 MONTH)  
INTRAMUSCULAR SYRINGE KIT** .....2  
**LUPRON DEPOT 7.5 MG  
INTRAMUSCULAR SYRINGE KIT** .....2  
**RYTARY 23.75 MG-95 MG  
CAPSULE,EXTENDED RELEASE**.....4  
**RYTARY 36.25 MG-145 MG  
CAPSULE,EXTENDED RELEASE**.....4  
**RYTARY 48.75 MG-195 MG  
CAPSULE,EXTENDED RELEASE**.....4  
**RYTARY 61.25 MG-245 MG  
CAPSULE,EXTENDED RELEASE**.....4  
**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