

2024 Incentive Formulary:

This Incentive Formulary applies to members of an employer/retiree, union, or trust fund health plan

For Medicare Part D: 5 Tier Incentive Formulary

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) Pharmacy Service at 1-844-576-1246
Freedom Blue PPO (PA) Pharmacy Service at 1-800-550-8722
Freedom Blue PPO (WV) Pharmacy Service at 1-888-459-4020
Security Blue HMO-POS Pharmacy Service at 1-800-935-2583
Community Blue Medicare HMO Pharmacy Service at 1-888-234-5397
Community Blue Medicare PPO Pharmacy Service at 1-888-757-2946
Community Blue Medicare Plus PPO Pharmacy Service at 1-888-757-2946
Blue Rx PDP Pharmacy Service at 1-800-290-3914

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

Notice: Oral Antivirals for COVID-19 Coverage

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

Formulary ID: 24011 Version: 21

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 or Highmark 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, or Blue Rx PDP.

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

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

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

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

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

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

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - 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 or Blue Rx PDP Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to 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.
 - 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 or Blue Rx PDP Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year.

You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

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

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

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

Medical Condition

The formulary begins on page 9. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular – Hypertension & Lipids.” If you know what your drug is used for, look for the category name in the list that begins on page number 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 that is covered. 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, or Blue Rx PDP Formulary?" on page 6 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, and Blue Rx PDP Formulary?

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

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

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

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

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

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

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

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

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

The following is a Formulary Format Example Only:

Drug Name	Incentive Drug Tier	Requirements/ Limits
Anti - Infectives		
XYZ DRUG	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

Drug Name	Drug Tier	Requirements/Limits
Anti - Infectives		
<i>abacavir</i>	T3	
<i>abacavir-lamivudine</i>	T4	
ABELCET	T4	PA-BvD
<i>acyclovir oral capsule</i>	T2	
<i>acyclovir oral suspension 200 mg/5 ml</i>	T2	
<i>acyclovir oral tablet</i>	T2	
<i>acyclovir sodium intravenous solution</i>	T2	PA-BvD
<i>adefovir</i>	T4	
AEMCOLO	T4	QL (12 EA per 3 days)
<i>albendazole</i>	T4	
<i>amantadine hcl oral capsule</i>	T2	QL (124 EA per 31 days)
<i>amantadine hcl oral solution</i>	T2	
<i>amantadine hcl oral tablet</i>	T2	
AMBISOME	T5	PA-BvD
<i>amikacin injection solution 500 mg/2 ml</i>	T2	
<i>amoxicillin oral capsule</i>	T1	
<i>amoxicillin oral suspension for reconstitution</i>	T1	
<i>amoxicillin oral tablet</i>	T1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	T1	

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

Drug Name	Drug Tier	Requirements/Limits
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	T2	
<i>amoxicillin-pot clavulanate oral tablet</i>	T2	
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr</i>	T2	
<i>amoxicillin-pot clavulanate oral tablet, chewable 400-57 mg</i>	T2	
<i>amphotericin b</i>	T4	PA-BvD
<i>amphotericin b liposome</i>	T5	PA-BvD
<i>ampicillin oral capsule 500 mg</i>	T2	
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	T2	
<i>ampicillin-sulbactam injection</i>	T2	
ANCOBON	T5	
APTIVUS	T5	
ARIKAYCE	T5	PA
<i>atazanavir</i>	T4	
<i>atovaquone</i>	T4	
<i>atovaquone-proguanil</i>	T2	
AUGMENTIN ES-600	T4	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	T4	
AVYCAZ	T5	
AZACTAM	T4	
<i>azithromycin</i>	T2	
<i>aztreonam</i>	T2	
BACTRIM	T4	
BACTRIM DS	T4	
BARACLUDE	T5	
BAXDELA	T5	
<i>benznidazole</i>	T4	PA
BETHKIS	T5	PA
BICILLIN C-R	T3	
BICILLIN L-A INTRAMUSCULAR SYRINGE 1,200,000 UNIT/2 ML, 600,000 UNIT/ML	T3	
BICILLIN L-A INTRAMUSCULAR SYRINGE 2,400,000 UNIT/4 ML	T5	
BIKTARVY	T5	QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
BILTRICIDE	T4	
CANCIDAS	T5	
<i>casprofungin intravenous recon soln 50 mg</i>	T5	
<i>casprofungin intravenous recon soln 70 mg</i>	T4	
CAYSTON	T5	PA
<i>cefaclor oral capsule</i>	T2	
<i>cefaclor oral suspension for reconstitution 250 mg/5 ml</i>	T2	
<i>cefaclor oral tablet extended release 12 hr</i>	T2	
<i>cefadroxil oral capsule</i>	T2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	T2	
<i>cefadroxil oral tablet</i>	T2	
<i>cefazolin injection recon soln 1 gram, 10 gram, 500 mg</i>	T2	
<i>cefdinir</i>	T2	
<i>cefepime injection</i>	T2	
<i>cefixime</i>	T2	
<i>cefotetan injection</i>	T2	
<i>cefoxitin</i>	T2	
<i>cefpodoxime</i>	T2	
<i>cefprozil</i>	T2	
<i>ceftazidime</i>	T2	
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	T2	
<i>cefuroxime axetil oral tablet</i>	T2	
<i>cefuroxime sodium injection recon soln 750 mg</i>	T2	
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	T2	
<i>cephalexin</i>	T2	
<i>chloroquine phosphate oral tablet 250 mg</i>	T2	QL (50 EA per 30 days)
<i>chloroquine phosphate oral tablet 500 mg</i>	T2	QL (25 EA per 30 days)
CIMDUO	T5	QL (31 EA per 31 days)
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON	T3	
CIPRO ORAL TABLET 250 MG, 500 MG	T4	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	T1	

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

Drug Name	Drug Tier	Requirements/Limits
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	T2	
<i>clarithromycin</i>	T2	
CLEOCIN HCL	T4	
CLEOCIN INJECTION	T4	
CLEOCIN PEDIATRIC	T4	
<i>clindamycin hcl</i>	T2	
<i>clindamycin in 5 % dextrose</i>	T2	
CLINDAMYCIN PEDIATRIC	T2	
<i>clindamycin phosphate injection</i>	T2	
<i>clotrimazole mucous membrane</i>	T2	
COARTEM	T4	
<i>colistin (colistimethate na)</i>	T4	
COMBIVIR	T5	
COMPLERA	T5	
CRESEMBA ORAL	T5	PA
CUBICIN RF	T5	
<i>cycloserine</i>	T4	
DALVANCE	T5	
<i>dapsone oral</i>	T3	
<i>daptomycin intravenous recon soln 350 mg</i>	T5	
<i>daptomycin intravenous recon soln 500 mg</i>	T4	
DARAPRIM	T5	PA
<i>darunavir</i>	T5	
DELSTRIGO	T5	QL (31 EA per 31 days)
<i>demeclocycline oral tablet 150 mg</i>	T2	
<i>demeclocycline oral tablet 300 mg</i>	T4	
DESCOVY	T5	QL (31 EA per 31 days)
<i>dicloxacillin</i>	T2	
DIFICID ORAL SUSPENSION FOR RECONSTITUTION	T5	QL (136 ML per 12 days)
DIFICID ORAL TABLET	T5	QL (20 EA per 10 days)
DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML	T4	
DIFLUCAN ORAL TABLET 100 MG, 200 MG	T4	
DORYX MPC ORAL TABLET,DELAYED RELEASE (DR/EC) 60 MG	T5	

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

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

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

Drug Name	Drug Tier	Requirements/Limits
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	T5	PA; QL (56 EA per 28 days)
EPCLUSA ORAL TABLET	T5	PA; QL (28 EA per 28 days)
EPIVIR	T4	
EPZICOM	T5	
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG	T5	
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 50 MG	T4	
<i>ertapenem</i>	T4	
ERYPED 200	T4	
ERYPED 400	T4	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 333 MG	T2	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 500 MG	T3	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	T3	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	T2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml</i>	T5	
<i>erythromycin ethylsuccinate oral tablet</i>	T2	
<i>erythromycin oral</i>	T2	
<i>ethambutol</i>	T2	
<i>etravirine</i>	T5	
EVOTAZ	T5	
<i>famciclovir</i>	T2	
FIRVANQ	T4	
FLAGYL ORAL CAPSULE	T4	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	T2	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	T3	
<i>fluconazole oral suspension for reconstitution</i>	T3	
<i>fluconazole oral tablet</i>	T2	
<i>flucytosine</i>	T5	
<i>fosamprenavir</i>	T5	
<i>fosfomycin tromethamine</i>	T4	

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

Drug Name	Drug Tier	Requirements/Limits
FUZEON SUBCUTANEOUS RECON SOLN	T5	
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	T2	
<i>gentamicin injection solution 40 mg/ml</i>	T1	
GENVOYA	T5	
<i>griseofulvin microsize</i>	T2	
<i>griseofulvin ultramicrosize</i>	T2	
HARVONI ORAL PELLETS IN PACKET	T5	PA; QL (28 EA per 28 days)
HARVONI ORAL TABLET 90-400 MG	T5	PA; QL (28 EA per 28 days)
HIPREX	T4	
HUMATIN	T4	
<i>hydroxychloroquine oral tablet 100 mg</i>	T4	QL (93 EA per 31 days)
<i>hydroxychloroquine oral tablet 200 mg</i>	T2	QL (93 EA per 31 days)
<i>hydroxychloroquine oral tablet 300 mg</i>	T4	QL (62 EA per 31 days)
<i>hydroxychloroquine oral tablet 400 mg</i>	T4	QL (31 EA per 31 days)
<i>imipenem-cilastatin</i>	T2	
IMPAVIDO	T5	
INTELENCE ORAL TABLET 100 MG, 200 MG	T5	
INTELENCE ORAL TABLET 25 MG	T4	
INVANZ INJECTION	T4	
ISENTRESS HD	T5	
ISENTRESS ORAL POWDER IN PACKET	T5	
ISENTRESS ORAL TABLET	T5	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	T5	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	T3	
<i>isoniazid oral solution</i>	T2	
<i>isoniazid oral tablet</i>	T1	
<i>itraconazole oral capsule</i>	T2	PA
<i>itraconazole oral solution</i>	T4	PA
<i>ivermectin oral</i>	T2	PA
JULUCA	T5	
KALETRA ORAL SOLUTION	T5	
KALETRA ORAL TABLET	T4	
<i>ketoconazole oral</i>	T2	

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

Drug Name	Drug Tier	Requirements/Limits
KITABIS PAK	T4	PA
KRINTAFEL	T4	
LAGEVRIO (EUA)	T3	QL (360 EA per 365 days)
<i>lamivudine</i>	T2	
<i>lamivudine-zidovudine</i>	T2	
LAMPIT	T4	PA
<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</i>	T2	
LEXIVA ORAL TABLET	T5	
<i>linezolid</i>	T4	
<i>linezolid in dextrose 5%</i>	T4	
LIVTENCITY	T5	PA; QL (372 EA per 31 days)
<i>lopinavir-ritonavir oral solution</i>	T4	
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	T3	
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	T4	
MACROBID	T4	QL (90 EA per 365 days)
MACRODANTIN ORAL CAPSULE 100 MG	T4	QL (90 EA per 365 days)
MACRODANTIN ORAL CAPSULE 25 MG	T4	QL (360 EA per 365 days)
MACRODANTIN ORAL CAPSULE 50 MG	T4	QL (180 EA per 365 days)
MALARONE	T4	
MALARONE PEDIATRIC	T4	
<i>maraviroc oral tablet 150 mg</i>	T5	
<i>maraviroc oral tablet 300 mg</i>	T4	
MAVYRET ORAL PELLETS IN PACKET	T5	PA; QL (140 EA per 28 days)
MAVYRET ORAL TABLET	T5	PA; QL (84 EA per 28 days)
<i>mefloquine</i>	T2	
MEPRON	T4	
<i>meropenem intravenous recon soln 1 gram, 500 mg</i>	T2	
<i>methenamine hippurate</i>	T2	
<i>metronidazole in nacl (iso-os)</i>	T2	
<i>metronidazole oral capsule</i>	T2	
<i>metronidazole oral tablet</i>	T1	
<i>micafungin intravenous recon soln 100 mg</i>	T4	
<i>micafungin intravenous recon soln 50 mg</i>	T5	

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

Drug Name	Drug Tier	Requirements/Limits
<i>minocycline oral capsule</i>	T2	
<i>minocycline oral tablet</i>	T2	
<i>minocycline oral tablet extended release 24 hr 105 mg, 115 mg, 135 mg, 45 mg, 65 mg, 80 mg, 90 mg</i>	T2	
<i>minocycline oral tablet extended release 24 hr 55 mg</i>	T4	
<i>moxifloxacin oral</i>	T3	
<i>moxifloxacin-sod.chloride(iso)</i>	T4	
MYCAMINE INTRAVENOUS RECON SOLN 50 MG	T5	
MYCOBUTIN	T4	
<i>naftillin injection recon soln 1 gram</i>	T2	
<i>naftillin injection recon soln 10 gram</i>	T5	
<i>naftillin injection recon soln 2 gram</i>	T4	
NEBUPENT	T4	PA-BvD
<i>neomycin</i>	T2	
<i>nevirapine oral suspension</i>	T2	
<i>nevirapine oral tablet</i>	T2	
<i>nevirapine oral tablet extended release 24 hr 400 mg</i>	T4	
<i>nitazoxanide</i>	T4	
<i>nitrofurantoin macrocrystal oral capsule 100 mg</i>	T2	QL (90 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	T2	QL (360 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 50 mg</i>	T2	QL (180 EA per 365 days)
<i>nitrofurantoin monohyd/m-cryst</i>	T2	QL (90 EA per 365 days)
<i>nitrofurantoin oral suspension 25 mg/5 ml</i>	T5	QL (1800 ML per 365 days)
<i>nitrofurantoin oral suspension 50 mg/5 ml</i>	T5	QL (900 ML per 365 days)
NORVIR ORAL POWDER IN PACKET	T3	
NORVIR ORAL TABLET	T4	
NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON	T5	PA; QL (32 EA per 31 days)
NOXAFIL ORAL SUSPENSION	T5	PA
NOXAFIL ORAL TABLET,DELAYED RELEASE (DR/EC)	T5	PA
NUZYRA	T5	
<i>nystatin oral</i>	T2	
ODEFSEY	T5	QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	T2	
ORACEA	T4	
<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)</i>	T2	
<i>oxacillin injection recon soln 1 gram, 2 gram</i>	T2	
<i>oxacillin injection recon soln 10 gram</i>	T4	
PAXLOVID ORAL TABLETS,DOSE PACK 150-100 MG	T3	QL (180 EA per 365 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	T3	QL (270 EA per 365 days)
<i>penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml</i>	T4	
<i>penicillin g potassium injection recon soln 20 million unit</i>	T2	
<i>penicillin g sodium</i>	T5	
<i>penicillin v potassium</i>	T1	
PENTAM	T4	
<i>pentamidine inhalation</i>	T4	PA-BvD
<i>pentamidine injection</i>	T4	
PIFELTRO	T5	QL (62 EA per 31 days)
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	T2	
PLAQUENIL	T4	QL (93 EA per 31 days)
<i>polymyxin b sulfate</i>	T2	
<i>posaconazole oral</i>	T5	PA
<i>praziquantel</i>	T4	
<i>pretomanid</i>	T4	PA; QL (31 EA per 31 days)
PREVYMIS ORAL	T5	QL (31 EA per 31 days)
PREZCOBIX	T5	
PREZISTA ORAL SUSPENSION	T5	
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	T5	
PRIFTIN	T4	
<i>primaquine</i>	T3	
PRIMAXIN IV INTRAVENOUS RECON SOLN 500 MG	T4	

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

Drug Name	Drug Tier	Requirements/Limits
<i>pyrazinamide</i>	T2	
<i>pyrimethamine</i>	T5	PA
QUALAQUIN	T4	PA; QL (42 EA per 28 days)
<i>quinine sulfate</i>	T3	PA; QL (42 EA per 28 days)
RELENZA DISKHALER	T3	
RETROVIR ORAL CAPSULE	T4	
RETROVIR ORAL SYRUP	T4	
REYATAZ ORAL CAPSULE 200 MG, 300 MG	T5	
REYATAZ ORAL POWDER IN PACKET	T5	
<i>ribavirin oral capsule</i>	T2	
<i>ribavirin oral tablet 200 mg</i>	T2	
<i>rifabutin</i>	T2	
<i>rifampin intravenous</i>	T5	
<i>rifampin oral</i>	T2	
<i>rimantadine</i>	T2	
<i>ritonavir</i>	T3	
RUKOBIA	T5	QL (62 EA per 31 days)
SELZENTRY ORAL SOLUTION	T5	
SELZENTRY ORAL TABLET 150 MG, 300 MG, 75 MG	T5	
SELZENTRY ORAL TABLET 25 MG	T4	
SEYSARA	T5	PA
SIRTURO	T5	PA
SIVEXTRO INTRAVENOUS	T5	
SIVEXTRO ORAL	T5	QL (6 EA per 31 days)
<i>sofosbuvir-velpatasvir</i>	T5	PA; QL (28 EA per 28 days)
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 80 MG	T4	
SOLOSEC	T4	
SOVALDI	T5	PA; QL (28 EA per 28 days)
SOVUNA ORAL TABLET 200 MG	T4	QL (93 EA per 31 days)
SOVUNA ORAL TABLET 300 MG	T4	QL (62 EA per 31 days)
SPORANOX ORAL CAPSULE	T5	PA
SPORANOX ORAL SOLUTION	T4	PA
<i>streptomycin</i>	T5	
STRIBILD	T5	

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

Drug Name	Drug Tier	Requirements/Limits
STROMEKTOL	T4	PA
<i>sulfadiazine</i>	T2	
<i>sulfamethoxazole-trimethoprim oral</i>	T1	
SUNLENCA ORAL	T5	
SYMFI	T5	QL (31 EA per 31 days)
SYMFI LO	T5	QL (31 EA per 31 days)
SYMTUZA	T5	QL (31 EA per 31 days)
TAMIFLU ORAL CAPSULE 30 MG	T3	QL (170 EA per 365 days)
TAMIFLU ORAL CAPSULE 45 MG, 75 MG	T3	QL (90 EA per 365 days)
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION	T3	QL (1080 ML per 365 days)
TARGADOX	T4	
TAZICEF INJECTION	T4	
TEFLARO INTRAVENOUS RECON SOLN 400 MG	T4	
TEFLARO INTRAVENOUS RECON SOLN 600 MG	T5	
<i>tenofovir disoproxil fumarate</i>	T3	
<i>terbinafine hcl oral</i>	T1	QL (90 EA per 180 days)
<i>tetracycline oral capsule</i>	T2	
<i>tigecycline</i>	T5	
<i>tinidazole</i>	T2	
TIVICAY ORAL TABLET 10 MG	T4	
TIVICAY ORAL TABLET 25 MG, 50 MG	T5	
TIVICAY PD	T5	
TOBI	T5	PA
TOBI PODHALER	T5	PA; QL (224 EA per 56 days)
<i>tobramycin in 0.225 % nacl</i>	T5	PA
<i>tobramycin inhalation</i>	T5	PA
<i>tobramycin sulfate injection solution</i>	T1	
TOLSURA	T5	PA; QL (130 EA per 31 days)
TRECTOR	T4	
<i>trimethoprim</i>	T2	
TRIUMEQ	T5	
TRIUMEQ PD	T5	QL (186 EA per 31 days)
TRIZIVIR	T5	
TRUVADA	T5	

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

Drug Name	Drug Tier	Requirements/Limits
TYBOST	T3	
TYGACIL	T4	
UNASYN INJECTION RECON SOLN 15 GRAM, 3 GRAM	T4	
VABOMERE	T4	
<i>valacyclovir</i>	T2	
VALCYTE	T5	
<i>valganciclovir oral recon soln</i>	T5	
<i>valganciclovir oral tablet</i>	T3	
VALTREX	T4	
VANCOCIN ORAL CAPSULE 125 MG	T4	PA; QL (124 EA per 31 days)
VANCOCIN ORAL CAPSULE 250 MG	T5	PA; QL (248 EA per 31 days)
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg</i>	T2	
<i>vancomycin oral capsule 125 mg</i>	T4	PA; QL (124 EA per 31 days)
<i>vancomycin oral capsule 250 mg</i>	T4	PA; QL (248 EA per 31 days)
<i>vancomycin oral recon soln</i>	T4	
VEMLIDY	T5	QL (31 EA per 31 days)
VFEND IV	T4	PA
VFEND ORAL SUSPENSION FOR RECONSTITUTION	T5	
VFEND ORAL TABLET	T4	
VIRACEPT ORAL TABLET	T5	
VIREAD	T5	
VIVJOA	T4	PA; QL (18 EA per 84 days)
<i>voriconazole intravenous</i>	T5	PA
<i>voriconazole oral suspension for reconstitution</i>	T5	
<i>voriconazole oral tablet</i>	T4	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	T4	QL (27 EA per 365 days)
XIFAXAN ORAL TABLET 550 MG	T5	PA; QL (62 EA per 31 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	T3	QL (9 EA per 365 days)
ZEMDRI	T5	
ZEPATIER	T5	PA; QL (28 EA per 28 days)
ZERBAXA	T4	
ZIAGEN ORAL SOLUTION	T3	
<i>zidovudine</i>	T2	

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

Drug Name	Drug Tier	Requirements/Limits
ZITHROMAX INTRAVENOUS	T4	
ZITHROMAX ORAL PACKET	T4	
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION	T4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG	T4	
ZITHROMAX TRI-PAK	T4	
ZITHROMAX Z-PAK	T4	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML	T4	
ZYVOX INTRAVENOUS PIGGYBACK 600 MG/300 ML	T4	
ZYVOX ORAL	T5	
Antineoplastic / Immunosuppressant Drugs		
<i>abiraterone oral tablet 250 mg</i>	T5	PA-NS; QL (124 EA per 31 days)
<i>abiraterone oral tablet 500 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR	T5	PA-NS; QL (31 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 5 MG	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG	T5	PA-NS; QL (93 EA per 31 days)
AKEEGA	T5	PA-NS; QL (62 EA per 31 days)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	T5	PA-NS; QL (31 EA per 31 days)
ALUNBRIG ORAL TABLET 30 MG	T5	PA-NS; QL (186 EA per 31 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	T5	PA-NS; QL (60 EA per 365 days)
<i>anastrozole</i>	T2	
ARIMIDEX	T5	
AROMASIN	T5	
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG	T3	PA-BvD
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 5 MG	T5	PA-BvD
AUGTYRO	T5	PA-NS; QL (248 EA per 31 days)
AYVAKIT	T5	PA-NS; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
AZASAN	T4	PA-BvD
<i>azathioprine oral tablet 100 mg, 75 mg</i>	T4	PA-BvD
<i>azathioprine oral tablet 50 mg</i>	T2	PA-BvD
BALVERSA	T5	PA-NS
<i>bexarotene oral</i>	T5	PA-NS
<i>bexarotene topical</i>	T5	PA-NS; QL (60 GM per 28 days)
<i>bicalutamide</i>	T2	
BOSULIF ORAL CAPSULE 100 MG	T5	PA-NS; QL (186 EA per 31 days)
BOSULIF ORAL CAPSULE 50 MG	T5	PA-NS; QL (341 EA per 31 days)
BOSULIF ORAL TABLET 100 MG	T5	PA-NS; QL (93 EA per 31 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	T5	PA-NS; QL (31 EA per 31 days)
BRAFTOVI	T5	PA-NS; QL (186 EA per 31 days)
BRUKINSA	T5	PA-NS; QL (124 EA per 31 days)
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CALQUENCE	T5	PA-NS; QL (62 EA per 31 days)
CALQUENCE (ACALABRUTINIB MAL)	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 300 MG	T5	PA-NS; QL (31 EA per 31 days)
CASODEX	T4	
CELLCEPT	T5	PA-BvD
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	T5	PA-NS; QL (112 EA per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	T5	PA-NS; QL (84 EA per 28 days)
COPIKTRA	T5	PA-NS; QL (62 EA per 31 days)
COTELLIC	T5	PA-NS; LA; QL (63 EA per 28 days)
<i>cyclophosphamide oral</i>	T3	PA-BvD
<i>cyclosporine modified oral capsule</i>	T2	PA-BvD
<i>cyclosporine modified oral solution</i>	T4	PA-BvD
<i>cyclosporine oral capsule</i>	T2	PA-BvD
DAURISMO ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
DAURISMO ORAL TABLET 25 MG	T5	PA-NS; QL (62 EA per 31 days)
DROXIA	T4	
ELIGARD	T4	
ELIGARD (3 MONTH)	T4	

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

Drug Name	Drug Tier	Requirements/Limits
ELIGARD (4 MONTH)	T4	
ELIGARD (6 MONTH)	T4	
ENSPRYNG	T5	PA; QL (1 ML per 28 days)
ENVARUSUS XR	T4	PA-BvD
ERIVEDGE	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA ORAL TABLET 240 MG	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA ORAL TABLET 60 MG	T5	PA-NS; QL (93 EA per 31 days)
<i>erlotinib</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 7.5 mg</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg, 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>everolimus (immunosuppressive)</i>	T5	PA-BvD
<i>exemestane</i>	T2	
FARESTON	T5	
FEMARA	T4	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	T5	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	T4	
FOTIVDA	T5	PA-NS; QL (21 EA per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	T5	PA-NS; QL (84 EA per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	T5	PA-NS; QL (21 EA per 28 days)
GAVRETO	T5	PA-NS; QL (124 EA per 31 days)
<i>gefitinib</i>	T5	PA-NS; QL (31 EA per 31 days)
GENGRAF	T2	PA-BvD
GILOTRIF	T5	PA-NS; QL (31 EA per 31 days)
GLEEVEC ORAL TABLET 100 MG	T5	PA-NS; QL (93 EA per 31 days)
GLEEVEC ORAL TABLET 400 MG	T5	PA-NS; QL (62 EA per 31 days)
GLEOSTINE ORAL CAPSULE 10 MG, 40 MG	T4	PA-NS
GLEOSTINE ORAL CAPSULE 100 MG	T5	PA-NS
HYDREA	T4	
<i>hydroxyurea</i>	T2	
IBRANCE	T5	PA-NS; QL (21 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
ICLUSIG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 50 MG	T5	PA-NS; QL (62 EA per 31 days)
<i>imatinib oral tablet 100 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>imatinib oral tablet 400 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
IMBRUVICA ORAL CAPSULE 140 MG	T5	PA-NS; QL (124 EA per 31 days)
IMBRUVICA ORAL CAPSULE 70 MG	T5	PA-NS; QL (31 EA per 31 days)
IMBRUVICA ORAL SUSPENSION	T5	PA-NS; QL (216 ML per 25 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	T5	PA-NS; QL (31 EA per 31 days)
IMURAN	T4	PA-BvD
INLYTA	T5	PA-NS; QL (124 EA per 31 days)
INQOVI	T5	PA-NS; QL (5 EA per 28 days)
INREBIC	T5	PA-NS; QL (124 EA per 31 days)
IRESSA	T5	PA-NS; QL (31 EA per 31 days)
IWILFIN	T5	PA-NS; QL (248 EA per 31 days)
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
JAYPIRCA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
JAYPIRCA ORAL TABLET 50 MG	T5	PA-NS; QL (31 EA per 31 days)
JYLAMVO	T4	PA-BvD
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	T5	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	T5	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	T5	PA-NS; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
KLISYRI	T5	PA
KOSELUGO ORAL CAPSULE 10 MG	T5	PA; QL (279 EA per 31 days)
KOSELUGO ORAL CAPSULE 25 MG	T5	PA; QL (124 EA per 31 days)
KRAZATI	T5	PA-NS; QL (186 EA per 31 days)
<i>lapatinib</i>	T5	PA-NS; QL (186 EA per 31 days)
<i>lenalidomide</i>	T5	PA-NS; QL (21 EA per 28 days)

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

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

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

Drug Name	Drug Tier	Requirements/Limits
MEKTOVI	T5	PA-NS; QL (186 EA per 31 days)
<i>mercaptopurine</i>	T2	
MESNEX ORAL	T3	
<i>methotrexate sodium (pf) injection solution</i>	T2	PA-BvD
<i>methotrexate sodium injection</i>	T2	PA-BvD
<i>methotrexate sodium oral</i>	T1	PA-BvD
MYCAPSSA	T5	PA; QL (124 EA per 31 days)
<i>mycophenolate mofetil oral capsule</i>	T2	PA-BvD
<i>mycophenolate mofetil oral suspension for reconstitution</i>	T5	PA-BvD
<i>mycophenolate mofetil oral tablet</i>	T2	PA-BvD
<i>mycophenolate sodium</i>	T2	PA-BvD
MYFORTIC ORAL TABLET,DELAYED RELEASE (DR/EC) 180 MG	T3	PA-BvD
MYFORTIC ORAL TABLET,DELAYED RELEASE (DR/EC) 360 MG	T5	PA-BvD
MYHIBBIN	T5	PA-BvD
NEORAL	T3	PA-BvD
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
NEXAVAR	T5	PA-NS; QL (124 EA per 31 days)
NILANDRON	T5	
<i>nilutamide</i>	T5	
NINLARO	T5	PA-NS; QL (3 EA per 28 days)
NUBEQA	T5	PA-NS; QL (124 EA per 31 days)
<i>octreotide acetate injection solution 1,000 mcg/ml</i>	T3	PA
<i>octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml</i>	T2	PA
<i>octreotide acetate injection solution 200 mcg/ml</i>	T4	PA
<i>octreotide acetate injection solution 500 mcg/ml</i>	T5	PA
ODOMZO	T5	PA-NS; LA; QL (31 EA per 31 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG	T5	PA-NS; QL (62 EA per 31 days)
OGSIVEO ORAL TABLET 50 MG	T5	PA-NS; QL (186 EA per 31 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	T5	PA-NS; QL (96 ML per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	T5	PA-NS; QL (20 EA per 28 days)
OJJAARA	T5	PA-NS; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
ONUREG	T5	PA-NS; QL (14 EA per 28 days)
ORGOVYX	T5	PA-NS; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 345 MG	T5	PA-NS; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 86 MG	T5	PA-NS; QL (93 EA per 31 days)
<i>pazopanib</i>	T5	PA-NS; QL (124 EA per 31 days)
PEMAZYRE	T5	PA-NS; QL (14 EA per 21 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (28 EA per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	T5	PA-NS; QL (56 EA per 28 days)
POMALYST	T5	PA-NS; QL (21 EA per 28 days)
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG	T4	PA-BvD
PROGRAF ORAL CAPSULE 5 MG	T5	PA-BvD
PROGRAF ORAL GRANULES IN PACKET	T4	PA-BvD
PURIXAN	T5	
QINLOCK	T5	PA-NS; QL (93 EA per 31 days)
RAPAMUNE ORAL SOLUTION	T5	PA-BvD
RAPAMUNE ORAL TABLET 0.5 MG	T4	PA-BvD
RAPAMUNE ORAL TABLET 1 MG, 2 MG	T5	PA-BvD
RETEVMO ORAL CAPSULE 40 MG	T5	PA-NS; QL (186 EA per 31 days)
RETEVMO ORAL CAPSULE 80 MG	T5	PA-NS; QL (124 EA per 31 days)
REVLIMID	T5	PA-NS; QL (21 EA per 28 days)
REZLIDHIA	T5	PA-NS; QL (62 EA per 31 days)
REZUROCK	T5	PA; QL (62 EA per 31 days)
ROZLYTREK ORAL CAPSULE 100 MG	T5	PA-NS; QL (155 EA per 31 days)
ROZLYTREK ORAL CAPSULE 200 MG	T5	PA-NS; QL (93 EA per 31 days)
ROZLYTREK ORAL PELLETS IN PACKET	T5	PA-NS; QL (372 EA per 31 days)
RUBRACA	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE ORAL CAPSULE 100 MG	T4	PA-BvD
SANDIMMUNE ORAL CAPSULE 25 MG	T3	PA-BvD
SANDIMMUNE ORAL SOLUTION	T3	PA-BvD
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML	T5	PA
SANDOSTATIN INJECTION SOLUTION 50 MCG/ML, 500 MCG/ML	T4	PA
SCEMBLIX ORAL TABLET 100 MG	T5	PA-NS; QL (124 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
SCSEMBLIX ORAL TABLET 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SCSEMBLIX ORAL TABLET 40 MG	T5	PA-NS; QL (310 EA per 31 days)
SIGNIFOR	T5	PA
SIKLOS ORAL TABLET 1,000 MG	T5	
SIKLOS ORAL TABLET 100 MG	T4	
<i>sirolimus oral solution</i>	T5	PA-BvD
<i>sirolimus oral tablet</i>	T2	PA-BvD
SOLTAMOX	T5	
<i>sorafenib</i>	T5	PA-NS; QL (124 EA per 31 days)
SPRYCEL	T5	PA-NS; QL (31 EA per 31 days)
STIVARGA	T5	PA-NS; QL (84 EA per 28 days)
<i>sunitinib malate</i>	T5	PA-NS; QL (31 EA per 31 days)
SUTENT	T5	PA-NS; QL (31 EA per 31 days)
TABLOID	T3	
TABRECTA	T5	PA-NS; QL (124 EA per 31 days)
<i>tacrolimus oral capsule</i>	T2	PA-BvD
TAFINLAR ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	T5	PA-NS; QL (930 EA per 31 days)
TAGRISO	T5	PA-NS; LA; QL (31 EA per 31 days)
TALZENNA	T5	PA-NS; QL (31 EA per 31 days)
<i>tamoxifen</i>	T1	
TARGRETIN ORAL	T5	PA-NS
TARGRETIN TOPICAL	T5	PA-NS; QL (60 GM per 28 days)
TASIGNA	T5	PA-NS; QL (124 EA per 31 days)
TAZVERIK	T5	PA-NS; QL (248 EA per 31 days)
TEPMETKO	T5	PA-NS; QL (62 EA per 31 days)
THALOMID ORAL CAPSULE 100 MG, 150 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 200 MG	T5	PA-NS; QL (56 EA per 28 days)
TIBSOVO	T5	PA-NS; QL (62 EA per 31 days)
<i>toremifene</i>	T4	
TORPENZ	T5	PA-NS; QL (31 EA per 31 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	T4	ST
<i>tretinoin (antineoplastic)</i>	T5	
TREXALL	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.

Drug Name	Drug Tier	Requirements/Limits
TRUQAP	T5	PA-NS; QL (64 EA per 28 days)
TUKYSA ORAL TABLET 150 MG	T5	PA-NS; QL (124 EA per 31 days)
TUKYSA ORAL TABLET 50 MG	T5	PA-NS; QL (248 EA per 31 days)
TURALIO ORAL CAPSULE 125 MG	T5	PA-NS; QL (124 EA per 31 days)
TYKERB	T5	PA-NS; QL (186 EA per 31 days)
VANFLYTA	T5	PA-NS; QL (62 EA per 31 days)
VENCLEXTA ORAL TABLET 10 MG	T4	PA-NS; QL (62 EA per 31 days)
VENCLEXTA ORAL TABLET 100 MG	T5	PA-NS; QL (186 EA per 31 days)
VENCLEXTA ORAL TABLET 50 MG	T5	PA-NS; QL (31 EA per 31 days)
VENCLEXTA STARTING PACK	T5	PA-NS; QL (84 EA per 365 days)
VERZENIO	T5	PA-NS; QL (62 EA per 31 days)
VIJOICE ORAL GRANULES IN PACKET	T5	PA-NS; QL (31 EA per 31 days)
VIJOICE ORAL TABLET 125 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
VITRAKVI ORAL CAPSULE 100 MG	T5	PA-NS; QL (62 EA per 31 days)
VITRAKVI ORAL CAPSULE 25 MG	T5	PA-NS; QL (186 EA per 31 days)
VITRAKVI ORAL SOLUTION	T5	PA-NS; QL (310 ML per 31 days)
VIZIMPRO	T5	PA-NS; QL (31 EA per 31 days)
VONJO	T5	PA-NS; QL (124 EA per 31 days)
VOTRIENT	T5	PA-NS; QL (124 EA per 31 days)
WELIREG	T5	PA-NS; QL (93 EA per 31 days)
XALKORI ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
XALKORI ORAL PELLETT 150 MG	T5	PA-NS; QL (186 EA per 31 days)
XALKORI ORAL PELLETT 20 MG, 50 MG	T5	PA-NS; QL (124 EA per 31 days)
XATMEP	T4	PA-BvD
XERMELO	T5	PA; QL (93 EA per 31 days)
XGEVA	T5	PA-NS
XOSPATA	T5	PA-NS; QL (124 EA per 31 days)
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2)	T5	PA-NS; QL (8 EA per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1)	T5	PA-NS; QL (4 EA per 28 days)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)	T5	PA-NS; QL (24 EA per 28 days)
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	T5	PA-NS; QL (32 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
XTANDI ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
XTANDI ORAL TABLET 40 MG	T5	PA-NS; QL (124 EA per 31 days)
XTANDI ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
YONSA	T5	PA-NS; QL (124 EA per 31 days)
ZEJULA ORAL TABLET	T5	PA-NS; QL (31 EA per 31 days)
ZELBORAF	T5	PA-NS; QL (248 EA per 31 days)
ZOLINZA	T5	PA-NS
ZORTRESS	T5	PA-BvD
ZYDELIG	T5	PA-NS; QL (62 EA per 31 days)
ZYKADIA	T5	PA-NS; QL (93 EA per 31 days)
ZYTIGA ORAL TABLET 250 MG	T5	PA-NS; QL (124 EA per 31 days)
ZYTIGA ORAL TABLET 500 MG	T5	PA-NS; QL (62 EA per 31 days)
Autonomic / Cns Drugs, Neurology / Psych		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	T5	QL (2.4 ML per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	T5	QL (3.2 ML per 56 days)
ABILIFY MAINTENA	T5	QL (1 EA per 28 days)
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET WITH SENSOR AND STRIP 15 MG, 2 MG, 20 MG, 30 MG, 5 MG	T5	PA-NS
ABILIFY MYCITE STARTER KIT ORAL TABLET WITH SENSOR, STRIP, POD 10 MG	T5	PA-NS
ABILIFY ORAL TABLET	T4	PA-NS
<i>acetaminophen-caff-dihydrocod</i>	T4	PA; QL (372 EA per 31 days)
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	T1	PA; QL (5167 ML per 31 days)
<i>acetaminophen-codeine oral tablet</i>	T2	PA; QL (403 EA per 31 days)
ADDERALL ORAL TABLET 20 MG	T4	ST; QL (93 EA per 31 days)
ADDERALL ORAL TABLET 5 MG, 7.5 MG	T4	ST; QL (62 EA per 31 days)
ADDERALL XR	T4	ST; QL (31 EA per 31 days)
ADLARITY	T4	PA; QL (4 EA per 28 days)
ADZENYS XR-ODT	T4	ST; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	T3	PA; QL (1 ML per 28 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	T3	PA; QL (2 ML per 28 days)
AJOVY AUTOINJECTOR	T3	PA; QL (1.5 ML per 28 days)
AJOVY SYRINGE	T3	PA; QL (1.5 ML per 28 days)
ALLZITAL	T4	QL (372 EA per 31 days)
<i>almotriptan malate oral tablet 12.5 mg</i>	T2	QL (8 EA per 28 days)
<i>almotriptan malate oral tablet 6.25 mg</i>	T2	QL (16 EA per 28 days)
ALPRAZOLAM INTENSOL	T2	PA
<i>alprazolam oral tablet 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg</i>	T2	PA; QL (31 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 3 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet, disintegrating 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet, disintegrating 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
AMBIEN	T4	PA; QL (31 EA per 31 days)
AMBIEN CR	T4	PA; QL (31 EA per 31 days)
<i>amitriptyline</i>	T2	PA-NS
<i>amitriptyline-chlordiazepoxide</i>	T2	PA-NS
<i>amoxapine</i>	T1	
<i>amphetamine sulfate</i>	T4	PA
AMPYRA	T5	PA; QL (62 EA per 31 days)
AMRIX	T5	QL (31 EA per 31 days)
ANAFRANIL	T4	PA-NS
ALENZIN	T5	QL (31 EA per 31 days)
APOKYN	T5	PA; QL (60 ML per 30 days)
<i>apomorphine</i>	T5	PA; QL (60 ML per 30 days)
APTENSIO XR	T4	ST; QL (31 EA per 31 days)
APTIOM ORAL TABLET 200 MG	T5	QL (186 EA per 31 days)
APTIOM ORAL TABLET 400 MG	T5	QL (93 EA per 31 days)
APTIOM ORAL TABLET 600 MG, 800 MG	T5	QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
ARICEPT	T4	
<i>aripiprazole oral solution</i>	T3	PA-NS
<i>aripiprazole oral tablet</i>	T3	PA-NS
<i>aripiprazole oral tablet, disintegrating</i>	T4	PA-NS
ARISTADA INITIO	T5	QL (4.8 ML per 365 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 1,064 MG/3.9 ML	T5	QL (3.9 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 441 MG/1.6 ML	T5	QL (1.6 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 662 MG/2.4 ML	T5	QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 882 MG/3.2 ML	T5	QL (3.2 ML per 28 days)
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
ARTHROTEC 50	T4	
ARTHROTEC 75	T4	
ASCOMP WITH CODEINE	T2	PA; QL (372 EA per 31 days)
<i>asenapine maleate</i>	T4	PA-NS; QL (62 EA per 31 days)
ATIVAN ORAL TABLET 0.5 MG	T5	PA; QL (124 EA per 31 days)
ATIVAN ORAL TABLET 1 MG	T5	PA; QL (186 EA per 31 days)
ATIVAN ORAL TABLET 2 MG	T5	PA; QL (155 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)
AUBAGIO	T5	PA; QL (31 EA per 31 days)
AUSTEDO ORAL TABLET 12 MG, 6 MG	T5	PA; QL (124 EA per 31 days)
AUSTEDO ORAL TABLET 9 MG	T5	PA; QL (155 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG	T5	PA; QL (93 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 24 MG	T5	PA; QL (62 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 30 MG, 36 MG, 42 MG, 48 MG	T5	PA; QL (31 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 6 MG	T5	PA; QL (217 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 6 MG (14)-12 MG (14)-24 MG (14)	T5	PA; QL (84 EA per 365 days)
AUVELITY	T4	PA-NS; QL (62 EA per 31 days)
AZILECT	T4	
AZSTARYS	T4	ST; QL (31 EA per 31 days)
<i>baclofen oral solution 10 mg/5 ml (2 mg/ml)</i>	T4	PA; QL (1240 ML per 31 days)
<i>baclofen oral suspension</i>	T4	PA; QL (496 ML per 31 days)
<i>baclofen oral tablet 10 mg</i>	T1	
<i>baclofen oral tablet 15 mg</i>	T4	
<i>baclofen oral tablet 20 mg, 5 mg</i>	T2	
BAFIERTAM	T5	PA; QL (124 EA per 31 days)
BANZEL	T5	PA-NS
BELBUCA	T4	PA; QL (62 EA per 31 days)
BELSOMRA	T4	ST; QL (31 EA per 31 days)
<i>benztropine oral</i>	T2	PA
BRIVIACT ORAL SOLUTION	T5	QL (620 ML per 31 days)
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 75 MG	T5	QL (62 EA per 31 days)
BRIVIACT ORAL TABLET 50 MG	T4	QL (62 EA per 31 days)
<i>bromocriptine</i>	T2	
BUPAP	T4	QL (403 EA per 31 days)
<i>buprenorphine</i>	T4	PA; QL (4 EA per 28 days)
<i>buprenorphine hcl sublingual tablet 2 mg</i>	T2	QL (93 EA per 31 days)
<i>buprenorphine hcl sublingual tablet 8 mg</i>	T2	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 12-3 mg, 4-1 mg, 8-2 mg</i>	T2	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>buprenorphine-naloxone sublingual tablet</i>	T4	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet</i>	T2	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	T2	QL (31 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 450 mg</i>	T4	QL (31 EA per 31 days)
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	T2	QL (62 EA per 31 days)
<i>bupirone</i>	T2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg</i>	T2	PA; QL (403 EA per 31 days)
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>butalbital-acetaminophen oral capsule</i>	T2	QL (403 EA per 31 days)
<i>butalbital-acetaminophen oral tablet 50-300 mg</i>	T2	QL (403 EA per 31 days)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	T2	QL (372 EA per 31 days)
<i>butalbital-acetaminophen-caff oral capsule 50-300-40 mg</i>	T2	QL (403 EA per 31 days)
<i>butalbital-acetaminophen-caff oral capsule 50-325-40 mg</i>	T2	QL (372 EA per 31 days)
<i>butalbital-acetaminophen-caff oral tablet</i>	T2	QL (372 EA per 31 days)
<i>butalbital-aspirin-caffeine oral capsule</i>	T2	
<i>butorphanol nasal</i>	T2	QL (5 ML per 28 days)
BUTRANS	T4	PA; QL (4 EA per 28 days)
CAMBIA	T4	
CAPLYTA	T5	PA-NS; QL (31 EA per 31 days)
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	T2	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	T1	
<i>carbamazepine oral tablet</i>	T1	
<i>carbamazepine oral tablet extended release 12 hr</i>	T2	
<i>carbamazepine oral tablet, chewable</i>	T1	
CARBATROL	T4	
<i>carbidopa</i>	T4	
<i>carbidopa-levodopa</i>	T2	
<i>carbidopa-levodopa-entacapone</i>	T2	
<i>carisoprodol</i>	T2	PA
CELEBREX	T4	ST; QL (62 EA per 31 days)
<i>celecoxib</i>	T2	ST; QL (62 EA per 31 days)
CELEXA ORAL TABLET	T4	
CELONTIN ORAL CAPSULE 300 MG	T4	
<i>chlordiazepoxide hcl</i>	T2	PA
<i>chlorpromazine oral</i>	T2	
<i>chlorzoxazone oral tablet 250 mg</i>	T5	PA
<i>chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg</i>	T2	PA
<i>citalopram oral capsule</i>	T4	PA-NS; QL (31 EA per 31 days)
<i>citalopram oral solution</i>	T1	

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

Drug Name	Drug Tier	Requirements/Limits
<i>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>	T2	PA-NS
<i>clonazepam oral tablet 0.5 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>clonazepam oral tablet 1 mg</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>clonazepam oral tablet 2 mg</i>	T2	PA-NS; QL (310 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 1 mg</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 2 mg</i>	T2	PA-NS; QL (310 EA per 31 days)
<i>clonidine hcl oral tablet extended release 12 hr</i>	T2	PA
<i>clorazepate dipotassium oral tablet 15 mg</i>	T2	PA-NS; QL (186 EA per 31 days)
<i>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>clozapine oral tablet 100 mg, 25 mg</i>	T2	QL (279 EA per 31 days)
<i>clozapine oral tablet 200 mg</i>	T2	QL (124 EA per 31 days)
<i>clozapine oral tablet 50 mg</i>	T2	QL (93 EA per 31 days)
<i>clozapine oral tablet, disintegrating 100 mg, 25 mg</i>	T2	QL (279 EA per 31 days)
<i>clozapine oral tablet, disintegrating 12.5 mg</i>	T2	QL (93 EA per 31 days)
<i>clozapine oral tablet, disintegrating 150 mg</i>	T4	QL (186 EA per 31 days)
<i>clozapine oral tablet, disintegrating 200 mg</i>	T4	QL (124 EA per 31 days)
CLOZARIL ORAL TABLET 100 MG	T5	QL (279 EA per 31 days)
CLOZARIL ORAL TABLET 200 MG	T4	QL (124 EA per 31 days)
CLOZARIL ORAL TABLET 25 MG	T4	QL (279 EA per 31 days)
CLOZARIL ORAL TABLET 50 MG	T4	QL (93 EA per 31 days)
<i>codeine sulfate</i>	T2	PA; QL (186 EA per 31 days)
<i>codeine-butalbital-asa-caff</i>	T2	PA; QL (372 EA per 31 days)
COMTAN	T4	
CONCERTA	T4	ST; QL (31 EA per 31 days)
CONZIP	T4	PA; QL (30 EA per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (31 ML per 31 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	T5	PA; QL (12 ML per 28 days)
COTEMPLA XR-ODT	T4	ST; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>cyclobenzaprine oral capsule,extended release 24hr</i>	T4	QL (31 EA per 31 days)
<i>cyclobenzaprine oral tablet 10 mg, 7.5 mg</i>	T2	QL (93 EA per 31 days)
<i>cyclobenzaprine oral tablet 5 mg</i>	T2	QL (155 EA per 31 days)
CYMBALTA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 MG, 60 MG	T4	QL (62 EA per 31 days)
CYMBALTA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 MG	T4	QL (31 EA per 31 days)
<i>dalfampridine</i>	T5	PA; QL (62 EA per 31 days)
DANTRIUM ORAL CAPSULE 25 MG	T4	
<i>dantrolene oral</i>	T2	
DAYBUE	T5	PA; QL (3600 ML per 30 days)
DAYPRO	T4	
DAYTRANA	T4	PA; QL (30 EA per 30 days)
DAYVIGO	T4	ST; QL (31 EA per 31 days)
DEMEROL (PF) INJECTION SYRINGE 25 MG/ML	T4	PA; QL (824 ML per 31 days)
DEMEROL INJECTION	T4	PA; QL (412 ML per 31 days)
DEPAKOTE	T4	
DEPAKOTE ER	T4	
DEPAKOTE SPRINKLES	T4	
<i>desipramine</i>	T2	
<i>desvenlafaxine oral tablet extended release 24 hr 100 mg</i>	T4	QL (124 EA per 31 days)
<i>desvenlafaxine oral tablet extended release 24 hr 50 mg</i>	T4	QL (31 EA per 31 days)
<i>desvenlafaxine succinate</i>	T3	QL (31 EA per 31 days)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG	T4	ST; QL (155 EA per 31 days)
<i>dexmethylphenidate oral capsule,er biphasic 50-50</i>	T2	QL (31 EA per 31 days)
<i>dexmethylphenidate oral tablet 10 mg</i>	T2	QL (62 EA per 31 days)
<i>dexmethylphenidate oral tablet 2.5 mg, 5 mg</i>	T2	QL (93 EA per 31 days)
<i>dextroamphetamine sulfate oral capsule, extended release 10 mg</i>	T2	QL (155 EA per 31 days)
<i>dextroamphetamine sulfate oral capsule, extended release 15 mg</i>	T2	QL (124 EA per 31 days)
<i>dextroamphetamine sulfate oral capsule, extended release 5 mg</i>	T2	QL (186 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>dextroamphetamine sulfate oral solution</i>	T3	
<i>dextroamphetamine sulfate oral tablet 10 mg</i>	T2	QL (186 EA per 31 days)
<i>dextroamphetamine sulfate oral tablet 15 mg, 20 mg, 30 mg</i>	T4	QL (62 EA per 31 days)
<i>dextroamphetamine sulfate oral tablet 5 mg</i>	T2	QL (341 EA per 31 days)
<i>dextroamphetamine-amphetamine oral capsule, er triphasic 24 hr</i>	T4	ST; QL (31 EA per 31 days)
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 30 mg</i>	T2	QL (62 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 12.5 mg, 15 mg, 5 mg, 7.5 mg</i>	T1	QL (62 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 20 mg</i>	T2	QL (93 EA per 31 days)
DHIVY	T4	ST
DIACOMIT ORAL CAPSULE 250 MG	T5	PA-NS; QL (341 EA per 31 days)
DIACOMIT ORAL CAPSULE 500 MG	T5	PA-NS; QL (186 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 250 MG	T5	PA-NS; QL (341 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 500 MG	T5	PA-NS; QL (186 EA per 31 days)
DIAZEPAM INTENSOL	T2	PA-NS; QL (248 ML per 31 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	T2	PA-NS; QL (1500 ML per 31 days)
<i>diazepam oral tablet</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>diazepam rectal</i>	T4	
<i>diclofenac epolamine</i>	T4	PA; QL (62 EA per 31 days)
<i>diclofenac potassium oral capsule</i>	T4	
<i>diclofenac potassium oral powder in packet</i>	T4	
<i>diclofenac potassium oral tablet 25 mg</i>	T5	
<i>diclofenac potassium oral tablet 50 mg</i>	T1	
<i>diclofenac sodium oral</i>	T1	
<i>diclofenac sodium topical drops</i>	T2	QL (450 ML per 28 days)
<i>diclofenac sodium topical solution in metered-dose pump</i>	T5	ST; QL (224 GM per 28 days)
<i>diclofenac-misoprostol</i>	T3	
<i>diflunisal</i>	T2	
<i>dihydroergotamine nasal</i>	T4	PA; QL (8 ML per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
DILANTIN	T4	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	
DILANTIN-125	T4	
DILAUDID ORAL LIQUID	T4	PA; QL (1550 ML per 31 days)
DILAUDID ORAL TABLET 2 MG	T4	PA; QL (186 EA per 31 days)
DILAUDID ORAL TABLET 4 MG, 8 MG	T5	PA; QL (186 EA per 31 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg (14)- 240 mg (46)</i>	T5	PA; QL (120 EA per 365 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 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>	T2	QL (31 EA per 31 days)
<i>donepezil oral tablet, disintegrating</i>	T2	
<i>doxepin oral capsule</i>	T2	PA-NS
<i>doxepin oral concentrate</i>	T2	PA-NS
<i>doxepin oral tablet</i>	T2	PA
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG	T4	PA-NS; QL (93 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 30 MG, 60 MG	T4	PA-NS; QL (62 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	T4	PA-NS; QL (31 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 60 mg</i>	T2	QL (62 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 30 mg</i>	T2	QL (31 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 40 mg</i>	T3	QL (31 EA per 31 days)
DUOPA	T5	PA-BvD
DYANAVEL XR ORAL SUSPEN, IR - ER, BIPHASIC 24HR	T4	ST; QL (248 ML per 31 days)
DYANAVEL XR ORAL TABLET, IR - ER, BIPHASIC 24HR	T4	ST; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
EDLUAR	T4	PA; QL (31 EA per 31 days)
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 37.5 MG	T4	QL (31 EA per 31 days)
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 75 MG	T4	QL (93 EA per 31 days)
<i>eletriptan oral tablet 20 mg</i>	T4	QL (12 EA per 28 days)
<i>eletriptan oral tablet 40 mg</i>	T4	QL (6 EA per 28 days)
ELYXYB	T4	PA
EMGALITY PEN	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	T5	PA; QL (3 ML per 28 days)
EMSAM	T5	QL (30 EA per 30 days)
ENDOCET	T2	PA; QL (372 EA per 31 days)
<i>entacapone</i>	T2	
EPIDIOLEX	T5	PA-NS
EPITOL	T1	
EPRONTIA	T4	PA-NS; QL (496 ML per 31 days)
EQUETRO	T4	
<i>ergoloid</i>	T4	PA
<i>ergotamine-caffeine</i>	T3	PA
<i>escitalopram oxalate oral solution</i>	T4	QL (620 ML per 31 days)
<i>escitalopram oxalate oral tablet 10 mg</i>	T2	QL (45 EA per 30 days)
<i>escitalopram oxalate oral tablet 20 mg, 5 mg</i>	T2	QL (30 EA per 30 days)
ESGIC ORAL TABLET	T4	QL (372 EA per 31 days)
<i>estazolam</i>	T2	PA
<i>eszopiclone</i>	T2	PA; QL (31 EA per 31 days)
<i>ethosuximide oral capsule</i>	T3	
<i>ethosuximide oral solution</i>	T2	
<i>etodolac</i>	T2	
EVEKEO	T4	PA
EVRYSDI	T5	PA; QL (240 ML per 31 days)
EXELON PATCH	T4	QL (30 EA per 30 days)
FANAPT ORAL TABLET 1 MG	T4	QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
FANAPT ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	T5	QL (62 EA per 31 days)
FANAPT ORAL TABLETS,DOSE PACK	T4	QL (16 EA per 365 days)
<i>felbamate oral suspension</i>	T5	
<i>felbamate oral tablet</i>	T2	
FELBATOL ORAL TABLET	T5	
<i>fenoprofen oral capsule 400 mg</i>	T4	
<i>fenoprofen oral tablet</i>	T2	
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg</i>	T5	PA; QL (40 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 1,600 mcg</i>	T5	PA; QL (30 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	T5	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 100 mcg, 200 mcg</i>	T5	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr</i>	T3	PA; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr</i>	T3	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 37.5 mcg/hour</i>	T4	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 62.5 mcg/hour</i>	T4	PA; QL (15 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 75 mcg/hr</i>	T3	PA; QL (12 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 87.5 mcg/hour</i>	T5	PA; QL (11 EA per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG	T5	PA; QL (124 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 400 MCG	T5	PA; QL (119 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 600 MCG	T5	PA; QL (79 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 800 MCG	T5	PA; QL (59 EA per 31 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	T4	PA-NS; QL (56 EA per 365 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG	T4	PA-NS; QL (31 EA per 31 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	T4	PA-NS; QL (93 EA per 31 days)
FEXMID	T4	QL (124 EA per 31 days)
<i>fingolimod</i>	T5	PA; QL (31 EA per 31 days)
FINTEPLA	T5	PA-NS; QL (360 ML per 30 days)
FIORICET	T4	QL (403 EA per 31 days)
FIORICET WITH CODEINE	T4	PA; QL (403 EA per 31 days)
FIRDAPSE	T5	PA; QL (248 EA per 31 days)
FLECTOR	T4	PA; QL (62 EA per 31 days)
FLEQSUVY	T4	PA; QL (496 ML per 31 days)
<i>fluoxetine (pmd)</i>	T1	
<i>fluoxetine oral capsule</i>	T1	
<i>fluoxetine oral capsule, delayed release(dr/ec)</i>	T2	
<i>fluoxetine oral solution</i>	T1	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	T1	
<i>fluoxetine oral tablet 60 mg</i>	T4	
<i>fluphenazine decanoate</i>	T2	
<i>fluphenazine hcl injection</i>	T2	
<i>fluphenazine hcl oral concentrate</i>	T2	
<i>fluphenazine hcl oral elixir</i>	T1	
<i>fluphenazine hcl oral tablet</i>	T1	
<i>flurazepam</i>	T2	PA
<i>flurbiprofen oral tablet 100 mg</i>	T2	
<i>fluvoxamine</i>	T2	
FOCALIN ORAL TABLET 10 MG	T4	ST; QL (62 EA per 31 days)
FOCALIN ORAL TABLET 2.5 MG, 5 MG	T4	ST; QL (93 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
FOCALIN XR	T4	ST; QL (31 EA per 31 days)
FORFIVO XL	T4	QL (31 EA per 31 days)
FROVA	T4	QL (12 EA per 28 days)
<i>frovatriptan</i>	T3	QL (12 EA per 28 days)
FYCOMPA ORAL SUSPENSION	T5	QL (744 ML per 31 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	T5	QL (31 EA per 31 days)
FYCOMPA ORAL TABLET 2 MG	T4	QL (31 EA per 31 days)
<i>gabapentin oral capsule 100 mg, 400 mg</i>	T2	PA-NS; QL (270 EA per 30 days)
<i>gabapentin oral capsule 300 mg</i>	T2	PA-NS; QL (360 EA per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	T2	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>gabapentin oral tablet extended release 24 hr 300 mg</i>	T4	PA; QL (155 EA per 31 days)
<i>gabapentin oral tablet extended release 24 hr 600 mg</i>	T4	PA; QL (93 EA per 31 days)
<i>galantamine</i>	T2	
GEODON INTRAMUSCULAR	T4	
GEODON ORAL	T5	QL (62 EA per 31 days)
GILENYA	T5	PA; QL (31 EA per 31 days)
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	T5	PA; QL (31 ML per 31 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	T5	PA; QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (31 ML per 31 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	T5	PA; QL (12 ML per 28 days)
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG	T5	PA; QL (62 EA per 31 days)
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 68.5 MG	T5	PA; QL (124 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T4	PA; QL (155 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG	T4	PA; QL (31 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T4	PA; QL (93 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 750 MG, 900 MG	T4	PA; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>guanfacine oral tablet extended release 24 hr</i>	T2	PA
HALCION ORAL TABLET 0.25 MG	T4	PA
HALDOL DECANOATE INTRAMUSCULAR SOLUTION 100 MG/ML	T4	
<i>haloperidol</i>	T1	
<i>haloperidol decanoate</i>	T2	
<i>haloperidol lactate injection</i>	T1	
<i>haloperidol lactate oral</i>	T2	
HETLIOZ	T5	PA; QL (31 EA per 31 days)
HETLIOZ LQ	T5	PA; QL (158 ML per 31 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG	T4	PA; QL (90 EA per 30 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG	T4	PA; QL (60 EA per 30 days)
<i>hydrocodone bitartrate oral capsule, oral only, er 12hr</i>	T4	PA; QL (100 EA per 31 days)
<i>hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr 100 mg, 120 mg</i>	T5	PA; QL (31 EA per 31 days)
<i>hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</i>	T4	PA; QL (31 EA per 31 days)
<i>hydrocodone-acetaminophen oral solution 7.5- 325 mg/15 ml</i>	T2	PA; QL (5723 ML per 31 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	T2	PA; QL (403 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>hydrocodone-ibuprofen</i>	T2	PA; QL (155 EA per 31 days)
<i>hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml</i>	T2	PA; QL (124 ML per 31 days)
<i>hydromorphone oral liquid</i>	T2	PA; QL (1550 ML per 31 days)
<i>hydromorphone oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<i>hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 8 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>hydromorphone oral tablet extended release 24 hr 32 mg</i>	T2	PA; QL (48 EA per 31 days)
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 120 MG, 80 MG	T5	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 20 MG, 30 MG, 40 MG, 60 MG	T4	PA; QL (31 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	
<i>ibuprofen oral suspension</i>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>ibuprofen-famotidine</i>	T4	PA; QL (93 EA per 31 days)
<i>imipramine hcl</i>	T2	PA-NS
<i>imipramine pamoate</i>	T2	PA-NS
IMITREX ORAL TABLET 100 MG	T4	QL (9 EA per 28 days)
IMITREX ORAL TABLET 25 MG	T4	QL (36 EA per 28 days)
IMITREX ORAL TABLET 50 MG	T4	QL (18 EA per 28 days)
IMITREX STATDOSE PEN SUBCUTANEOUS PEN INJECTOR 4 MG/0.5 ML	T4	QL (6 ML per 28 days)
IMITREX STATDOSE REFILL SUBCUTANEOUS CARTRIDGE 6 MG/0.5 ML	T5	QL (4 ML per 28 days)
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	T5	PA; QL (300 EA per 30 days)
INDOCIN ORAL	T4	
INDOCIN RECTAL	T5	
<i>indomethacin oral capsule</i>	T1	
<i>indomethacin oral capsule, extended release</i>	T1	
<i>indomethacin oral suspension</i>	T4	
<i>indomethacin rectal suppository 50 mg</i>	T5	
INGREZZA INITIATION PK(TARDIV)	T5	PA; QL (56 EA per 365 days)
INGREZZA ORAL CAPSULE 40 MG	T5	PA; QL (62 EA per 31 days)
INGREZZA ORAL CAPSULE 60 MG, 80 MG	T5	PA; QL (31 EA per 31 days)
INGREZZA SPRINKLE	T5	PA; QL (31 EA per 31 days)
INTUNIV ER	T4	PA
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	T5	QL (3.5 ML per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	T5	QL (5 ML per 180 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 3 MG, 9 MG	T4	QL (31 EA per 31 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG	T4	QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	T5	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	T5	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	T5	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T4	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	T5	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	T5	QL (0.88 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	T5	QL (1.32 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	T5	QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	T5	QL (2.63 ML per 84 days)
JORNAY PM	T4	ST; QL (31 EA per 31 days)
KEPPRA ORAL SOLUTION	T5	
KEPPRA ORAL TABLET 1,000 MG	T5	
KEPPRA ORAL TABLET 250 MG, 500 MG, 750 MG	T4	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR 500 MG	T5	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR 750 MG	T4	
KESIMPTA PEN	T5	PA; QL (0.4 ML per 28 days)
<i>ketoprofen oral capsule 25 mg, 50 mg</i>	T2	
<i>ketoprofen oral capsule, ext rel. pellets 24 hr 200 mg</i>	T2	
<i>ketorolac oral</i>	T2	
KEVEYIS	T5	PA; QL (124 EA per 31 days)
KIPROFEN	T2	
KLONOPIN ORAL TABLET 0.5 MG	T4	PA-NS; QL (93 EA per 31 days)
KLONOPIN ORAL TABLET 1 MG	T4	PA-NS; QL (124 EA per 31 days)
KLONOPIN ORAL TABLET 2 MG	T4	PA-NS; QL (310 EA per 31 days)
KLOXXADO	T3	
<i>lacosamide oral</i>	T4	

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

Drug Name	Drug Tier	Requirements/Limits
LAMICTAL ODT ORAL TABLET,DISINTEGRATING 100 MG	T5	
LAMICTAL ODT ORAL TABLET,DISINTEGRATING 200 MG, 25 MG, 50 MG	T4	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG	T5	
LAMICTAL ORAL TABLET 25 MG	T4	
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	T4	
LAMICTAL STARTER (BLUE) KIT	T4	
LAMICTAL STARTER (GREEN) KIT	T4	
LAMICTAL STARTER (ORANGE) KIT	T4	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR 100 MG, 250 MG, 300 MG, 50 MG	T4	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR 200 MG, 25 MG	T5	
LAMICTAL XR STARTER (BLUE)	T4	
LAMICTAL XR STARTER (GREEN)	T4	
LAMICTAL XR STARTER (ORANGE)	T4	
<i>lamotrigine oral tablet</i>	T2	
<i>lamotrigine oral tablet disintegrating, dose pk</i>	T4	
<i>lamotrigine oral tablet extended release 24hr</i>	T2	
<i>lamotrigine oral tablet, chewable dispersible</i>	T2	
<i>lamotrigine oral tablet,disintegrating</i>	T2	
<i>lamotrigine oral tablets,dose pack</i>	T4	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	T5	PA-NS; QL (31 EA per 31 days)
LATUDA ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
<i>levetiracetam oral solution 100 mg/ml</i>	T2	
<i>levetiracetam oral tablet</i>	T2	
<i>levetiracetam oral tablet extended release 24 hr</i>	T2	
<i>levorphanol tartrate</i>	T5	PA; QL (186 EA per 31 days)
LEXAPRO ORAL TABLET 10 MG	T4	QL (45 EA per 30 days)
LEXAPRO ORAL TABLET 20 MG, 5 MG	T4	QL (30 EA per 30 days)
LIBERVANT	T5	PA-NS; QL (10 EA per 30 days)
LICART	T4	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>lisdexamfetamine</i>	T4	ST; QL (31 EA per 31 days)
<i>lithium carbonate</i>	T1	
<i>lithium citrate</i>	T1	
LITHOBID	T4	
LODINE ORAL TABLET	T4	
LODOSYN	T4	
LOFENA	T5	
LORAZEPAM INTENSOL	T2	PA; QL (155 ML per 31 days)
<i>lorazepam oral tablet 0.5 mg</i>	T2	PA; QL (124 EA per 31 days)
<i>lorazepam oral tablet 1 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>lorazepam oral tablet 2 mg</i>	T2	PA; QL (155 EA per 31 days)
LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1 MG, 3 MG	T4	PA; QL (93 EA per 31 days)
LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1.5 MG, 2 MG	T4	PA; QL (155 EA per 31 days)
LORZONE	T4	PA
<i>loxapine succinate</i>	T2	
LUCEMYRA	T5	
LUMRYZ	T5	PA; QL (31 EA per 31 days)
LUNESTA	T4	PA; QL (31 EA per 31 days)
<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)
LYBALVI	T5	PA-NS; QL (31 EA per 31 days)
LYRICA CR	T4	PA; QL (31 EA per 31 days)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	T4	PA-NS; QL (93 EA per 31 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	T4	PA-NS; QL (62 EA per 31 days)
LYRICA ORAL SOLUTION	T4	PA-NS; QL (930 ML per 31 days)
LYVISPAH	T4	PA; QL (124 EA per 31 days)
MARPLAN	T3	
MAVENCLAD (10 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (4 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (5 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (6 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (7 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (8 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (9 TABLET PACK)	T5	PA; QL (40 EA per 365 days)

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

Drug Name	Drug Tier	Requirements/Limits
MAXALT ORAL TABLET 10 MG	T4	QL (12 EA per 28 days)
MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG	T4	QL (12 EA per 28 days)
MAYZENT ORAL TABLET 0.25 MG	T5	PA; QL (155 EA per 31 days)
MAYZENT ORAL TABLET 1 MG, 2 MG	T5	PA; QL (31 EA per 31 days)
MAYZENT STARTER(FOR 1MG MAINT)	T4	PA; QL (14 EA per 365 days)
MAYZENT STARTER(FOR 2MG MAINT)	T4	PA; QL (24 EA per 365 days)
<i>meclofenamate</i>	T2	
<i>mefenamic acid</i>	T4	
<i>meloxicam oral tablet</i>	T1	
<i>meloxicam submicronized</i>	T4	PA; QL (31 EA per 31 days)
<i>memantine oral capsule,sprinkle,er 24hr</i>	T3	
<i>memantine oral solution</i>	T3	
<i>memantine oral tablet</i>	T2	
<i>memantine oral tablets,dose pack</i>	T4	
<i>meperidine (pf) injection solution 100 mg/ml</i>	T2	PA; QL (200 ML per 31 days)
<i>meperidine (pf) injection solution 25 mg/ml</i>	T2	PA; QL (800 ML per 31 days)
<i>meperidine (pf) injection solution 50 mg/ml</i>	T2	PA; QL (400 ML per 31 days)
<i>meperidine oral solution</i>	T2	PA; QL (6200 ML per 31 days)
<i>meperidine oral tablet 50 mg</i>	T2	PA; QL (1240 EA per 31 days)
<i>meprobamate oral tablet 200 mg</i>	T2	QL (341 EA per 31 days)
<i>meprobamate oral tablet 400 mg</i>	T2	QL (186 EA per 31 days)
MESTINON ORAL	T5	
MESTINON TIMESPAN	T5	
METADATE CD	T4	ST; QL (31 EA per 31 days)
<i>metaxalone oral tablet 400 mg</i>	T2	PA
<i>metaxalone oral tablet 800 mg</i>	T3	PA
<i>methadone oral solution 10 mg/5 ml</i>	T2	PA; QL (1033 ML per 31 days)
<i>methadone oral solution 5 mg/5 ml</i>	T2	PA; QL (2066 ML per 31 days)
<i>methadone oral tablet 10 mg</i>	T2	PA; QL (206 EA per 31 days)
<i>methadone oral tablet 5 mg</i>	T2	PA; QL (248 EA per 31 days)
<i>methamphetamine</i>	T5	PA
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	T2	
<i>methsuximide</i>	T4	
METHYLIN ORAL SOLUTION	T4	ST
<i>methylphenidate</i>	T4	PA; QL (30 EA per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>methylphenidate hcl oral cap,er sprinkle,biphasic 40-60</i>	T4	QL (31 EA per 31 days)
<i>methylphenidate hcl oral capsule, er biphasic 30-70</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 10 mg</i>	T2	QL (186 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 20 mg</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 40 mg</i>	T2	QL (62 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 60 mg</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral solution</i>	T2	
<i>methylphenidate hcl oral tablet</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 10 mg</i>	T2	QL (186 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 20 mg</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 18 mg (bx rating), 27 mg, 27 mg (bx rating), 36 mg, 36 mg (bx rating), 54 mg, 54 mg (bx rating)</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 24hr 45 mg, 63 mg, 72 mg</i>	T4	ST; QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet,chewable 10 mg</i>	T2	QL (186 EA per 31 days)
<i>methylphenidate hcl oral tablet,chewable 2.5 mg, 5 mg</i>	T2	QL (93 EA per 31 days)
MIGERGOT	T5	
MIGRANAL	T5	PA; QL (8 ML per 31 days)
<i>mirtazapine</i>	T2	
<i>modafinil</i>	T2	PA; QL (31 EA per 31 days)
<i>molindone</i>	T4	
<i>morphine concentrate oral solution</i>	T2	PA; QL (310 ML per 31 days)
<i>morphine oral capsule, er multiphase 24 hr 120 mg</i>	T2	PA; QL (51 EA per 31 days)
<i>morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>morphine oral capsule,extend.release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>morphine oral solution 10 mg/5 ml</i>	T2	PA; QL (2800 ML per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>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>	T2	PA; QL (62 EA per 31 days)
<i>morphine oral tablet extended release 15 mg, 30 mg, 60 mg</i>	T2	PA; QL (100 EA per 31 days)
<i>morphine oral tablet extended release 200 mg</i>	T2	PA; QL (31 EA per 31 days)
MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG	T4	PA-NS; QL (31 EA per 31 days)
MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 200 MG	T5	PA-NS; QL (62 EA per 31 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG	T5	PA; QL (62 EA per 31 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG, 60 MG	T4	PA; QL (100 EA per 31 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 200 MG	T5	PA; QL (31 EA per 31 days)
MYDAYIS	T4	ST; QL (31 EA per 31 days)
MYSOLINE	T5	
<i>nabumetone</i>	T1	
NALFON ORAL CAPSULE 400 MG	T4	
NALFON ORAL TABLET	T4	
NALOCET	T4	PA; QL (403 EA per 31 days)
<i>naloxone injection solution</i>	T2	
<i>naloxone injection syringe</i>	T2	
<i>naloxone nasal</i>	T3	
<i>naltrexone</i>	T2	
NAMENDA TITRATION PAK	T4	PA
NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR 14 MG, 21 MG, 28 MG	T4	PA
NAMZARIC	T4	PA
NAPRELAN CR	T4	
NAPROSYN ORAL SUSPENSION	T4	
<i>naproxen oral suspension</i>	T1	
<i>naproxen oral tablet</i>	T1	
<i>naproxen oral tablet,delayed release (dr/ec)</i>	T2	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T1	

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

Drug Name	Drug Tier	Requirements/Limits
<i>naproxen sodium oral tablet, er multiphase 24 hr 375 mg, 750 mg</i>	T4	
<i>naproxen sodium oral tablet, er multiphase 24 hr 500 mg</i>	T5	
<i>naproxen-esomeprazole</i>	T5	PA; QL (62 EA per 31 days)
<i>naratriptan oral tablet 1 mg</i>	T2	QL (20 EA per 28 days)
<i>naratriptan oral tablet 2.5 mg</i>	T2	QL (9 EA per 28 days)
NARDIL	T4	
NAYZILAM	T4	PA-NS; QL (10 EA per 30 days)
<i>nefazodone</i>	T2	
NEUPRO	T4	
NEURONTIN ORAL CAPSULE 100 MG, 400 MG	T4	PA-NS; QL (270 EA per 30 days)
NEURONTIN ORAL CAPSULE 300 MG	T4	PA-NS; QL (360 EA per 30 days)
NEURONTIN ORAL SOLUTION	T4	PA-NS; QL (2160 ML per 30 days)
NEURONTIN ORAL TABLET 600 MG	T5	PA-NS; QL (180 EA per 30 days)
NEURONTIN ORAL TABLET 800 MG	T4	PA-NS; QL (120 EA per 30 days)
NORGESIC	T4	PA; QL (248 EA per 31 days)
NORGESIC FORTE	T4	PA; QL (124 EA per 31 days)
NORPRAMIN ORAL TABLET 10 MG, 25 MG	T4	
<i>nortriptyline</i>	T2	
NOURIANZ	T5	PA; QL (31 EA per 31 days)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 150 MG, 200 MG, 250 MG	T5	PA; QL (62 EA per 31 days)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 50 MG	T4	PA; QL (62 EA per 31 days)
NUCYNTA ORAL TABLET 100 MG	T5	PA; QL (186 EA per 31 days)
NUCYNTA ORAL TABLET 50 MG, 75 MG	T4	PA; QL (186 EA per 31 days)
NUDEXTA	T3	PA; QL (62 EA per 31 days)
NUPLAZID	T5	PA-NS; QL (31 EA per 31 days)
NURTEC ODT	T5	PA; QL (18 EA per 28 days)
NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG	T5	PA; QL (31 EA per 31 days)
NUVIGIL ORAL TABLET 50 MG	T4	PA; QL (31 EA per 31 days)
<i>olanzapine intramuscular</i>	T2	
<i>olanzapine oral</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.

Drug Name	Drug Tier	Requirements/Limits
<i>olanzapine-fluoxetine</i>	T2	
ONFI ORAL SUSPENSION	T5	PA-NS; QL (496 ML per 31 days)
ONFI ORAL TABLET	T5	PA-NS; QL (62 EA per 31 days)
ONGENTYS	T4	PA; QL (31 EA per 31 days)
ONZETRA XSAIL	T4	QL (16 EA per 28 days)
OPVEE	T4	
ORMALVI	T5	PA; QL (124 EA per 31 days)
<i>orphenadrine citrate oral</i>	T2	PA
<i>orphenadrine-asa-caffeine oral tablet 25-385-30 mg</i>	T4	PA; QL (248 EA per 31 days)
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG	T4	PA; QL (31 EA per 31 days)
<i>oxaprozin oral tablet</i>	T2	
<i>oxazepam</i>	T2	PA
<i>oxcarbazepine oral suspension</i>	T2	
<i>oxcarbazepine oral tablet</i>	T2	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG	T4	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T5	
<i>oxycodone oral capsule</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral concentrate</i>	T2	PA; QL (180 ML per 31 days)
<i>oxycodone oral solution</i>	T2	PA; QL (4133 ML per 31 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral tablet 30 mg</i>	T3	PA; QL (138 EA per 31 days)
<i>oxycodone oral tablet,oral only,ext.rel.12 hr 10 mg, 20 mg</i>	T4	PA; QL (100 EA per 31 days)
<i>oxycodone-acetaminophen oral solution 5-325 mg/5 ml</i>	T4	PA; QL (1907 ML per 31 days)
<i>oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	T5	PA; QL (403 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg</i>	T3	PA; QL (372 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG	T4	PA; QL (100 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG	T5	PA; QL (69 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	T5	PA; QL (62 EA per 31 days)
<i>oxymorphone oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<i>oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg</i>	T2	PA; QL (100 EA per 31 days)
<i>oxymorphone oral tablet extended release 12 hr 30 mg</i>	T2	PA; QL (69 EA per 31 days)
<i>oxymorphone oral tablet extended release 12 hr 40 mg</i>	T4	PA; QL (51 EA per 31 days)
OZOBAX DS	T4	PA; QL (1240 ML 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)
PAMELOR ORAL CAPSULE 10 MG, 50 MG, 75 MG	T4	
PAMELOR ORAL CAPSULE 25 MG	T5	
PARLODEL	T4	
PARNATE	T4	
<i>paroxetine hcl oral suspension</i>	T4	
<i>paroxetine hcl oral tablet</i>	T1	
<i>paroxetine hcl oral tablet extended release 24 hr</i>	T2	
<i>paroxetine mesylate(menop.sym)</i>	T4	
PAXIL	T4	
PAXIL CR	T4	
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP	T5	ST; QL (224 GM per 28 days)
<i>pentazocine-naloxone</i>	T2	QL (335 EA per 31 days)
PERCOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	T5	PA; QL (372 EA per 31 days)
PERCOCET ORAL TABLET 2.5-325 MG	T4	PA; QL (372 EA per 31 days)
<i>perphenazine</i>	T2	
<i>perphenazine-amitriptyline</i>	T2	PA-NS
PERSERIS	T5	QL (1 EA per 28 days)
<i>phenelzine</i>	T2	
<i>phenobarbital</i>	T2	PA-NS
PHENYTEK	T4	
<i>phenytoin oral suspension 125 mg/5 ml</i>	T2	
<i>phenytoin oral tablet,chewable</i>	T2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>phenytoin sodium extended</i>	T2	
<i>pimozide</i>	T2	
<i>piroxicam</i>	T2	
PONVORY	T5	PA; QL (31 EA per 31 days)
PONVORY 14-DAY STARTER PACK	T5	PA; QL (28 EA per 365 days)
<i>pramipexole</i>	T2	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	T2	PA-NS; QL (62 EA per 31 days)
<i>pregabalin oral solution</i>	T2	PA-NS; QL (930 ML per 31 days)
<i>pregabalin oral tablet extended release 24 hr</i>	T4	PA; QL (31 EA per 31 days)
<i>primidone oral tablet 125 mg</i>	T4	
<i>primidone oral tablet 250 mg, 50 mg</i>	T2	
PRISTIQ	T4	QL (31 EA per 31 days)
PROCENTRA	T3	
PROLATE ORAL SOLUTION	T4	PA; QL (5167 ML per 31 days)
PROLATE ORAL TABLET	T4	PA; QL (403 EA per 31 days)
<i>protriptyline</i>	T2	
PROVIGIL	T5	PA; QL (31 EA per 31 days)
PROZAC ORAL CAPSULE 10 MG, 20 MG	T4	
PROZAC ORAL CAPSULE 40 MG	T5	
<i>pyridostigmine bromide oral syrup</i>	T2	
<i>pyridostigmine bromide oral tablet 30 mg</i>	T3	
<i>pyridostigmine bromide oral tablet 60 mg</i>	T2	
<i>pyridostigmine bromide oral tablet extended release</i>	T2	
QDOLO	T5	PA; QL (2400 ML per 30 days)
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG	T4	PA; QL (93 EA per 31 days)
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG	T4	PA; QL (62 EA per 31 days)
QUDEXY XR ORAL CAPSULE,SPRINKLE,ER 24HR 100 MG, 150 MG, 25 MG, 50 MG	T4	
QUDEXY XR ORAL CAPSULE,SPRINKLE,ER 24HR 200 MG	T5	
<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)

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

Drug Name	Drug Tier	Requirements/Limits
<i>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)
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 20 MG, 40 MG	T4	ST; QL (31 EA per 31 days)
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 30 MG	T4	ST; QL (62 EA per 31 days)
QUILLIVANT XR	T4	ST; QL (360 ML per 30 days)
QULIPTA	T5	PA; QL (31 EA per 31 days)
QUVIVIQ	T4	ST; QL (31 EA per 31 days)
RADICAVA ORS STARTER KIT SUSP	T5	PA; QL (70 ML per 28 days)
<i>ramelteon</i>	T4	QL (31 EA per 31 days)
<i>rasagiline</i>	T3	
RELAFEN DS	T5	
RELEXXII ORAL TABLET EXTENDED RELEASE 24HR 18 MG, 27 MG, 36 MG, 45 MG, 63 MG	T4	ST; QL (31 EA per 31 days)
RELPAK ORAL TABLET 20 MG	T4	QL (12 EA per 28 days)
RELPAK ORAL TABLET 40 MG	T4	QL (6 EA per 28 days)
REMERON ORAL TABLET 15 MG, 30 MG	T4	
REMERON SOLTAB	T4	
RESTORIL	T4	PA; QL (31 EA per 31 days)
REXULTI ORAL TABLET	T5	PA-NS; QL (31 EA per 31 days)
REYVOW ORAL TABLET 100 MG	T4	QL (8 EA per 28 days)
REYVOW ORAL TABLET 50 MG	T4	QL (4 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML	T4	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 50 MG/2 ML	T5	QL (2 EA per 28 days)
RISPERDAL ORAL SOLUTION	T4	QL (496 ML per 31 days)
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG	T4	QL (31 EA per 31 days)
RISPERDAL ORAL TABLET 3 MG	T4	QL (93 EA per 31 days)
RISPERDAL ORAL TABLET 4 MG	T4	QL (124 EA per 31 days)
<i>risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml, 25 mg/2 ml, 37.5 mg/2 ml</i>	T4	QL (2 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>risperidone microspheres intramuscular suspension,extended rel recon 50 mg/2 ml</i>	T5	QL (2 EA per 28 days)
<i>risperidone oral solution</i>	T1	QL (496 ML per 31 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T1	QL (31 EA per 31 days)
<i>risperidone oral tablet 3 mg</i>	T1	QL (93 EA per 31 days)
<i>risperidone oral tablet 4 mg</i>	T1	QL (124 EA per 31 days)
<i>risperidone oral tablet,disintegrating 0.25 mg</i>	T2	QL (31 EA per 31 days)
<i>risperidone oral tablet,disintegrating 0.5 mg, 1 mg, 2 mg</i>	T1	QL (31 EA per 31 days)
<i>risperidone oral tablet,disintegrating 3 mg</i>	T1	QL (93 EA per 31 days)
<i>risperidone oral tablet,disintegrating 4 mg</i>	T1	QL (124 EA per 31 days)
RITALIN	T4	ST; QL (93 EA per 31 days)
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG	T4	ST; QL (186 EA per 31 days)
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 20 MG, 40 MG	T4	ST; QL (31 EA per 31 days)
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 30 MG	T4	ST; QL (62 EA per 31 days)
<i>rivastigmine</i>	T2	QL (30 EA per 30 days)
<i>rivastigmine tartrate</i>	T2	
<i>rizatriptan oral tablet 10 mg</i>	T2	QL (12 EA per 28 days)
<i>rizatriptan oral tablet 5 mg</i>	T2	QL (24 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 10 mg</i>	T2	QL (12 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 5 mg</i>	T2	QL (24 EA per 28 days)
<i>ropinirole</i>	T2	
ROWEEPRA ORAL TABLET 500 MG	T2	
ROXICODONE ORAL TABLET 15 MG	T4	PA; QL (186 EA per 31 days)
ROXICODONE ORAL TABLET 30 MG	T5	PA; QL (138 EA per 31 days)
ROXYBOND	T5	PA; QL (186 EA per 31 days)
ROZEREM	T4	QL (31 EA per 31 days)
<i>rufinamide oral suspension</i>	T5	PA-NS
<i>rufinamide oral tablet 200 mg</i>	T4	PA-NS
<i>rufinamide oral tablet 400 mg</i>	T5	PA-NS
RYTARY	T3	ST
SABRIL	T5	PA-NS
SAPHRIS	T4	PA-NS; QL (62 EA per 31 days)
SECUADO	T5	PA-NS; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
SEGLENTIS	T4	PA; QL (124 EA per 31 days)
<i>selegiline hcl</i>	T2	
SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	T4	QL (62 EA per 31 days)
SEROQUEL ORAL TABLET 400 MG	T5	QL (62 EA per 31 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG, 50 MG	T4	QL (62 EA per 31 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 400 MG	T5	QL (62 EA per 31 days)
<i>sertraline oral capsule</i>	T4	PA-NS; QL (31 EA per 31 days)
<i>sertraline oral concentrate</i>	T1	
<i>sertraline oral tablet</i>	T1	
SILENOR	T4	PA
SINEMET ORAL TABLET 10-100 MG, 25-100 MG	T4	
SKYCLARYS	T5	PA; QL (93 EA per 31 days)
<i>sodium oxybate</i>	T5	PA; QL (540 ML per 30 days)
SOMA	T4	PA
SPRITAM	T4	
SPRIX	T5	QL (5 EA per 31 days)
STALEVO 100	T4	
STALEVO 125	T4	
STALEVO 150	T4	
STALEVO 200	T4	
STALEVO 50	T4	
STALEVO 75	T4	
STRATTERA ORAL CAPSULE 10 MG, 25 MG, 40 MG	T4	ST; QL (62 EA per 31 days)
STRATTERA ORAL CAPSULE 100 MG, 60 MG, 80 MG	T4	ST; QL (31 EA per 31 days)
STRATTERA ORAL CAPSULE 18 MG	T4	ST; QL (124 EA per 31 days)
SUBOXONE SUBLINGUAL FILM 12-3 MG, 4-1 MG, 8-2 MG	T4	ST; QL (62 EA per 31 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG	T4	ST; QL (93 EA per 31 days)
SUBVENITE	T2	
SUBVENITE STARTER (BLUE) KIT	T4	
SUBVENITE STARTER (GREEN) KIT	T4	

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

Drug Name	Drug Tier	Requirements/Limits
SUBVENITE STARTER (ORANGE) KIT	T4	
<i>sulindac</i>	T2	
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation</i>	T2	QL (8 EA per 28 days)
<i>sumatriptan nasal spray,non-aerosol 5 mg/actuation</i>	T2	QL (32 EA per 28 days)
<i>sumatriptan succinate oral tablet 100 mg</i>	T2	QL (9 EA per 28 days)
<i>sumatriptan succinate oral tablet 25 mg</i>	T2	QL (36 EA per 28 days)
<i>sumatriptan succinate oral tablet 50 mg</i>	T2	QL (18 EA per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	T4	QL (6 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous solution</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan-naproxen</i>	T4	QL (9 EA per 28 days)
SUNOSI	T4	PA; QL (31 EA per 31 days)
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG	T4	
SYMPAZAN ORAL FILM 10 MG, 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SYMPAZAN ORAL FILM 5 MG	T4	PA-NS; QL (62 EA per 31 days)
TASCENSO ODT	T5	PA; QL (31 EA per 31 days)
<i>tasimelteon</i>	T5	PA; QL (31 EA per 31 days)
TASMAR ORAL TABLET 100 MG	T5	
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG (14)- 240 MG (46)	T5	PA; QL (120 EA per 365 days)
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 240 MG	T5	PA; QL (62 EA per 31 days)
TEGRETOL ORAL SUSPENSION	T4	
TEGRETOL ORAL TABLET	T4	
TEGRETOL XR	T4	
TEGSEDI	T5	PA; QL (6 ML per 28 days)
<i>temazepam</i>	T2	PA; QL (31 EA per 31 days)
TENCON	T2	QL (372 EA per 31 days)
<i>teriflunomide</i>	T5	PA; QL (31 EA per 31 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>tetrabenazine oral tablet 25 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>thioridazine</i>	T2	

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Drug Name	Drug Tier	Requirements/Limits
<i>thiothixene</i>	T1	
<i>tiagabine</i>	T2	
<i>tizanidine</i>	T2	
<i>tolcapone</i>	T5	
TOLECTIN 600	T5	
<i>tolmetin oral capsule</i>	T2	
TOPAMAX ORAL CAPSULE, SPRINKLE	T4	
TOPAMAX ORAL TABLET 100 MG, 200 MG	T5	
TOPAMAX ORAL TABLET 25 MG, 50 MG	T4	
<i>topiramate oral capsule, sprinkle</i>	T2	
<i>topiramate oral capsule, extended release 24hr</i>	T4	
<i>topiramate oral capsule, sprinkle, er 24hr 100 mg, 150 mg, 25 mg, 50 mg</i>	T4	
<i>topiramate oral capsule, sprinkle, er 24hr 200 mg</i>	T5	
<i>topiramate oral tablet</i>	T2	
TOSYMRA	T5	QL (12 EA per 28 days)
<i>tramadol oral capsule, er biphasic 24 hr 17-83</i>	T4	PA; QL (30 EA per 30 days)
<i>tramadol oral capsule, er biphasic 24 hr 25-75 100 mg, 200 mg</i>	T4	PA; QL (30 EA per 30 days)
<i>tramadol oral solution</i>	T5	PA; QL (2400 ML per 30 days)
<i>tramadol oral tablet 100 mg</i>	T4	PA; QL (124 EA per 31 days)
<i>tramadol oral tablet 25 mg</i>	T4	PA; QL (496 EA per 31 days)
<i>tramadol oral tablet 50 mg</i>	T1	PA; QL (240 EA per 30 days)
<i>tramadol oral tablet extended release 24 hr</i>	T2	PA; QL (30 EA per 30 days)
<i>tramadol oral tablet, er multiphasic 24 hr</i>	T2	PA; QL (30 EA per 30 days)
<i>tramadol-acetaminophen</i>	T2	PA; QL (372 EA per 31 days)
<i>tranlycypromine</i>	T2	
<i>trazodone oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>trazodone oral tablet 300 mg</i>	T2	
TREXIMET	T5	QL (9 EA per 28 days)
TREZIX	T4	PA; QL (372 EA per 31 days)
<i>triazolam</i>	T2	PA
<i>trifluoperazine</i>	T2	
<i>trihexyphenidyl</i>	T2	
TRILEPTAL	T4	
<i>trimipramine</i>	T3	PA-NS

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

Drug Name	Drug Tier	Requirements/Limits
TRINTELLIX	T3	
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 25 MG, 50 MG	T4	
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 200 MG	T5	
TRUDHESA	T5	PA; QL (12 ML per 28 days)
UBRELVY ORAL TABLET 100 MG	T5	PA; QL (17 EA per 28 days)
UBRELVY ORAL TABLET 50 MG	T5	PA; QL (34 EA per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 100 MG/0.28 ML	T5	QL (0.28 ML per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 125 MG/0.35 ML	T5	QL (0.35 ML per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 150 MG/0.42 ML	T5	QL (0.42 ML per 60 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 200 MG/0.56 ML	T5	QL (0.56 ML per 60 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 250 MG/0.7 ML	T5	QL (0.7 ML per 60 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 50 MG/0.14 ML	T5	QL (0.14 ML per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 75 MG/0.21 ML	T5	QL (0.21 ML per 30 days)
VALIUM	T4	PA-NS; QL (124 EA per 31 days)
<i>valproic acid</i>	T2	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	T2	
VALTOCO NASAL SPRAY,NON-AEROSOL 10 MG/SPRAY (0.1 ML), 5 MG/SPRAY (0.1 ML)	T4	PA-NS; QL (10 EA per 30 days)
VALTOCO NASAL SPRAY,NON-AEROSOL 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2)	T5	PA-NS; QL (10 EA per 30 days)
<i>venlafaxine besylate</i>	T4	PA-NS; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg</i>	T2	QL (31 EA per 31 days)
<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	T2	QL (93 EA per 31 days)
<i>venlafaxine oral tablet</i>	T2	
<i>venlafaxine oral tablet extended release 24hr 150 mg, 37.5 mg, 75 mg</i>	T2	QL (31 EA per 31 days)
<i>venlafaxine oral tablet extended release 24hr 225 mg</i>	T4	QL (31 EA per 31 days)
VERSACLOZ	T5	QL (558 ML per 31 days)
<i>vigabatrin</i>	T5	PA-NS
VIGADRONE	T5	PA-NS
VIGPODER	T5	PA-NS
VIIBRYD ORAL TABLET	T4	QL (31 EA per 31 days)
<i>vilazodone</i>	T3	QL (31 EA per 31 days)
VIMOVO	T5	PA; QL (62 EA per 31 days)
VIMPAT ORAL SOLUTION	T5	
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG	T5	
VIMPAT ORAL TABLET 50 MG	T4	
VIVITROL	T5	
VRAYLAR ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
VUMERITY	T5	PA; QL (124 EA per 31 days)
VYVANSE	T4	ST; QL (31 EA per 31 days)
WAINUA	T5	PA; QL (0.8 ML per 30 days)
WAKIX	T5	PA; QL (62 EA per 31 days)
WELLBUTRIN SR	T4	QL (62 EA per 31 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG	T5	QL (93 EA per 31 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T5	QL (31 EA per 31 days)
XANAX ORAL TABLET 0.25 MG, 0.5 MG	T4	PA; QL (93 EA per 31 days)
XANAX ORAL TABLET 1 MG, 2 MG	T4	PA; QL (155 EA per 31 days)
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 0.5 MG, 1 MG	T4	PA; QL (31 EA per 31 days)
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 2 MG	T4	PA; QL (155 EA per 31 days)
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 3 MG	T4	PA; QL (93 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
XCOPRI	T5	PA-NS
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1)	T4	PA-NS
XCOPRI MAINTENANCE PACK ORAL TABLET 350 MG/DAY (200 MG X1-150MG X1)	T5	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	T4	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	T5	PA-NS
XELSTRYM	T4	ST; QL (30 EA per 30 days)
XENAZINE ORAL TABLET 12.5 MG	T5	PA; QL (93 EA per 31 days)
XENAZINE ORAL TABLET 25 MG	T5	PA; QL (124 EA per 31 days)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 13.5 MG, 18 MG, 27 MG, 9 MG	T4	PA; QL (62 EA per 31 days)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 36 MG	T5	PA; QL (62 EA per 31 days)
XYREM	T5	PA; QL (540 ML per 30 days)
XYWAV	T5	PA; QL (540 ML per 30 days)
<i>zaleplon oral capsule 10 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>zaleplon oral capsule 5 mg</i>	T2	PA; QL (93 EA per 31 days)
ZANAFLEX	T4	
ZARONTIN	T4	
ZAVZPRET	T5	PA; QL (8 EA per 30 days)
ZELAPAR	T5	
ZEMBRACE SYMTOUCH	T5	QL (8 ML per 28 days)
ZENZEDI	T4	QL (62 EA per 31 days)
ZEPOSIA	T5	PA; QL (31 EA per 31 days)
ZEPOSIA STARTER KIT (28-DAY)	T5	PA; QL (56 EA per 365 days)
ZEPOSIA STARTER PACK (7-DAY)	T5	PA; QL (14 EA per 365 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML	T5	PA; QL (11.648 ML per 28 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 23 MG/0.574 ML	T5	PA; QL (16 ML per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
ZILBRYSQ SUBCUTANEOUS SYRINGE 32.4 MG/0.81 ML	T5	PA; QL (22.68 ML per 28 days)
ZIMHI	T4	
<i>ziprasidone hcl</i>	T2	QL (62 EA per 31 days)
<i>ziprasidone mesylate</i>	T2	
ZIPSOR	T4	
<i>zolmitriptan nasal spray,non-aerosol 5 mg</i>	T4	QL (8 EA per 28 days)
<i>zolmitriptan oral tablet 2.5 mg</i>	T2	QL (16 EA per 28 days)
<i>zolmitriptan oral tablet 5 mg</i>	T2	QL (8 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 2.5 mg</i>	T2	QL (16 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 5 mg</i>	T2	QL (8 EA per 28 days)
ZOLOFT	T4	
<i>zolpidem oral capsule</i>	T4	PA; QL (31 EA per 31 days)
<i>zolpidem oral tablet</i>	T2	PA; QL (31 EA per 31 days)
<i>zolpidem oral tablet,ext release multiphase</i>	T2	PA; QL (31 EA per 31 days)
<i>zolpidem sublingual</i>	T3	PA; QL (31 EA per 31 days)
ZOMIG NASAL SPRAY,NON-AEROSOL 5 MG	T4	QL (8 EA per 28 days)
ZOMIG ORAL TABLET 2.5 MG	T4	QL (16 EA per 28 days)
ZOMIG ORAL TABLET 5 MG	T4	QL (8 EA per 28 days)
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG	T5	
ZONISADE	T5	PA-NS; QL (930 ML per 31 days)
<i>zonisamide</i>	T2	
ZTALMY	T5	PA-NS; QL (1100 ML per 30 days)
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 2.9-0.71 MG, 8.6-2.1 MG	T3	QL (62 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG	T3	QL (93 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 5.7-1.4 MG	T3	QL (31 EA per 31 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	T5	PA-NS; QL (28 EA per 180 days)
ZURZUVAE ORAL CAPSULE 30 MG	T5	PA-NS; QL (14 EA per 180 days)
ZYPREXA INTRAMUSCULAR	T4	
ZYPREXA ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	T4	QL (31 EA per 31 days)
ZYPREXA ORAL TABLET 15 MG, 20 MG	T5	QL (31 EA per 31 days)

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Drug Name	Drug Tier	Requirements/Limits
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	T5	QL (2 EA per 28 days)
ZYPREXA ZYDIS ORAL TABLET,DISINTEGRATING 10 MG, 5 MG	T4	QL (31 EA per 31 days)
ZYPREXA ZYDIS ORAL TABLET,DISINTEGRATING 15 MG, 20 MG	T5	QL (31 EA per 31 days)
Cardiovascular, Hypertension / Lipids		
<i>acebutolol</i>	T1	
ALDACTONE	T4	
<i>aliskiren</i>	T4	
ALTACE ORAL CAPSULE 1.25 MG	T4	QL (62 EA per 31 days)
ALTACE ORAL CAPSULE 10 MG	T4	QL (93 EA per 31 days)
ALTACE ORAL CAPSULE 2.5 MG, 5 MG	T4	
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR 20 MG, 60 MG	T5	
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR 40 MG	T4	
ALVAIZ ORAL TABLET 18 MG, 9 MG	T5	PA; QL (31 EA per 31 days)
ALVAIZ ORAL TABLET 36 MG, 54 MG	T5	PA; QL (62 EA per 31 days)
<i>amiloride</i>	T1	
<i>amiloride-hydrochlorothiazide</i>	T1	
<i>amiodarone oral</i>	T2	
<i>amlodipine</i>	T1	
<i>amlodipine-atorvastatin</i>	T2	
<i>amlodipine-benazepril</i>	T1	
<i>amlodipine-olmesartan</i>	T3	QL (31 EA per 31 days)
<i>amlodipine-valsartan</i>	T2	
<i>amlodipine-valsartan-hcthiazid</i>	T4	
ARIXTRA SUBCUTANEOUS SYRINGE 10 MG/0.8 ML, 5 MG/0.4 ML, 7.5 MG/0.6 ML	T5	
ARIXTRA SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	T4	
<i>aspirin-dipyridamole</i>	T2	
ASPRUZYO SPRINKLE	T4	PA; QL (60 EA per 30 days)
ATACAND	T4	
ATACAND HCT	T4	
<i>atenolol</i>	T1	

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

Drug Name	Drug Tier	Requirements/Limits
<i>atenolol-chlorthalidone</i>	T1	
ATORVALIQ	T4	PA; QL (600 ML per 30 days)
<i>atorvastatin</i>	T1	
AVALIDE	T4	QL (31 EA per 31 days)
AVAPRO	T4	QL (31 EA per 31 days)
AZOR	T4	QL (31 EA per 31 days)
<i>benazepril</i>	T1	
<i>benazepril-hydrochlorothiazide</i>	T1	
BENICAR HCT	T4	QL (31 EA per 31 days)
BENICAR ORAL TABLET 20 MG, 40 MG	T4	QL (31 EA per 31 days)
BENICAR ORAL TABLET 5 MG	T4	QL (93 EA per 31 days)
BETAPACE AF	T4	
<i>betaxolol oral</i>	T1	
BIDIL	T4	
<i>bisoprolol fumarate</i>	T1	
<i>bisoprolol-hydrochlorothiazide</i>	T1	
BRILINTA	T3	
<i>bumetanide</i>	T1	
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG	T4	QL (93 EA per 31 days)
BYSTOLIC ORAL TABLET 20 MG	T4	QL (62 EA per 31 days)
BYSTOLIC ORAL TABLET 5 MG	T4	QL (217 EA per 31 days)
CABLIVI INJECTION KIT	T5	PA; QL (31 EA per 31 days)
CADUET	T4	
CAMZYOS	T5	PA; QL (31 EA per 31 days)
<i>candesartan</i>	T1	
<i>candesartan-hydrochlorothiazid</i>	T1	
<i>captopril</i>	T1	
CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 180 MG, 240 MG, 300 MG	T4	
CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 360 MG	T5	
CARDIZEM LA	T4	
CARDIZEM ORAL TABLET 120 MG, 30 MG	T4	
CARDIZEM ORAL TABLET 60 MG	T5	
CARDURA	T4	

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

Drug Name	Drug Tier	Requirements/Limits
CARDURA XL	T4	
CAROSPIR	T4	
CARTIA XT	T1	
<i>carvedilol</i>	T1	
<i>carvedilol phosphate</i>	T4	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>cholestyramine (with sugar) oral powder in packet</i>	T2	
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET	T2	
<i>cilostazol</i>	T2	
<i>clonidine</i>	T2	
<i>clonidine hcl oral tablet</i>	T1	
<i>clonidine hcl oral tablet extended release 24 hr</i>	T4	ST
<i>clopidogrel oral tablet 75 mg</i>	T1	
<i>colesevelam</i>	T3	
COLESTID ORAL TABLET	T4	
<i>colestipol oral packet</i>	T2	
<i>colestipol oral tablet</i>	T2	
COREG	T4	
COREG CR	T4	
CORGARD ORAL TABLET 40 MG	T4	
CORLANOR ORAL SOLUTION	T4	PA; QL (420 ML per 28 days)
CORLANOR ORAL TABLET 5 MG	T4	PA; QL (93 EA per 31 days)
CORLANOR ORAL TABLET 7.5 MG	T4	PA; QL (62 EA per 31 days)
COZAAR ORAL TABLET 100 MG	T4	QL (31 EA per 31 days)
COZAAR ORAL TABLET 25 MG	T4	QL (93 EA per 31 days)
COZAAR ORAL TABLET 50 MG	T4	QL (62 EA per 31 days)
CRESTOR	T4	
<i>dabigatran etexilate oral capsule 110 mg</i>	T4	QL (124 EA per 31 days)
<i>dabigatran etexilate oral capsule 150 mg, 75 mg</i>	T4	QL (62 EA per 31 days)
DEMSER	T5	PA
DIBENZYLINE	T5	PA
<i>digoxin oral solution</i>	T2	QL (155 ML per 31 days)
<i>digoxin oral tablet 125 mcg (0.125 mg)</i>	T1	QL (62 EA per 31 days)
<i>digoxin oral tablet 250 mcg (0.25 mg)</i>	T2	QL (31 EA per 31 days)
<i>digoxin oral tablet 62.5 mcg (0.0625 mg)</i>	T4	QL (124 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	T1	
<i>diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg</i>	T1	
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	
<i>diltiazem hcl oral tablet</i>	T1	
<i>diltiazem hcl oral tablet extended release 24 hr</i>	T1	
DILT-XR	T1	
DIOVAN HCT	T4	QL (31 EA per 31 days)
DIOVAN ORAL TABLET 160 MG, 40 MG, 80 MG	T4	QL (62 EA per 31 days)
DIOVAN ORAL TABLET 320 MG	T4	QL (31 EA per 31 days)
<i>dipyridamole oral</i>	T2	
<i>disopyramide phosphate oral capsule</i>	T2	
DIURIL	T4	
<i>dofetilide</i>	T3	
DOPTELET (10 TAB PACK)	T5	PA
DOPTELET (15 TAB PACK)	T5	PA
DOPTELET (30 TAB PACK)	T5	PA
<i>doxazosin</i>	T1	
DYRENIUM	T4	
EDARBI	T4	
EDARBYCLOR	T4	
EDECIN	T5	
EFFIENT	T4	
ELIQUIS DVT-PE TREAT 30D START	T3	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 30 days)
<i>enalapril maleate oral solution</i>	T4	
<i>enalapril maleate oral tablet</i>	T1	
<i>enalapril-hydrochlorothiazide</i>	T1	
<i>enoxaparin subcutaneous syringe 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml</i>	T4	
<i>enoxaparin subcutaneous syringe 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml</i>	T2	
ENTRESTO ORAL TABLET 24-26 MG	T3	QL (186 EA per 31 days)
ENTRESTO ORAL TABLET 49-51 MG	T3	QL (93 EA per 31 days)
ENTRESTO ORAL TABLET 97-103 MG	T3	QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
ENTRESTO SPRINKLE	T5	PA; QL (248 EA per 31 days)
<i>eplerenone</i>	T2	
<i>ethacrynic acid</i>	T2	
EXFORGE	T4	
EXFORGE HCT	T4	
EZALLOR SPRINKLE	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 130 mg, 134 mg, 200 mg, 43 mg, 67 mg</i>	T2	
<i>fenofibrate nanocrystallized</i>	T2	
<i>fenofibrate oral capsule</i>	T4	
<i>fenofibrate oral tablet 120 mg, 40 mg</i>	T4	
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	T2	
<i>fenofibric acid (choline)</i>	T3	
FENOGLIDE	T4	
FILSPARI	T5	PA; QL (31 EA per 31 days)
<i>flecainide</i>	T2	
FLOLIPID	T4	PA
<i>fluvastatin oral capsule</i>	T1	
<i>fluvastatin oral tablet extended release 24 hr</i>	T3	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	T5	
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	T2	
<i>fosinopril</i>	T1	
<i>fosinopril-hydrochlorothiazide</i>	T1	
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 18,000 ANTI-XA UNIT/0.72 ML, 7,500 ANTI- XA UNIT/0.3 ML	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI- XA UNIT/0.2 ML	T3	
FUROSCIX	T5	PA; QL (8 EA per 30 days)
<i>furosemide injection solution</i>	T2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>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>guanfacine oral tablet</i>	T2	
<i>heparin (porcine) injection solution</i>	T2	
<i>hydralazine oral</i>	T1	
<i>hydrochlorothiazide</i>	T1	
HYZAAR	T4	
<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	
INDERAL LA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 60 MG	T4	
INDERAL LA ORAL CAPSULE,EXTENDED RELEASE 24 HR 160 MG, 80 MG	T5	
INNOPRAN XL	T5	
INSPRA	T4	
<i>irbesartan</i>	T1	QL (31 EA per 31 days)
<i>irbesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
ISORDIL	T4	
ISORDIL TITRADOSE ORAL TABLET 5 MG	T4	
<i>isosorbide dinitrate oral tablet</i>	T2	
<i>isosorbide mononitrate</i>	T1	
<i>isosorbide-hydralazine</i>	T4	
<i>isradipine</i>	T2	
<i>ivabradine oral tablet 5 mg</i>	T4	PA; QL (93 EA per 31 days)
<i>ivabradine oral tablet 7.5 mg</i>	T4	PA; QL (62 EA per 31 days)
JANTOVEN	T1	
JUXTAPID	T5	PA
KATERZIA	T4	PA
KERENDIA	T4	PA; QL (31 EA per 31 days)
<i>labetalol oral</i>	T1	
LANOXIN ORAL TABLET 125 MCG (0.125 MG)	T4	QL (62 EA per 31 days)
LANOXIN ORAL TABLET 250 MCG (0.25 MG)	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.

Drug Name	Drug Tier	Requirements/Limits
LANOXIN ORAL TABLET 62.5 MCG (0.0625 MG)	T4	QL (124 EA per 31 days)
LASIX	T4	
LESCOL XL	T4	
<i>levamlodipine</i>	T4	ST; QL (31 EA per 31 days)
LIPITOR	T4	
LIPOFEN	T4	
<i>lisinopril</i>	T1	
<i>lisinopril-hydrochlorothiazide</i>	T1	
LIVALO	T3	
LODOCO	T4	PA; QL (31 EA per 31 days)
LOPID	T4	
LOPRESSOR ORAL	T4	
<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	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	T4	
LOTREL	T4	
<i>lovastatin</i>	T1	
LOVAZA	T3	PA; QL (124 EA per 31 days)
LOVENOX SUBCUTANEOUS SYRINGE 100 MG/ML	T5	
LOVENOX SUBCUTANEOUS SYRINGE 120 MG/0.8 ML, 150 MG/ML, 30 MG/0.3 ML, 40 MG/0.4 ML, 60 MG/0.6 ML, 80 MG/0.8 ML	T4	
MATZIM LA	T1	
<i>metolazone</i>	T2	
<i>metoprolol succinate</i>	T1	
<i>metoprolol ta-hydrochlorothiaz</i>	T1	
<i>metoprolol tartrate oral</i>	T1	
<i>metyrosine</i>	T5	PA
<i>mexiletine</i>	T2	
MICARDIS	T4	
MICARDIS HCT	T4	
<i>minoxidil oral</i>	T2	
<i>moexipril</i>	T1	

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

Drug Name	Drug Tier	Requirements/Limits
MULPLETA	T5	PA
MULTAQ	T4	
<i>nadolol</i>	T1	
<i>nebivolol oral tablet 10 mg, 2.5 mg</i>	T2	QL (93 EA per 31 days)
<i>nebivolol oral tablet 20 mg</i>	T2	QL (62 EA per 31 days)
<i>nebivolol oral tablet 5 mg</i>	T2	QL (217 EA per 31 days)
NEXICLON XR	T4	ST
NEXLETOL	T4	PA; QL (31 EA per 31 days)
NEXLIZET	T4	PA; QL (31 EA per 31 days)
<i>niacin oral tablet 500 mg</i>	T4	
<i>niacin oral tablet extended release 24 hr 1,000 mg, 750 mg</i>	T3	
<i>niacin oral tablet extended release 24 hr 500 mg</i>	T3	QL (31 EA per 31 days)
NIACOR	T4	
<i>nicardipine oral</i>	T2	
<i>nifedipine</i>	T2	
<i>nimodipine oral capsule</i>	T2	
<i>nisoldipine</i>	T2	
NITRO-BID	T2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.4 MG/HR, 0.6 MG/HR	T3	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	T5	
<i>nitroglycerin sublingual</i>	T2	
<i>nitroglycerin transdermal patch 24 hour</i>	T2	
<i>nitroglycerin translingual</i>	T2	
NITROLINGUAL	T4	
NITROSTAT	T4	
NORLIQVA	T4	PA; QL (300 ML per 30 days)
NORPACE	T4	
NORPACE CR	T4	
NORVASC	T4	
NYMALIZE ORAL SYRINGE 60 MG/10 ML	T5	
<i>olmesartan oral tablet 20 mg, 40 mg</i>	T2	QL (31 EA per 31 days)
<i>olmesartan oral tablet 5 mg</i>	T2	QL (93 EA per 31 days)
<i>olmesartan-amlodipin-hcthiazyd</i>	T3	
<i>olmesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>omega-3 acid ethyl esters</i>	T3	QL (124 EA per 31 days)
ORENITRAM MONTH 1 TITRATION KT	T5	PA; QL (336 EA per 365 days)
ORENITRAM MONTH 2 TITRATION KT	T5	PA; QL (672 EA per 365 days)
ORENITRAM MONTH 3 TITRATION KT	T5	PA; QL (504 EA per 365 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	T4	PA; QL (93 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG	T5	PA; QL (186 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG	T5	PA; QL (521 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG	T5	PA; QL (261 EA per 31 days)
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	T2	
<i>pentoxifylline</i>	T2	
<i>perindopril erbumine</i>	T1	
<i>phenoxybenzamine</i>	T5	PA
<i>pindolol</i>	T1	
<i>pitavastatin calcium</i>	T3	
PLAVIX ORAL TABLET 75 MG	T4	
PRADAXA ORAL CAPSULE 110 MG	T4	QL (124 EA per 31 days)
PRADAXA ORAL CAPSULE 150 MG, 75 MG	T4	QL (62 EA per 31 days)
PRADAXA ORAL PELLETS IN PACKET 110 MG, 30 MG, 40 MG, 50 MG	T5	QL (120 EA per 30 days)
PRADAXA ORAL PELLETS IN PACKET 150 MG, 20 MG	T5	QL (60 EA per 30 days)
PRALUENT PEN	T4	PA; QL (2 ML per 28 days)
<i>prasugrel</i>	T3	
<i>pravastatin</i>	T1	
<i>prazosin</i>	T1	
PREVALITE ORAL POWDER IN PACKET	T2	
PROCARDIA XL	T4	
PROMACTA ORAL POWDER IN PACKET 12.5 MG	T5	PA; QL (372 EA per 31 days)
PROMACTA ORAL POWDER IN PACKET 25 MG	T5	PA; QL (31 EA per 31 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG	T5	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
PROMACTA ORAL TABLET 50 MG, 75 MG	T5	PA; QL (62 EA per 31 days)
<i>propafenone</i>	T2	
<i>propranolol oral capsule, extended release 24 hr</i>	T2	
<i>propranolol oral solution</i>	T1	
<i>propranolol oral tablet</i>	T1	
QBRELIS	T5	
QUESTRAN LIGHT	T4	
QUESTRAN ORAL POWDER	T4	
<i>quinapril</i>	T1	
<i>quinidine gluconate oral</i>	T2	
<i>quinidine sulfate oral tablet</i>	T2	
<i>ramipril</i>	T1	
<i>ranolazine</i>	T3	QL (62 EA per 31 days)
REPATHA PUSHTRONEX	T3	PA; QL (7 ML per 28 days)
REPATHA SURECLICK	T3	PA; QL (3 ML per 28 days)
REPATHA SYRINGE	T3	PA; QL (3 ML per 28 days)
<i>rosuvastatin</i>	T1	
RYTHMOL SR	T4	
SAVAYSA	T4	QL (31 EA per 31 days)
<i>simvastatin</i>	T1	
SOANZ	T4	ST
SORINE ORAL TABLET 120 MG, 160 MG	T1	
SOTALOL AF	T1	
<i>sotalol oral</i>	T1	
SOTYLIZE	T5	
<i>spironolactone oral suspension</i>	T4	
<i>spironolactone oral tablet</i>	T1	
<i>spironolacton-hydrochlorothiaz</i>	T1	
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	T4	
TAVALISSE	T5	PA; QL (62 EA per 31 days)
TEKTURNA	T4	
<i>telmisartan</i>	T1	
<i>telmisartan-amlodipine</i>	T1	
<i>telmisartan-hydrochlorothiazid</i>	T1	
TENORETIC 100	T4	
TENORETIC 50	T4	

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

Drug Name	Drug Tier	Requirements/Limits
TENORMIN	T4	
<i>terazosin</i>	T1	
THALITONE	T4	
TIADYLT ER	T1	
TIAZAC	T4	
TIKOSYN	T3	
<i>timolol maleate oral</i>	T1	
TOPROL XL	T4	
<i>torseamide oral</i>	T1	
<i>trandolapril</i>	T1	
<i>trandolapril-verapamil</i>	T2	
<i>triamterene</i>	T4	
<i>triamterene-hydrochlorothiazid</i>	T1	
TRIBENZOR	T4	
TRICOR	T4	
TRILIPIX	T4	
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	T5	PA; QL (62 EA per 31 days)
UPTRAVI ORAL TABLET 200 MCG	T5	PA; QL (224 EA per 28 days)
UPTRAVI ORAL TABLETS,DOSE PACK	T5	PA; QL (400 EA per 365 days)
<i>valsartan oral solution</i>	T5	QL (2480 ML per 31 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)
VASCEPA ORAL CAPSULE 0.5 GRAM	T4	QL (248 EA per 31 days)
VASCEPA ORAL CAPSULE 1 GRAM	T4	QL (124 EA per 31 days)
VASERETIC	T4	
VASOTEC ORAL TABLET 10 MG	T5	
VASOTEC ORAL TABLET 2.5 MG, 20 MG, 5 MG	T4	
VECAMYL	T5	
<i>verapamil oral</i>	T2	
VERELAN	T4	
VERELAN PM	T4	
VERQUVO	T4	PA; QL (31 EA per 31 days)
VYNDAMAX	T5	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
VYNDAQEL	T5	PA; QL (124 EA per 31 days)
VYTORIN 10-10	T4	QL (31 EA per 31 days)
VYTORIN 10-20	T4	QL (31 EA per 31 days)
VYTORIN 10-40	T4	QL (31 EA per 31 days)
VYTORIN 10-80	T4	QL (31 EA per 31 days)
<i>warfarin</i>	T1	
WELCHOL	T4	
XARELTO DVT-PE TREAT 30D START	T3	QL (51 EA per 30 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	T3	QL (930 ML per 31 days)
XARELTO ORAL TABLET 10 MG, 20 MG	T3	QL (31 EA per 31 days)
XARELTO ORAL TABLET 15 MG	T3	QL (52 EA per 31 days)
XARELTO ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
ZESTORETIC	T4	
ZESTRIL	T4	
ZETIA	T4	
ZIAC	T4	
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG	T4	
ZONTIVITY	T4	
ZYPITAMAG	T4	
Dermatologicals/Topical Therapy		
ABSORICA	T5	
ABSORICA LD	T5	
ACANYA TOPICAL GEL WITH PUMP	T4	
ACUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG	T2	
<i>acitretin</i>	T4	PA
<i>acyclovir topical cream</i>	T3	QL (5 GM per 28 days)
<i>acyclovir topical ointment</i>	T1	QL (30 GM per 30 days)
ACZONE	T4	QL (90 GM per 28 days)
<i>adapalene topical cream</i>	T2	PA
<i>adapalene topical gel 0.3 %</i>	T2	PA
<i>adapalene topical swab</i>	T2	PA
<i>adapalene-benzoyl peroxide</i>	T4	PA
ADBRY SUBCUTANEOUS SYRINGE	T5	PA; QL (4 ML per 28 days)
AKLIEF	T4	PA

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

Drug Name	Drug Tier	Requirements/Limits
ALA-CORT TOPICAL CREAM 1 %	T1	
ALA-CORT TOPICAL CREAM 2.5 %	T1	QL (30 GM per 28 days)
ALA-SCALP	T4	
<i>alclometasone</i>	T1	
ALTABAX	T4	QL (30 GM per 28 days)
ALTRENO	T4	PA; QL (45 GM per 28 days)
<i>amcinonide topical cream</i>	T2	
<i>amcinonide topical ointment</i>	T2	
<i>ammonium lactate</i>	T2	
AMNESTEEM	T2	
AMZEEQ	T4	
APEXICON E	T4	QL (60 GM per 28 days)
ARAZLO	T4	PA; QL (45 GM per 28 days)
ATRALIN	T4	PA; QL (45 GM per 28 days)
<i>azelaic acid</i>	T4	QL (50 GM per 28 days)
AZELEX	T4	QL (50 GM per 28 days)
BENZAMYCIN	T4	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate topical cream</i>	T1	
<i>betamethasone valerate topical foam</i>	T4	
<i>betamethasone valerate topical lotion</i>	T1	
<i>betamethasone valerate topical ointment</i>	T1	
<i>betamethasone, augmented</i>	T2	
BIMZELX	T5	PA; QL (2 ML per 28 days)
BIMZELX AUTOINJECTOR	T5	PA; QL (2 ML per 28 days)
<i>brimonidine topical</i>	T4	
BRYHALI	T4	QL (100 GM per 28 days)
CABTREO	T4	PA; QL (50 GM per 28 days)
<i>calcipotriene scalp</i>	T2	QL (60 ML per 28 days)
<i>calcipotriene topical cream</i>	T2	QL (60 GM per 28 days)
<i>calcipotriene topical foam</i>	T5	ST; QL (120 GM per 28 days)
<i>calcipotriene topical ointment</i>	T2	QL (60 GM per 28 days)
<i>calcipotriene-betamethasone</i>	T4	ST; QL (400 GM per 28 days)
<i>calcitriol topical</i>	T3	ST
CARAC	T5	PA
CIBINQO	T5	PA; QL (31 EA per 31 days)
<i>ciclopirox topical cream</i>	T2	QL (90 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>ciclopirox topical gel</i>	T2	QL (45 GM per 28 days)
<i>ciclopirox topical shampoo</i>	T2	QL (120 ML per 28 days)
<i>ciclopirox topical solution</i>	T2	
<i>ciclopirox topical suspension</i>	T2	QL (60 ML per 28 days)
CLARAVIS	T2	
CLEOCIN T TOPICAL LOTION	T4	QL (60 ML per 28 days)
CLINDACIN	T2	QL (100 GM per 28 days)
CLINDACIN ETZ TOPICAL SWAB	T4	
CLINDAGEL	T5	QL (75 ML per 28 days)
<i>clindamycin phosphate topical foam</i>	T2	QL (100 GM per 28 days)
<i>clindamycin phosphate topical gel</i>	T2	QL (60 GM per 28 days)
<i>clindamycin phosphate topical gel, once daily</i>	T2	QL (75 ML per 28 days)
<i>clindamycin phosphate topical lotion</i>	T2	QL (60 ML per 28 days)
<i>clindamycin phosphate topical solution</i>	T2	QL (60 ML per 28 days)
<i>clindamycin phosphate topical swab</i>	T2	
<i>clindamycin-benzoyl peroxide topical gel</i>	T2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2 %(1 % base) -3.75 %</i>	T4	
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2-2.5 %</i>	T2	
<i>clindamycin-tretinoin</i>	T2	PA; QL (60 GM per 28 days)
<i>clobetasol scalp</i>	T2	QL (50 ML per 28 days)
<i>clobetasol topical cream</i>	T3	QL (60 GM per 28 days)
<i>clobetasol topical foam</i>	T2	QL (100 GM per 28 days)
<i>clobetasol topical gel</i>	T2	QL (60 GM per 28 days)
<i>clobetasol topical lotion</i>	T2	QL (118 ML per 28 days)
<i>clobetasol topical ointment</i>	T3	QL (60 GM per 28 days)
<i>clobetasol topical shampoo</i>	T2	QL (118 ML per 28 days)
<i>clobetasol topical spray,non-aerosol</i>	T2	QL (125 ML per 28 days)
<i>clobetasol-emollient topical cream</i>	T3	QL (60 GM per 28 days)
<i>clobetasol-emollient topical foam</i>	T3	QL (100 GM per 28 days)
CLOBEX TOPICAL LOTION	T4	QL (118 ML per 28 days)
CLOBEX TOPICAL SHAMPOO	T4	QL (118 ML per 28 days)
CLOBEX TOPICAL SPRAY,NON-AEROSOL	T4	QL (125 ML per 28 days)
<i>clocortolone pivalate</i>	T4	
CLODAN	T2	QL (118 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>clotrimazole topical cream</i>	T2	QL (45 GM per 28 days)
<i>clotrimazole topical solution</i>	T2	QL (30 ML per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	T2	QL (45 GM per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	T2	QL (60 ML per 28 days)
CONDYLOX TOPICAL GEL	T4	
CORDRAN TAPE LARGE ROLL	T4	
CORDRAN TOPICAL CREAM 0.05 %	T3	QL (120 GM per 28 days)
CORDRAN TOPICAL LOTION	T3	QL (120 ML per 28 days)
COSENTYX (2 SYRINGES)	T5	PA; QL (2 ML per 28 days)
COSENTYX PEN (2 PENS)	T5	PA; QL (2 ML per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
COSENTYX UNOREADY PEN	T5	PA; QL (2 ML per 28 days)
CROTAN	T4	
<i>dapsone topical</i>	T4	QL (90 GM per 28 days)
DENA VIR	T4	QL (5 GM per 28 days)
DERMA-SMOOTHIE/FS SCALP OIL	T4	QL (118.28 ML per 28 days)
<i>desonide topical cream</i>	T3	QL (60 GM per 28 days)
<i>desonide topical gel</i>	T3	QL (60 GM per 28 days)
<i>desonide topical lotion</i>	T3	QL (118 ML per 28 days)
<i>desonide topical ointment</i>	T3	QL (60 GM per 28 days)
DESOWEN TOPICAL CREAM	T4	QL (60 GM per 28 days)
<i>desoximetasone topical cream</i>	T2	QL (100 GM per 28 days)
<i>desoximetasone topical gel</i>	T2	QL (60 GM per 28 days)
<i>desoximetasone topical ointment 0.05 %</i>	T4	QL (100 GM per 28 days)
<i>desoximetasone topical ointment 0.25 %</i>	T2	QL (100 GM per 28 days)
<i>desoximetasone topical spray,non-aerosol</i>	T2	QL (100 ML per 28 days)
<i>diclofenac sodium topical gel 3 %</i>	T4	PA; QL (100 GM per 28 days)
DIFFERIN TOPICAL CREAM	T4	PA
DIFFERIN TOPICAL GEL WITH PUMP	T4	PA
DIFFERIN TOPICAL LOTION	T4	PA
<i>diflorasone</i>	T4	QL (60 GM per 28 days)
DIPROLENE (AUGMENTED) TOPICAL OINTMENT	T4	
<i>doxepin topical</i>	T4	PA; QL (45 GM per 28 days)
DUOBRII	T4	PA; QL (200 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	T5	PA; QL (1.34 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
<i>econazole</i>	T2	QL (85 GM per 28 days)
EFUDEX TOPICAL CREAM	T4	
ELIDEL	T4	QL (100 GM per 28 days)
ENSTILAR	T5	ST; QL (60 GM per 28 days)
EPIDUO FORTE	T4	PA
EPIDUO TOPICAL GEL WITH PUMP	T4	PA
EPSOLAY	T4	QL (30 GM per 28 days)
ERTACZO	T4	ST; QL (60 GM per 28 days)
ERY PADS	T2	
ERYGEL	T3	QL (60 GM per 28 days)
<i>erythromycin with ethanol topical gel</i>	T2	QL (60 GM per 28 days)
<i>erythromycin with ethanol topical solution</i>	T2	QL (60 ML per 28 days)
<i>erythromycin-benzoyl peroxide</i>	T2	
EUCRISA	T4	PA; QL (60 GM per 30 days)
EXELDERM TOPICAL CREAM	T4	ST; QL (60 GM per 28 days)
EXELDERM TOPICAL SOLUTION	T4	ST; QL (30 ML per 28 days)
FABIOR	T4	PA; QL (100 GM per 28 days)
FILSUEVZ	T5	PA
FINACEA	T4	QL (50 GM per 28 days)
<i>fluocinolone and shower cap</i>	T2	QL (118.28 ML per 28 days)
<i>fluocinolone topical cream 0.01 %</i>	T2	QL (60 GM per 28 days)
<i>fluocinolone topical cream 0.025 %</i>	T2	QL (120 GM per 28 days)
<i>fluocinolone topical ointment</i>	T2	QL (120 GM per 28 days)
<i>fluocinolone topical solution</i>	T2	QL (90 ML per 28 days)
<i>fluocinonide topical cream 0.05 %</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical cream 0.1 %</i>	T4	QL (120 GM per 28 days)
<i>fluocinonide topical gel</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical ointment</i>	T2	QL (60 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>fluocinonide topical solution</i>	T2	QL (60 ML per 28 days)
<i>fluocinonide-emollient</i>	T2	QL (60 GM per 28 days)
<i>fluorouracil topical cream 5 %</i>	T2	
<i>fluorouracil topical solution</i>	T2	
<i>flurandrenolide topical cream</i>	T3	QL (120 GM per 28 days)
<i>flurandrenolide topical lotion</i>	T3	QL (120 ML per 28 days)
<i>fluticasone propionate topical cream</i>	T2	
<i>fluticasone propionate topical lotion</i>	T4	QL (120 ML per 28 days)
<i>fluticasone propionate topical ointment</i>	T2	
<i>gentamicin topical</i>	T2	QL (60 GM per 28 days)
<i>halcinonide topical cream</i>	T4	QL (60 GM per 28 days)
<i>halobetasol propionate topical cream</i>	T2	QL (50 GM per 28 days)
<i>halobetasol propionate topical foam</i>	T4	QL (120 GM per 28 days)
<i>halobetasol propionate topical ointment</i>	T2	QL (50 GM per 28 days)
HALOG TOPICAL CREAM	T4	QL (60 GM per 28 days)
HALOG TOPICAL OINTMENT	T4	QL (60 GM per 28 days)
HALOG TOPICAL SOLUTION	T4	QL (120 ML per 28 days)
<i>hydrocortisone butyrate topical cream</i>	T2	QL (45 GM per 28 days)
<i>hydrocortisone butyrate topical lotion</i>	T4	QL (118 ML per 28 days)
<i>hydrocortisone butyrate topical ointment</i>	T2	QL (45 GM per 28 days)
<i>hydrocortisone butyrate topical solution</i>	T2	QL (60 ML per 28 days)
<i>hydrocortisone topical cream 1 %</i>	T1	
<i>hydrocortisone topical lotion 2.5 %</i>	T1	QL (118 ML per 28 days)
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	T1	
<i>hydrocortisone valerate</i>	T2	QL (60 GM per 28 days)
HYFTOR	T5	PA; QL (30 GM per 30 days)
ILUMYA	T5	PA; QL (1 ML per 84 days)
<i>imiquimod topical cream in metered-dose pump</i>	T5	
<i>imiquimod topical cream in packet 5 %</i>	T2	
<i>isotretinoin</i>	T2	
<i>ivermectin topical cream</i>	T4	QL (45 GM per 28 days)
JUBLIA	T4	QL (8 ML per 28 days)
KENALOG TOPICAL	T3	QL (100 GM per 28 days)
<i>ketoconazole topical cream</i>	T2	QL (60 GM per 28 days)
<i>ketoconazole topical foam</i>	T4	QL (100 GM per 28 days)
<i>ketoconazole topical shampoo</i>	T2	QL (120 ML per 28 days)
KETODAN	T2	ST; QL (100 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
KLARON	T4	
LEXETTE	T5	QL (200 GM 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>	T2	PA; QL (93 EA per 31 days)
<i>lidocaine topical ointment</i>	T2	PA; QL (50 GM per 28 days)
LIDOCAINE VISCOUS	T2	
<i>lidocaine-prilocaine topical cream</i>	T2	PA; QL (30 GM per 28 days)
LIDOCAN III	T4	PA; QL (93 EA per 31 days)
LIDODERM	T5	PA; QL (93 EA per 31 days)
LOCOID LIPOCREAM	T4	QL (60 GM per 28 days)
LOCOID TOPICAL LOTION	T4	QL (118 ML per 28 days)
LOPROX TOPICAL SHAMPOO	T4	QL (120 ML per 28 days)
<i>luliconazole</i>	T4	QL (60 GM per 28 days)
LUZU	T4	QL (60 GM per 28 days)
<i>mafenide acetate</i>	T4	
<i>malathion</i>	T2	
<i>methoxsalen</i>	T5	
METROCREAM	T4	
METROGEL TOPICAL GEL 1 %	T4	
METROLOTION	T4	
<i>metronidazole topical cream</i>	T2	
<i>metronidazole topical gel 0.75 %</i>	T2	
<i>metronidazole topical gel 1 %</i>	T1	
<i>metronidazole topical lotion</i>	T2	
MIRVASO	T4	
<i>mometasone topical</i>	T2	
<i>mupirocin</i>	T2	
<i>mupirocin calcium</i>	T4	ST
<i>naftifine topical cream 1 %</i>	T4	ST; QL (90 GM per 28 days)
<i>naftifine topical cream 2 %</i>	T4	ST; QL (60 GM per 28 days)
<i>naftifine topical gel 2 %</i>	T4	ST; QL (60 GM per 28 days)
NAFTIN TOPICAL GEL 1 %	T4	ST; QL (90 GM per 28 days)
NAFTIN TOPICAL GEL 2 %	T4	ST; QL (60 GM per 28 days)
NATROBA	T4	
NEO-SYNALAR	T4	
NEUAC	T2	

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

Drug Name	Drug Tier	Requirements/Limits
NORITATE	T5	
NYAMYC	T2	QL (60 GM per 28 days)
<i>nystatin topical cream</i>	T2	QL (30 GM per 28 days)
<i>nystatin topical ointment</i>	T2	QL (30 GM per 28 days)
<i>nystatin topical powder</i>	T2	QL (60 GM per 28 days)
<i>nystatin-triamcinolone</i>	T3	QL (60 GM per 28 days)
NYSTOP	T2	QL (60 GM per 28 days)
ONEXTON TOPICAL GEL WITH PUMP	T4	
OPZELURA	T5	PA; QL (240 GM per 28 days)
OVIDE	T4	
<i>oxiconazole</i>	T4	ST; QL (90 GM per 28 days)
OXISTAT TOPICAL LOTION	T4	ST; QL (60 ML per 28 days)
PANDEL	T5	QL (80 GM per 28 days)
PANRETIN	T5	PA-NS
<i>penciclovir</i>	T3	QL (5 GM per 28 days)
<i>permethrin</i>	T2	
<i>pimecrolimus</i>	T3	QL (100 GM per 28 days)
PLIAGLIS	T4	PA; QL (100 GM per 28 days)
<i>podofilox topical gel</i>	T4	
<i>podofilox topical solution</i>	T2	
PRUDOXIN	T4	PA; QL (45 GM per 28 days)
QBREXZA	T4	QL (30 EA per 30 days)
REGRANEX	T5	PA
RETIN-A	T4	PA; QL (45 GM per 28 days)
RETIN-A MICRO	T4	PA; QL (45 GM per 28 days)
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %	T4	PA; QL (50 GM per 28 days)
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.08 %	T5	PA; QL (50 GM per 28 days)
SANTYL	T4	QL (180 GM per 30 days)
<i>selenium sulfide topical lotion</i>	T1	
SILIQ	T5	PA; QL (6 ML per 28 days)
SILVADENE	T4	
<i>silver sulfadiazine</i>	T1	
SKYRIZI SUBCUTANEOUS PEN INJECTOR	T5	PA; QL (1 ML per 84 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (1 ML per 84 days)

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

Drug Name	Drug Tier	Requirements/Limits
SOOLANTRA	T4	QL (45 GM per 28 days)
SORILUX	T5	ST; QL (120 GM per 28 days)
SOTYKTU	T5	PA; QL (31 EA per 31 days)
SPEVIGO SUBCUTANEOUS	T5	PA; QL (2 ML per 28 days)
<i>spinosad</i>	T4	
SSD	T4	
STELARA SUBCUTANEOUS SOLUTION	T5	PA; QL (0.5 ML per 84 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 84 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
<i>sulfacetamide sodium (acne)</i>	T1	
SULFAMYLON TOPICAL CREAM	T3	
SYNALAR TOPICAL CREAM	T4	QL (120 GM per 28 days)
SYNALAR TOPICAL OINTMENT	T4	QL (120 GM per 28 days)
TACLONEX TOPICAL OINTMENT	T4	ST; QL (400 GM per 28 days)
TACLONEX TOPICAL SUSPENSION	T5	ST; QL (400 GM per 28 days)
<i>tacrolimus topical</i>	T2	QL (100 GM per 28 days)
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML	T5	PA; QL (1 ML per 28 days)
<i>tavaborole</i>	T4	QL (10 ML per 28 days)
<i>tazarotene topical cream 0.1 %</i>	T4	PA; QL (60 GM per 28 days)
<i>tazarotene topical foam</i>	T4	PA; QL (100 GM per 28 days)
<i>tazarotene topical gel</i>	T4	PA; QL (100 GM per 28 days)
TAZORAC TOPICAL CREAM	T4	PA; QL (60 GM per 28 days)
TAZORAC TOPICAL GEL	T4	PA; QL (100 GM per 28 days)
TEXACORT	T4	
TOPICORT TOPICAL CREAM	T4	QL (100 GM per 28 days)
TOPICORT TOPICAL GEL	T4	QL (60 GM per 28 days)
TOPICORT TOPICAL OINTMENT 0.05 %	T4	QL (100 GM per 28 days)
TOPICORT TOPICAL SPRAY, NON-AEROSOL	T4	QL (100 ML per 28 days)
TOVET EMOLLIENT	T3	QL (100 GM per 28 days)
TREMFYA SUBCUTANEOUS AUTO-INJECTOR	T5	PA; QL (1 ML per 56 days)
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (1 ML per 56 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>tretinoin</i>	T2	PA; QL (45 GM per 28 days)
<i>tretinoin microspheres topical gel</i>	T2	PA; QL (50 GM per 28 days)
<i>tretinoin microspheres topical gel with pump 0.08 %</i>	T4	PA; QL (50 GM per 28 days)
<i>triamcinolone acetonide topical cream</i>	T1	
<i>triamcinolone acetonide topical lotion</i>	T1	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>triamcinolone acetonide topical ointment 0.05 %</i>	T4	
TRIDACAINE II	T4	PA; QL (93 EA per 31 days)
TRIDERM TOPICAL CREAM	T1	
TWYNEO	T4	PA; QL (30 GM per 28 days)
ULTRAVATE TOPICAL LOTION	T4	QL (120 ML per 28 days)
VALCHLOR	T5	PA-NS
VANOS	T5	QL (120 GM per 28 days)
VECTICAL	T4	ST
VELTIN	T4	PA; QL (60 GM per 28 days)
VERDESO	T4	QL (100 GM per 28 days)
VEREGEN	T5	QL (30 GM per 28 days)
VTAMA	T5	PA; QL (60 GM per 28 days)
WINLEVI	T4	PA; QL (60 GM per 28 days)
XERESE	T5	
ZENATANE	T2	
ZIANA	T4	PA; QL (60 GM per 28 days)
ZILXI	T4	
ZONALON	T4	PA; QL (30 GM per 28 days)
ZORYVE TOPICAL CREAM 0.3 %	T4	PA; QL (60 GM per 28 days)
ZORYVE TOPICAL FOAM	T4	PA; QL (60 GM per 28 days)
ZOVIRAX TOPICAL CREAM	T4	QL (5 GM per 28 days)
ZOVIRAX TOPICAL OINTMENT	T4	QL (30 GM per 30 days)
ZTLIDO	T4	PA; QL (93 EA per 31 days)
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP	T5	
Diagnostics / Miscellaneous Agents		
<i>acamprosate</i>	T2	
AGRYLIN	T4	
<i>anagrelide</i>	T2	

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

Drug Name	Drug Tier	Requirements/Limits
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
AURYXIA	T5	PA; QL (372 EA per 31 days)
BUPHENYL	T5	PA
<i>bupropion hcl (smoking deter)</i>	T2	QL (62 EA per 31 days)
CARBAGLU	T5	PA
<i>carglumic acid</i>	T5	PA
CARNITOR ORAL	T4	PA-BvD
<i>cevimeline</i>	T2	
CHEMET	T4	
CLINIMIX 4.25%/D5W SULFIT FREE	T4	PA-BvD
CLINIMIX E 2.75%/D5W SULF FREE	T4	PA-BvD
CUVRIOR	T5	PA; QL (310 EA per 31 days)
<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 granules in packet</i>	T5	PA
<i>deferasirox oral tablet 180 mg, 360 mg</i>	T5	PA
<i>deferasirox oral tablet 90 mg</i>	T4	PA
<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 % and 0.2 % nacl</i>	T2	
<i>dextrose 10 % in water (d10w)</i>	T2	
<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	T2	
<i>dextrose 5%-0.2 % sod chloride</i>	T2	
<i>disulfiram</i>	T2	
<i>droxidopa oral capsule 100 mg</i>	T5	PA; QL (465 EA per 31 days)
<i>droxidopa oral capsule 200 mg, 300 mg</i>	T5	PA; QL (186 EA per 31 days)
DUVYZAT	T5	PA; QL (420 ML per 35 days)
ENDARI	T5	PA; QL (180 EA per 30 days)
EVOXAC	T4	
EXJADE	T5	PA
EXSERVAN	T5	PA; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
FABHALTA	T5	PA; QL (62 EA per 31 days)
FERRIPROX	T5	PA
FERRIPROX (2 TIMES A DAY)	T5	PA
FOSRENOL ORAL POWDER IN PACKET	T5	
FOSRENOL ORAL TABLET,CHEWABLE 1,000 MG, 750 MG	T5	
FOSRENOL ORAL TABLET,CHEWABLE 500 MG	T4	
GLASSIA	T5	PA
<i>glutamine (sickle cell)</i>	T5	PA; QL (180 EA per 30 days)
INCRELEX	T5	PA
JADENU	T5	PA
JADENU SPRINKLE	T5	PA
JOENJA	T5	PA; QL (60 EA per 30 days)
KIONEX (WITH SORBITOL)	T2	
<i>lanthanum oral tablet,chewable 1,000 mg</i>	T5	
<i>lanthanum oral tablet,chewable 500 mg, 750 mg</i>	T4	
<i>levocarnitine (with sugar)</i>	T2	PA-BvD
<i>levocarnitine oral tablet</i>	T2	PA-BvD
LITFULO	T5	PA; QL (28 EA per 28 days)
LITHOSTAT	T4	
LOKELMA	T3	PA; QL (93 EA per 31 days)
<i>midodrine</i>	T2	
NICOTROL	T4	
NICOTROL NS	T5	
<i>nitisinone</i>	T5	PA
NITYR	T5	PA
NORTHERA ORAL CAPSULE 100 MG	T5	PA; QL (465 EA per 31 days)
NORTHERA ORAL CAPSULE 200 MG, 300 MG	T5	PA; QL (186 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 2 GRAM, 3 GRAM	T5	PA; QL (186 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 4 GRAM	T5	PA; QL (155 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 5 GRAM	T5	PA; QL (124 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 6 GRAM	T5	PA; QL (93 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
OLPRUVA ORAL PELLETS IN PACKET 6.67 GRAM	T5	PA; QL (62 EA per 31 days)
ORFADIN	T5	PA
OXBRYTA ORAL TABLET 300 MG	T5	PA; QL (248 EA per 31 days)
OXBRYTA ORAL TABLET 500 MG	T5	PA; QL (155 EA per 31 days)
OXBRYTA ORAL TABLET FOR SUSPENSION	T5	PA; QL (248 EA per 31 days)
PHEBURANE	T5	PA; QL (620 GM per 31 days)
<i>pilocarpine hcl oral</i>	T2	
PROLASTIN-C INTRAVENOUS SOLUTION	T5	PA
PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG	T5	PA; QL (56 EA per 28 days)
PYRUKYND ORAL TABLET 5 MG	T5	PA; QL (14 EA per 365 days)
PYRUKYND ORAL TABLETS,DOSE PACK	T5	PA; QL (28 EA per 365 days)
RAVICTI	T5	PA
REVELA	T4	
REVCIVI	T5	
REZDIFFRA	T5	PA; QL (31 EA per 31 days)
<i>riluzole</i>	T4	
<i>risedronate oral tablet 30 mg</i>	T3	
SALAGEN (PILOCARPINE)	T4	
<i>sevelamer carbonate</i>	T3	
<i>sevelamer hcl</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	
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 2.5 MG, 5 MG	T5	PA; QL (31 EA per 31 days)
SOHONOS ORAL CAPSULE 10 MG	T5	PA; QL (62 EA per 31 days)
SPS (WITH SORBITOL) ORAL	T2	
SYPRINE	T5	QL (248 EA per 31 days)
TAVNEOS	T5	PA; QL (186 EA per 31 days)
TEGLUTIK	T5	PA
THIOLA	T5	PA
THIOLA EC	T5	PA
<i>tiopronin</i>	T5	PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>trientine oral capsule 250 mg</i>	T5	QL (248 EA per 31 days)
<i>trientine oral capsule 500 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>varenicline oral tablet</i>	T4	QL (60 EA per 30 days)
<i>varenicline oral tablets,dose pack</i>	T4	QL (106 EA per 365 days)
VELPHORO	T5	
VELTASSA	T5	PA; QL (30 EA per 30 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML	T5	PA; QL (2 ML per 28 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 1.7 MG/0.75 ML, 2.4 MG/0.75 ML	T5	PA; QL (3 ML per 28 days)
XURIDEN	T5	PA; QL (124 EA per 31 days)
ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
ZOKINVY	T5	PA
Ear, Nose / Throat Medications		
<i>acetic acid otic (ear)</i>	T2	
<i>azelastine nasal spray,non-aerosol 137 mcg (0.1 %)</i>	T2	QL (30 ML per 25 days)
CETRAXAL	T4	
<i>chlorhexidine gluconate mucous membrane</i>	T1	
CIPRO HC	T4	
<i>ciprofloxacin hcl otic (ear)</i>	T1	
<i>ciprofloxacin-dexamethasone</i>	T3	
<i>ciprofloxacin-fluocinolone</i>	T4	
DERMOTIC OIL	T4	
FLAC OTIC OIL	T2	
<i>fluocinolone acetonide oil</i>	T2	
<i>hydrocortisone-acetic acid</i>	T2	
<i>ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)</i>	T1	QL (30 ML per 28 days)
<i>ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)</i>	T1	QL (15 ML per 28 days)
KOURZEQ	T2	
<i>neomycin-polymyxin-hc otic (ear)</i>	T2	
<i>ofloxacin otic (ear)</i>	T2	
<i>olopatadine nasal</i>	T2	QL (30.5 GM per 30 days)
OTOVEL	T4	

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

Drug Name	Drug Tier	Requirements/Limits
PERIOGARD	T1	
<i>triamcinolone acetonide dental</i>	T2	
Endocrine/Diabetes		
<i>acarbose</i>	T1	QL (93 EA per 31 days)
ACTHAR	T5	PA
ACTHAR SELFJECT	T5	PA
ACTOPLUS MET ORAL TABLET 15-850 MG	T4	QL (93 EA per 31 days)
ACTOS	T4	QL (31 EA per 31 days)
ADMELOG SOLOSTAR U-100 INSULIN	T4	
ADMELOG U-100 INSULIN LISPRO	T4	
AFREZZA INHALATION CARTRIDGE WITH INHALER 12 UNIT, 4 UNIT (90)/ 8 UNIT (90), 4 UNIT/8 UNIT/ 12 UNIT (60), 8 UNIT (90)/ 12 UNIT (90)	T5	
AFREZZA INHALATION CARTRIDGE WITH INHALER 4 UNIT, 8 UNIT	T4	
AGAMREE	T5	PA; QL (300 ML per 40 days)
ALCOHOL PADS	T2	
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG	T4	PA
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 1 MG, 2 MG, 5 MG	T5	PA
<i>alogliptin</i>	T4	ST; QL (31 EA per 31 days)
<i>alogliptin-metformin</i>	T4	ST; QL (62 EA per 31 days)
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	T4	ST; QL (31 EA per 31 days)
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP	T3	PA
APIDRA SOLOSTAR U-100 INSULIN	T4	
APIDRA U-100 INSULIN	T4	
AVEED	T4	PA
BAQSIMI	T3	
BASAGLAR KWIKPEN U-100 INSULIN	T4	
BASAGLAR TEMPO PEN(U-100)INSLN	T4	
BYDUREON BCISE	T4	PA; QL (3.4 ML per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	T4	PA; QL (2.4 ML per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	T4	PA; QL (1.2 ML per 30 days)
<i>cabergoline</i>	T2	
<i>calcitonin (salmon) nasal</i>	T2	PA-BvD
<i>calcitriol oral capsule</i>	T2	PA-BvD
<i>calcitriol oral solution</i>	T3	PA-BvD
CERDELGA	T5	PA; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	T3	PA-BvD; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 90 mg</i>	T3	PA-BvD; QL (124 EA per 31 days)
CORTEF	T4	
CORTROPHIN GEL	T5	PA
CYCLOSET	T4	
CYTOMEL	T4	
<i>danazol</i>	T2	
<i>dapaglifloz propaned-metformin oral tablet, ir - er, biphasic 24hr 10-1,000 mg</i>	T4	ST; QL (31 EA per 31 days)
<i>dapaglifloz propaned-metformin oral tablet, ir - er, biphasic 24hr 5-1,000 mg</i>	T4	ST; QL (62 EA per 31 days)
<i>dapagliflozin propanediol</i>	T4	ST; QL (31 EA per 31 days)
DDAVP ORAL	T4	
<i>deflazacort</i>	T5	PA
DEPO-TESTOSTERONE	T4	PA
<i>desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)</i>	T4	
<i>desmopressin oral</i>	T2	
DEXABLISS	T2	
<i>dexamethasone oral solution</i>	T1	
<i>dexamethasone oral tablet</i>	T1	
<i>dexamethasone oral tablets,dose pack</i>	T2	
<i>diazoxide</i>	T3	
<i>doxercalciferol oral capsule 0.5 mcg, 2.5 mcg</i>	T2	PA-BvD
<i>doxercalciferol oral capsule 1 mcg</i>	T4	PA-BvD
DUETACT	T4	QL (31 EA per 31 days)
EMFLAZA	T5	PA
ERMEZA	T4	
EUTHYROX	T4	

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

Drug Name	Drug Tier	Requirements/Limits
FARXIGA	T3	QL (31 EA per 31 days)
FIASP FLEXTOUCH U-100 INSULIN	T3	
FIASP PENFILL U-100 INSULIN	T3	
FIASP U-100 INSULIN	T3	
<i>fludrocortisone</i>	T2	
GALAFOLD	T5	PA; QL (14 EA per 28 days)
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	T1	
<i>glipizide oral tablet 10 mg, 5 mg</i>	T1	
<i>glipizide oral tablet 2.5 mg</i>	T3	
<i>glipizide oral tablet extended release 24hr</i>	T1	
<i>glipizide-metformin</i>	T1	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG, 5 MG	T4	
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 1,000 MG	T5	ST; QL (62 EA per 31 days)
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 500 MG	T5	ST; QL (31 EA per 31 days)
<i>glyburide</i>	T2	
<i>glyburide micronized</i>	T2	
<i>glyburide-metformin</i>	T2	
GLYXAMBI	T3	QL (31 EA per 31 days)
GVOKE	T3	
GVOKE HYPOPEN 2-PACK	T3	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	T3	
HEMADY	T4	PA-NS
HUMALOG JUNIOR KWIKPEN U-100	T3	
HUMALOG KWIKPEN INSULIN	T3	
HUMALOG MIX 50-50 KWIKPEN	T3	
HUMALOG MIX 75-25 KWIKPEN	T3	
HUMALOG MIX 75-25(U-100)INSULN	T3	
HUMALOG TEMPO PEN(U-100)INSULN	T3	
HUMALOG U-100 INSULIN	T3	
HUMULIN 70/30 U-100 INSULIN	T3	
HUMULIN 70/30 U-100 KWIKPEN	T3	
HUMULIN N NPH INSULIN KWIKPEN	T3	
HUMULIN N NPH U-100 INSULIN	T3	

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

Drug Name	Drug Tier	Requirements/Limits
HUMULIN R REGULAR U-100 INSULN	T3	
HUMULIN R U-500 (CONC) INSULIN	T3	
HUMULIN R U-500 (CONC) KWIKPEN	T3	
<i>hydrocortisone oral</i>	T1	
INPEFA ORAL TABLET 200 MG	T4	ST; QL (62 EA per 31 days)
INPEFA ORAL TABLET 400 MG	T4	ST; QL (31 EA per 31 days)
<i>insulin asp prt-insulin aspart</i>	T3	
<i>insulin aspart u-100</i>	T3	
<i>insulin degludec</i>	T4	
<i>insulin glargine u-300 conc</i>	T4	
<i>insulin glargine-yfgn</i>	T4	
<i>insulin lispro</i>	T3	
<i>insulin lispro protamin-lispro</i>	T3	
INVOKAMET	T3	QL (62 EA per 31 days)
INVOKAMET XR	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 100 MG	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 300 MG	T3	QL (31 EA per 31 days)
ISTURISA ORAL TABLET 1 MG	T5	PA; QL (248 EA per 31 days)
ISTURISA ORAL TABLET 5 MG	T5	PA; QL (62 EA per 31 days)
JANUMET	T3	QL (62 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	T3	QL (31 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	T3	QL (62 EA per 31 days)
JANUVIA ORAL TABLET 100 MG, 50 MG	T3	QL (31 EA per 31 days)
JANUVIA ORAL TABLET 25 MG	T3	QL (93 EA per 31 days)
JARDIANCE ORAL TABLET 10 MG	T3	QL (62 EA per 31 days)
JARDIANCE ORAL TABLET 25 MG	T3	QL (31 EA per 31 days)
JATENZO ORAL CAPSULE 158 MG, 198 MG	T4	PA; QL (124 EA per 31 days)
JATENZO ORAL CAPSULE 237 MG	T4	PA; QL (62 EA per 31 days)
JAVYGTOR	T5	PA
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG	T3	QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	T3	QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	T3	QL (31 EA per 31 days)
JYNARQUE ORAL TABLET	T5	PA; QL (112 EA per 28 days)
JYNARQUE ORAL TABLETS, SEQUENTIAL	T5	PA; QL (56 EA per 28 days)
KAZANO	T4	ST; QL (62 EA per 31 days)
KORLYM	T5	PA; QL (124 EA per 31 days)
KUVAN	T5	PA
LANTUS SOLOSTAR U-100 INSULIN	T3	
LANTUS U-100 INSULIN	T3	
LEVEMIR FLEXPEN	T3	
LEVEMIR U-100 INSULIN	T3	
<i>levothyroxine oral capsule</i>	T4	
<i>levothyroxine oral tablet</i>	T1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	T3	
<i>liothyronine oral</i>	T2	
<i>liraglutide</i>	T4	PA; QL (9 ML per 30 days)
LYUMJEV KWIKPEN U-100 INSULIN	T4	
LYUMJEV KWIKPEN U-200 INSULIN	T4	
LYUMJEV TEMPO PEN(U-100)INSULN	T4	
LYUMJEV U-100 INSULIN	T4	
MEDROL (PAK)	T4	
MEDROL ORAL TABLET 16 MG, 2 MG, 4 MG, 8 MG	T4	
<i>metformin oral solution</i>	T4	ST; QL (791 ML per 31 days)
<i>metformin oral tablet 1,000 mg, 500 mg, 850 mg</i>	T1	
<i>metformin oral tablet 625 mg</i>	T4	QL (124 EA per 31 days)
<i>metformin oral tablet extended release 24 hr</i>	T1	
<i>metformin oral tablet extended release 24hr 1,000 mg</i>	T4	ST; QL (62 EA per 31 days)
<i>metformin oral tablet extended release 24hr 500 mg</i>	T4	ST; QL (31 EA per 31 days)
<i>metformin oral tablet,er gast.retention 24 hr 1,000 mg</i>	T5	ST; QL (62 EA per 31 days)
<i>metformin oral tablet,er gast.retention 24 hr 500 mg</i>	T4	ST; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>methimazole oral tablet 10 mg, 5 mg</i>	T2	
METHITEST	T5	PA
<i>methylprednisolone</i>	T2	
<i>methyltestosterone oral capsule</i>	T5	PA
<i>mifepristone oral tablet 300 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>miglitol</i>	T2	
<i>miglustat</i>	T5	PA; QL (93 EA per 31 days)
MOUNJARO	T3	PA; QL (2 ML per 28 days)
MYALEPT	T5	PA
<i>nateglinide</i>	T1	QL (93 EA per 31 days)
NATESTO	T4	PA
NESINA	T4	ST; QL (31 EA per 31 days)
NOVOLIN 70/30 U-100 INSULIN	T3	
NOVOLIN 70-30 FLEXPEN U-100	T3	
NOVOLIN N FLEXPEN	T3	
NOVOLIN N NPH U-100 INSULIN	T3	
NOVOLIN R FLEXPEN	T3	
NOVOLIN R REGULAR U100 INSULIN	T3	
NOVOLOG FLEXPEN U-100 INSULIN	T3	
NOVOLOG MIX 70-30 U-100 INSULN	T3	
NOVOLOG MIX 70-30FLEXPEN U-100	T3	
NOVOLOG PENFILL U-100 INSULIN	T3	
NOVOLOG U-100 INSULIN ASPART	T3	
ORAPRED ODT	T4	
ORILISSA ORAL TABLET 150 MG	T5	PA; QL (31 EA per 31 days)
ORILISSA ORAL TABLET 200 MG	T5	PA; QL (62 EA per 31 days)
OSENI ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	T4	ST; QL (31 EA per 31 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	T3	PA; QL (3 ML per 28 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	T5	PA; QL (15 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	T5	PA; QL (4 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (90 ML per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>paricalcitol oral</i>	T2	PA-BvD
<i>pioglitazone</i>	T1	QL (31 EA per 31 days)
<i>pioglitazone-glimepiride</i>	T1	QL (31 EA per 31 days)
<i>pioglitazone-metformin</i>	T1	QL (93 EA per 31 days)
<i>prednisolone</i>	T2	
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	T2	
<i>prednisolone sodium phosphate oral tablet, disintegrating</i>	T2	
PREDNISON INTENSOL	T4	
<i>prednisone oral solution</i>	T2	
<i>prednisone oral tablet</i>	T1	
<i>prednisone oral tablets, dose pack</i>	T2	
PROGLYCEM	T4	
<i>propylthiouracil</i>	T2	
QTERN	T4	ST; QL (31 EA per 31 days)
RAYALDEE	T5	QL (62 EA per 31 days)
RAYOS	T5	
RECORLEV	T5	PA; QL (248 EA per 31 days)
<i>repaglinide oral tablet 0.5 mg</i>	T1	QL (124 EA per 31 days)
<i>repaglinide oral tablet 1 mg</i>	T2	QL (124 EA per 31 days)
<i>repaglinide oral tablet 2 mg</i>	T2	QL (248 EA per 31 days)
REZVOGLAR KWIKPEN	T4	
ROCALTROL	T4	PA-BvD
RYBELSUS	T3	PA; QL (31 EA per 31 days)
SAMSCA	T5	PA
<i>sapropterin</i>	T5	PA
<i>saxagliptin</i>	T4	ST; QL (31 EA per 31 days)
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg</i>	T4	ST; QL (62 EA per 31 days)
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg</i>	T4	ST; QL (31 EA per 31 days)
SEGLUROMET	T4	ST; QL (62 EA per 31 days)
SEMGLEE(INSULIN GLARGINE-YFGN)	T4	
SEMGLEE(INSULIN GLARG-YFGN)PEN	T4	
SENSIPAR ORAL TABLET 30 MG, 60 MG	T4	PA-BvD; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
SENSIPAR ORAL TABLET 90 MG	T5	PA-BvD; QL (124 EA per 31 days)
<i>sitagliptin oral tablet 100 mg, 50 mg</i>	T4	ST; QL (31 EA per 31 days)
<i>sitagliptin oral tablet 25 mg</i>	T4	ST; QL (93 EA per 31 days)
<i>sitagliptin-metformin</i>	T4	ST; QL (62 EA per 31 days)
SOLQUA 100/33	T3	QL (18 ML per 30 days)
SOMAVERT	T5	PA
STEGLATRO	T4	ST; QL (31 EA per 31 days)
STEGLUJAN	T4	ST; QL (31 EA per 31 days)
SYMLINPEN 120	T5	QL (10.8 ML per 28 days)
SYMLINPEN 60	T5	QL (6 ML per 28 days)
SYNAREL	T5	PA
SYNJARDY	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	T3	QL (31 EA per 31 days)
SYNTHROID	T3	
TAPERDEX	T4	
TARPEYO	T5	PA; QL (124 EA per 31 days)
TESTIM	T4	PA
<i>testosterone cypionate</i>	T2	PA
<i>testosterone enanthate</i>	T2	PA
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 12.5 mg/ 1.25 gram (1 %)</i>	T4	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 % (25 mg/2.5gram), 1 % (50 mg/5 gram)</i>	T4	PA
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)</i>	T3	PA
<i>testosterone transdermal solution in metered pump w/app</i>	T4	PA
THYQUIDITY	T4	
TIROSINT	T4	
TIROSINT-SOL	T4	
TLANDO	T4	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.

Drug Name	Drug Tier	Requirements/Limits
<i>tolvaptan</i>	T5	PA
TOUJEO MAX U-300 SOLOSTAR	T3	
TOUJEO SOLOSTAR U-300 INSULIN	T3	
TRADJENTA	T3	QL (31 EA per 31 days)
TRESIBA FLEXTOUCH U-100	T3	
TRESIBA FLEXTOUCH U-200	T3	
TRESIBA U-100 INSULIN	T3	
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	T3	QL (31 EA per 31 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	T3	QL (62 EA per 31 days)
TRULICITY	T3	PA; QL (2 ML per 28 days)
UNITHROID	T3	
VICTOZA 3-PAK	T3	PA; QL (9 ML per 30 days)
VOGELXO TRANSDERMAL GEL	T4	PA
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	T4	PA
VOXZOGO	T5	PA; QL (31 EA per 31 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 5-500 MG	T3	QL (31 EA per 31 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
XULTOPHY 100/3.6	T3	QL (15 ML per 30 days)
XYOSTED	T4	PA
YARGESA	T5	PA; QL (93 EA per 31 days)
ZAVESCA	T5	PA; QL (93 EA per 31 days)
ZEGALOGUE AUTOINJECTOR	T3	
ZEGALOGUE SYRINGE	T3	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	T4	PA-BvD
ZITUVIO ORAL TABLET 100 MG, 50 MG	T4	ST; QL (31 EA per 31 days)
ZITUVIO ORAL TABLET 25 MG	T4	ST; QL (93 EA per 31 days)
Gastroenterology		
ACIPHEX	T4	QL (62 EA per 31 days)
<i>alosetron oral tablet 0.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>alosetron oral tablet 1 mg</i>	T5	PA; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
AMITIZA	T4	QL (62 EA per 31 days)
<i>amoxicil-clarithromy-lansopraz</i>	T2	
ANTIVERT ORAL TABLET 50 MG	T4	
ANTIVERT ORAL TABLET,CHEWABLE	T4	
ANUSOL-HC TOPICAL	T4	
ANZEMET ORAL TABLET 50 MG	T4	PA-BvD
<i>aprepitant</i>	T4	PA-BvD
APRISO	T4	QL (124 EA per 31 days)
AZULFIDINE	T4	
AZULFIDINE EN-TABS	T4	
<i>balsalazide</i>	T2	
<i>betaine</i>	T5	
<i>bismuth subcit k-metronidz-tcn</i>	T4	
BONJESTA	T4	PA; QL (62 EA per 31 days)
<i>budesonide oral capsule,delayed,extend.release</i>	T4	
<i>budesonide oral tablet,delayed and ext.release</i>	T5	
<i>budesonide rectal</i>	T4	
BYLVAY ORAL CAPSULE 1,200 MCG	T5	PA; QL (186 EA per 31 days)
BYLVAY ORAL CAPSULE 400 MCG	T5	PA; QL (558 EA per 31 days)
BYLVAY ORAL PELLETT 200 MCG	T5	PA; QL (1116 EA per 31 days)
BYLVAY ORAL PELLETT 600 MCG	T5	PA; QL (372 EA per 31 days)
CANASA	T5	QL (31 EA per 31 days)
CARAFATE ORAL SUSPENSION	T3	
CARAFATE ORAL TABLET	T4	
CHENODAL	T5	PA
<i>chlordiazepoxide-clidinium</i>	T2	
CHOLBAM	T5	PA
<i>cimetidine</i>	T2	
CIMZIA POWDER FOR RECONST	T5	PA; QL (2 EA per 28 days)
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	T5	PA; QL (2 EA per 28 days)
CLENPIQ	T4	
COLAZAL	T5	
COMPRO	T2	
CONSTULOSE	T2	
CREON	T3	
<i>cromolyn oral</i>	T4	

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

Drug Name	Drug Tier	Requirements/Limits
CUVPOSA	T4	
CYSTADANE	T5	
CYTOTEC	T4	
DELZICOL	T4	QL (186 EA per 31 days)
DEXILANT	T4	QL (31 EA per 31 days)
<i>dexlansoprazole</i>	T4	QL (31 EA per 31 days)
DICLEGIS	T4	PA; QL (124 EA per 31 days)
<i>dicyclomine oral capsule</i>	T2	
<i>dicyclomine oral solution</i>	T2	
<i>dicyclomine oral tablet</i>	T2	
DIPENTUM	T5	
<i>diphenoxylate-atropine oral liquid</i>	T3	
<i>diphenoxylate-atropine oral tablet</i>	T2	
<i>doxylamine-pyridoxine (vit b6)</i>	T4	PA; QL (124 EA per 31 days)
<i>dronabinol oral capsule 10 mg</i>	T4	PA-BvD
<i>dronabinol oral capsule 2.5 mg, 5 mg</i>	T2	PA-BvD
EMEND ORAL CAPSULE 80 MG	T4	PA-BvD
EMEND ORAL CAPSULE,DOSE PACK	T4	PA-BvD
EMEND ORAL SUSPENSION FOR RECONSTITUTION	T4	PA-BvD
ENTYVIO PEN	T5	PA; QL (1.36 ML per 28 days)
ENULOSE	T2	
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec)</i>	T2	QL (31 EA per 31 days)
<i>esomeprazole magnesium oral granules dr for susp in packet</i>	T4	QL (31 EA per 31 days)
<i>famotidine oral suspension for reconstitution</i>	T1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
GASTROCROM	T4	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T2	
GAVILYTE-G	T2	
GENERLAC	T2	
GIMOTI	T5	PA; QL (9.8 ML per 28 days)
GLYCATE	T4	PA; QL (155 EA per 31 days)
<i>glycopyrrolate oral solution</i>	T4	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>glycopyrrolate oral tablet 1.5 mg</i>	T4	PA; QL (155 EA per 31 days)
GOLYTELY	T4	
<i>granisetron hcl oral</i>	T2	PA-BvD
HELIDAC	T4	
<i>hydrocortisone rectal</i>	T3	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	T1	
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	T4	
IBSRELA	T5	PA; QL (62 EA per 31 days)
IQIRVO	T5	PA; QL (31 EA per 31 days)
KONVOMEPI	T4	
KRISTALOSE	T4	ST
<i>lactulose oral packet</i>	T5	ST
<i>lactulose oral solution 10 gram/15 ml</i>	T1	
<i>lansoprazole oral capsule, delayed release(dr/ec) 15 mg</i>	T3	QL (31 EA per 31 days)
<i>lansoprazole oral capsule, delayed release(dr/ec) 30 mg</i>	T3	QL (62 EA per 31 days)
<i>lansoprazole oral tablet, disintegrat, delay rel 15 mg</i>	T3	QL (31 EA per 31 days)
<i>lansoprazole oral tablet, disintegrat, delay rel 30 mg</i>	T3	QL (62 EA per 31 days)
LIALDA	T4	QL (124 EA per 31 days)
LIBRAX (WITH CLIDINIUM)	T4	
LINZESS	T3	QL (31 EA per 31 days)
LIVMARLI ORAL SOLUTION 9.5 MG/ML	T5	PA; QL (93 ML per 31 days)
LOMOTIL	T4	
<i>loperamide oral capsule</i>	T2	
LOTRONEX ORAL TABLET 0.5 MG	T5	PA; QL (93 EA per 31 days)
LOTRONEX ORAL TABLET 1 MG	T5	PA; QL (62 EA per 31 days)
<i>lubiprostone</i>	T3	QL (62 EA per 31 days)
MARINOL ORAL CAPSULE 10 MG, 5 MG	T5	PA-BvD
MARINOL ORAL CAPSULE 2.5 MG	T4	PA-BvD
<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)

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

Drug Name	Drug Tier	Requirements/Limits
<i>mesalamine oral tablet, delayed release (dr/ec) 1.2 gram</i>	T3	QL (124 EA per 31 days)
<i>mesalamine oral tablet, delayed release (dr/ec) 800 mg</i>	T4	QL (186 EA per 31 days)
<i>mesalamine rectal enema</i>	T2	QL (1860 ML per 31 days)
<i>mesalamine rectal suppository</i>	T4	QL (31 EA per 31 days)
<i>methscopolamine</i>	T2	
<i>metoclopramide hcl oral solution</i>	T2	
<i>metoclopramide hcl oral tablet</i>	T2	
<i>metoclopramide hcl oral tablet, disintegrating 5 mg</i>	T2	
<i>misoprostol</i>	T2	
MOTEGRITY	T4	PA; QL (31 EA per 31 days)
MOVANTI	T3	QL (31 EA per 31 days)
MOVIPREP	T4	
MYTESI	T5	QL (62 EA per 31 days)
NEXIUM	T4	QL (31 EA per 31 days)
NEXIUM PACKET	T4	QL (31 EA per 31 days)
<i>nitroglycerin rectal</i>	T4	
<i>nizatidine oral capsule</i>	T2	
OCALIVA	T5	PA; QL (31 EA per 31 days)
<i>omeprazole oral capsule, delayed release (dr/ec)</i>	T1	
<i>omeprazole-sodium bicarbonate oral capsule</i>	T2	
<i>omeprazole-sodium bicarbonate oral packet</i>	T5	
OMVOH PEN	T5	PA; QL (2 ML per 28 days)
OMVOH SUBCUTANEOUS	T5	PA; QL (2 ML per 28 days)
<i>ondansetron hcl oral solution</i>	T2	PA-BvD
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	T2	PA-BvD
<i>ondansetron oral tablet, disintegrating 4 mg, 8 mg</i>	T2	PA-BvD
PANCREAZE ORAL CAPSULE, DELAYED RELEASE (DR/EC) 10,500-35,500- 61,500 UNIT, 16,800-56,800- 98,400 UNIT, 2,600- 8,800- 15,200 UNIT, 21,000-54,700- 83,900 UNIT, 37,000-97,300- 149,900 UNIT, 4,200- 14,200- 24,600 UNIT	T4	
<i>pantoprazole oral granules dr for susp in packet</i>	T4	
<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	

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

Drug Name	Drug Tier	Requirements/Limits
<i>peg-electrolyte soln</i>	T2	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	T3	QL (496 EA per 31 days)
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	T5	QL (248 EA per 31 days)
PEPCID ORAL TABLET	T4	
PERTZYE	T4	
PLENVU	T4	
PREVACID	T4	QL (62 EA per 31 days)
PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 15 MG	T4	QL (31 EA per 31 days)
PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 30 MG	T4	QL (62 EA per 31 days)
PRILOSEC ORAL SUSP,DELAYED RELEASE FOR RECON	T4	
<i>prochlorperazine</i>	T2	
<i>prochlorperazine maleate</i>	T2	
PROCTOFOAM HC	T4	
PROCTO-MED HC	T2	
PROCTOSOL HC TOPICAL	T2	
PROCTOZONE-HC	T2	
PROTONIX ORAL	T4	
PYLERA	T4	
<i>rabeprazole oral tablet, delayed release (dr/ec)</i>	T2	QL (62 EA per 31 days)
RECTIV	T4	
REGLAN ORAL	T4	
RELISTOR ORAL	T5	PA; QL (93 EA per 31 days)
RELISTOR SUBCUTANEOUS SOLUTION	T5	PA; QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	T5	PA; QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	T5	PA; QL (12.4 ML per 31 days)
RELTONE	T5	ST
ROBINUL FORTE	T4	
ROBINUL ORAL	T4	
ROWASA RECTAL ENEMA KIT	T4	QL (31 EA per 31 days)
<i>scopolamine base</i>	T3	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.

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	T5	PA; QL (1.2 ML per 56 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	T5	PA; QL (2.4 ML per 56 days)
<i>sodium,potassium,mag sulfates</i>	T3	
SUCRAID	T5	PA
<i>sucralfate</i>	T2	
SUFLAVE	T4	
<i>sulfasalazine</i>	T2	
SUPREP BOWEL PREP KIT	T4	
SUTAB	T4	
SYMPROIC	T4	PA; QL (31 EA per 31 days)
SYNDROS	T5	PA
TALICIA	T4	
TRANSDERM-SCOP	T3	QL (10 EA per 30 days)
<i>trimethobenzamide oral</i>	T2	PA
TRULANCE	T4	QL (31 EA per 31 days)
UCERIS ORAL	T5	
UCERIS RECTAL	T4	
URSO 250	T4	ST
URSO FORTE	T4	ST
<i>ursodiol oral capsule 200 mg, 400 mg</i>	T4	ST
<i>ursodiol oral capsule 300 mg</i>	T3	
<i>ursodiol oral tablet</i>	T3	
VARUBI	T4	PA-BvD
VELSIPITY	T5	PA; QL (31 EA per 31 days)
VIBERZI	T5	PA; QL (62 EA per 31 days)
VIOKACE ORAL TABLET 10,440-39,150-39,150 UNIT	T4	
VIOKACE ORAL TABLET 20,880-78,300-78,300 UNIT	T5	
VOQUEZNA DUAL PAK	T4	PA; QL (112 EA per 14 days)
VOQUEZNA ORAL TABLET 10 MG	T4	PA; QL (31 EA per 31 days)
VOQUEZNA ORAL TABLET 20 MG	T4	PA; QL (62 EA per 31 days)
VOQUEZNA TRIPLE PAK	T4	PA; QL (112 EA per 14 days)
VOWST	T5	PA; QL (12 EA per 14 days)
ZEGERID ORAL CAPSULE	T5	

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

Drug Name	Drug Tier	Requirements/Limits
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT	T3	
ZYMFENTRA	T5	PA; QL (1 EA per 28 days)
Immunology, Vaccines / Biotechnology		
ABRYSVO (PF)	T3	QL (2 EA per 365 days)
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	T4	PA-BvD; ST
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 200 MCG/ML	T5	PA-BvD; ST
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML	T4	PA-BvD; ST
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML, 60 MCG/0.3 ML	T5	PA-BvD; ST
ARCALYST	T5	PA
AREXVY (PF)	T3	QL (2 EA per 365 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	PA; QL (4 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	PA; QL (4 EA per 28 days)
<i>bcg vaccine, live (pf)</i>	T4	
BESREMI	T5	PA-NS; QL (2 ML per 28 days)
BETASERON SUBCUTANEOUS KIT	T5	PA; QL (14 EA per 28 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T3	
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
EGRIFTA SV	T5	PA
ENGERIX-B (PF)	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.

Drug Name	Drug Tier	Requirements/Limits
ENGERIX-B PEDIATRIC (PF)	T3	PA-BvD
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T4	PA-BvD; ST
FULPHILA	T5	
FYLNETRA	T5	ST
GAMMAGARD LIQUID	T5	PA
GAMMAGARD S-D (IGA < 1 MCG/ML)	T5	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GAMMAPLEX	T5	PA
GAMMAPLEX (WITH SORBITOL)	T5	PA
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GARDASIL 9 (PF)	T3	
GENOTROPIN	T5	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	T4	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML	T5	PA
GRANIX	T5	ST
GRASTEK	T4	PA
HAVRIX (PF)	T3	
HEPLISA V-B (PF)	T3	PA-BvD
HIBERIX (PF)	T3	
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT)	T5	PA
HUMATROPE INJECTION CARTRIDGE 6 MG (18 UNIT)	T4	PA
IMOVAX RABIES VACCINE (PF)	T3	PA-BvD
INFANRIX (DTAP) (PF)	T3	
IPOL	T3	
IXCHIQ (PF)	T3	
IXIARO (PF)	T3	
JYNNEOS (PF)	T3	PA-BvD

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

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

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

Drug Name	Drug Tier	Requirements/Limits
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	T5	PA-BvD
PROQUAD (PF)	T3	
QUADRACEL (PF)	T3	
RABAVERT (PF)	T3	PA-BvD
REBIF (WITH ALBUMIN)	T5	PA; QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	T5	PA; QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	T5	PA; QL (4.2 ML per 365 days)
REBIF TITRATION PACK	T5	PA; QL (8.4 ML per 365 days)
RECOMBIVAX HB (PF)	T3	PA-BvD
RELEUKO SUBCUTANEOUS	T5	ST
RETACRIT	T3	PA-BvD
ROTARIX	T3	
ROTATEQ VACCINE	T3	
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	T5	PA
SHINGRIX (PF)	T3	QL (2 EA per 999 days)
SKYTROFA	T5	PA
SOGROYA	T5	PA
STIMUFEND	T5	ST
TDVAX	T3	
TENIVAC (PF)	T3	
<i>tetanus, diphtheria tox ped(pf)</i>	T4	
TICOVAC	T3	
TRUMENBA	T3	
TWINRIX (PF)	T3	
TYPHIM VI	T3	
UDENYCA	T5	ST
UDENYCA AUTOINJECTOR	T5	ST
VAQTA (PF)	T3	
VARIVAX (PF)	T3	
XOLREMDI	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.

Drug Name	Drug Tier	Requirements/Limits
YF-VAX (PF)	T3	
ZARXIO	T5	
ZIEXTENZO	T5	
ZOMACTON	T4	PA
Miscellaneous Supplies		
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T2	
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge</i>	T3	
<i>pen needle, diabetic needle 29 gauge x 1/2"</i>	T4	
Musculoskeletal / Rheumatology		
ABRILADA(CF)	T5	PA; QL (2 EA per 28 days)
ABRILADA(CF) PEN	T5	PA; QL (2 EA per 28 days)
ACTEMRA ACTPEN	T5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
ACTONEL ORAL TABLET 150 MG, 35 MG	T4	
<i>adalimumab-aacf subcutaneous pen injector kit</i>	T5	PA; QL (2 EA per 28 days)
<i>adalimumab-aaty</i>	T5	PA; QL (2 EA per 28 days)
<i>adalimumab-adaz</i>	T5	PA; QL (0.8 ML per 28 days)
<i>adalimumab-adbm subcutaneous pen injector kit 40 mg/0.4 ml</i>	T5	PA; QL (2 EA per 28 days)
<i>adalimumab-adbm subcutaneous pen injector kit 40 mg/0.8 ml</i>	T5	PA; QL (1.6 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 10 mg/0.2 ml</i>	T5	PA; QL (0.4 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 20 mg/0.4 ml</i>	T5	PA; QL (0.8 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 40 mg/0.4 ml</i>	T5	PA; QL (2 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 40 mg/0.8 ml</i>	T5	PA; QL (1.6 EA per 28 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	T5	PA; QL (12 EA per 365 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	T5	PA; QL (9.6 EA per 365 days)

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

Drug Name	Drug Tier	Requirements/Limits
ADALIMUMAB-ADBM(CF) PEN PS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	T5	PA; QL (8 EA per 365 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	T5	PA; QL (6.4 EA per 365 days)
<i>adalimumab-fkjp subcutaneous pen injector kit</i>	T5	PA; QL (2 EA per 28 days)
<i>adalimumab-fkjp subcutaneous syringe kit</i>	T5	PA; QL (2 EA per 28 days)
<i>adalimumab-ryvk subcutaneous auto-injector, kit</i>	T5	PA; QL (2 EA per 28 days)
<i>alendronate oral solution</i>	T1	
<i>alendronate oral tablet 10 mg, 35 mg, 70 mg</i>	T1	
<i>allopurinol oral tablet 100 mg, 300 mg</i>	T1	
<i>allopurinol oral tablet 200 mg</i>	T4	
AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.8 ML	T5	PA; QL (1.6 EA per 28 days)
AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 80 MG/0.8 ML	T5	PA; QL (1.6 ML per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML, 20 MG/0.2 ML	T5	PA; QL (0.4 ML per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 20 MG/0.4 ML	T5	PA; QL (0.8 EA per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 40 MG/0.8 ML	T5	PA; QL (1.6 EA per 28 days)
ARAVA	T5	
AELVIA	T4	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
BINOSTO	T4	
<i>colchicine oral capsule</i>	T3	QL (62 EA per 31 days)
<i>colchicine oral tablet</i>	T4	QL (62 EA per 31 days)
COLCRYS	T4	QL (124 EA per 31 days)
CUPRIMINE	T5	
CYLTEZO(CF)	T5	PA; QL (2 EA per 28 days)
CYLTEZO(CF) PEN	T5	PA; QL (2 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
CYLTEZO(CF) PEN CROHN'S-UC-HS	T5	PA; QL (12 EA per 365 days)
CYLTEZO(CF) PEN PSORIASIS-UV	T5	PA; QL (8 EA per 365 days)
DEPEN TITRATABS	T5	
ENBREL MINI	T5	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)	T5	PA; QL (8 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (8 ML per 28 days)
EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	T5	PA; QL (2.34 ML per 28 days)
EVISTA	T3	
<i>febuxostat</i>	T4	PA
FORTEO	T5	PA; QL (2.4 ML per 28 days)
FOSAMAX ORAL TABLET 70 MG	T4	
FOSAMAX PLUS D	T4	
GLOPERBA	T4	QL (300 ML per 30 days)
HADLIMA	T5	PA; QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH	T5	PA; QL (1.6 ML per 28 days)
HADLIMA(CF)	T5	PA; QL (0.8 ML per 28 days)
HADLIMA(CF) PUSHTOUCH	T5	PA; QL (0.8 ML per 28 days)
HULIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT	T5	PA; QL (2 EA per 28 days)
HULIO(CF) SUBCUTANEOUS SYRINGE KIT	T5	PA; QL (2 EA per 28 days)
HUMIRA PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF)	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEN PEDIATRIC UC	T5	PA; QL (4 EA per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA; QL (3 EA per 28 days)
HYRIMOZ PEN CROHN'S-UC STARTER	T5	PA; QL (4.8 ML per 365 days)
HYRIMOZ PEN PSORIASIS STARTER	T5	PA; QL (3.2 ML per 365 days)
HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML	T5	PA; QL (4.8 ML per 365 days)

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

Drug Name	Drug Tier	Requirements/Limits
HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML-40 MG/0.4 ML	T5	PA; QL (2.4 ML per 365 days)
HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 80 MG/0.8 ML	T5	PA; QL (1.6 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML	T5	PA; QL (0.2 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML	T5	PA; QL (0.4 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
<i>ibandronate oral</i>	T2	
IDACIO(CF)	T5	PA; QL (2 EA per 28 days)
IDACIO(CF) PEN CROHN-UC STARTR	T5	PA; QL (12 EA per 365 days)
IDACIO(CF) PEN PSORIASIS START	T5	PA; QL (8 EA per 365 days)
IDACIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT	T5	PA; QL (2 EA per 28 days)
KEVZARA	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
<i>leflunomide</i>	T2	
MITIGARE	T3	QL (62 EA per 31 days)
OLUMIANT	T5	PA; QL (31 EA per 31 days)
ORENCIA CLICKJECT	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	T5	PA; QL (2.8 ML per 28 days)
OTEZLA ORAL TABLET 30 MG	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (55 EA per 28 days)
OTREXUP (PF)	T4	PA
<i>penicillamine</i>	T5	
<i>probenecid</i>	T2	
<i>probenecid-colchicine</i>	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)
<i>raloxifene</i>	T3	

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

Drug Name	Drug Tier	Requirements/Limits
RASUVO (PF)	T4	PA
RIDAURA	T5	
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	T5	PA; QL (31 EA per 31 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	T5	PA; QL (168 EA per 365 days)
<i>risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg</i>	T3	
<i>risedronate oral tablet, delayed release (dr/ec)</i>	T3	
SAVELLA	T4	PA
SIMLANDI(CF) AUTOINJECTOR	T5	PA; QL (2 EA per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
<i>teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)</i>	T5	PA; QL (2.48 ML per 28 days)
TYENNE AUTOINJECTOR	T5	PA; QL (3.6 ML per 28 days)
TYENNE SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
TYMLOS	T5	PA; QL (1.56 ML per 30 days)
ULORIC	T4	PA
XELJANZ ORAL SOLUTION	T5	PA; QL (310 ML per 31 days)
XELJANZ ORAL TABLET	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
YUFLYMA(CF)	T5	PA; QL (2 EA per 28 days)
YUFLYMA(CF) AI CROHN'S-UC-HS	T5	PA; QL (6 EA per 365 days)
YUFLYMA(CF) AUTOINJECTOR	T5	PA; QL (2 EA per 28 days)
YUSIMRY(CF) PEN	T5	PA; QL (1.6 ML per 28 days)
Obstetrics / Gynecology		
ACTIVELLA	T4	
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
AMETHIA	T2	
ANGELIQ	T4	

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

Drug Name	Drug Tier	Requirements/Limits
ANNOVERA	T4	
APRI	T2	
ARANELLE (28)	T2	
ASHLYNA	T2	
AUBRA EQ	T2	
AVIANE	T2	
BALCOLTRA	T4	
BALZIVA (28)	T2	
BEYAZ	T4	
BIJUVA	T4	
BLISOVI 24 FE	T2	
BLISOVI FE 1.5/30 (28)	T2	
BRIELLYN	T2	
CAMILA	T2	
CAMRESE LO	T2	
CLEOCIN VAGINAL	T4	
CLIMARA	T4	
CLIMARA PRO	T4	
<i>clindamycin phosphate vaginal</i>	T2	
CLINDESSE	T4	
COMBIPATCH	T4	
CRINONE	T4	PA
CRYSELLE (28)	T2	
CYRED EQ	T2	
DEBLITANE	T2	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML	T4	
DEPO-ESTRADIOL	T4	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	T4	
DEPO-PROVERA INTRAMUSCULAR SYRINGE	T4	
DEPO-SUBQ PROVERA 104	T4	
<i>desog-e.estradiol/e.estradiol</i>	T2	
<i>desogestrel-ethinyl estradiol</i>	T2	
DIVIGEL	T4	
DOLISHALE	T2	

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

Drug Name	Drug Tier	Requirements/Limits
DOTTI	T2	
<i>drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4)</i>	T2	
<i>drospirenone-ethinyl estradiol</i>	T2	
DUAVEE	T4	
ELESTRIN	T4	
ELURYNG	T3	
ENILLORING	T4	
ENPRESSE	T2	
ENSKYCE	T2	
ERRIN	T2	
ESTARYLLA	T2	
ESTRACE	T4	
<i>estradiol oral</i>	T1	
<i>estradiol transdermal gel in metered-dose pump</i>	T4	
<i>estradiol transdermal gel in packet</i>	T4	
<i>estradiol transdermal patch semiweekly</i>	T2	
<i>estradiol transdermal patch weekly</i>	T2	
<i>estradiol vaginal</i>	T4	
<i>estradiol valerate</i>	T2	
<i>estradiol-norethindrone acet</i>	T2	
ESTRING	T4	
ESTROGEL	T4	
<i>ethynodiol diac-eth estradiol</i>	T2	
<i>etonogestrel-ethinyl estradiol</i>	T3	
EVAMIST	T4	
FALMINA (28)	T2	
FEMRING	T4	
FINZALA	T2	
FYAVOLV	T2	
GEMMILY	T4	
GYNAZOLE-1	T3	
HAILEY 24 FE	T2	
HALOETTE	T3	
HEATHER	T2	
ICLEVIA	T2	
IMVEXXY MAINTENANCE PACK	T3	

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

Drug Name	Drug Tier	Requirements/Limits
IMVEXXY STARTER PACK	T3	
INCASSIA	T2	
INTRAROSA	T4	PA; QL (28 EA per 28 days)
INTROVALE	T2	
ISIBLOOM	T2	
JASMIEL (28)	T2	
JINTELI	T2	
JOYEAUX	T4	
JULEBER	T2	
JUNEL 1.5/30 (21)	T2	
JUNEL 1/20 (21)	T2	
JUNEL FE 1.5/30 (28)	T2	
JUNEL FE 1/20 (28)	T2	
JUNEL FE 24	T2	
KAITLIB FE	T2	
KARIVA (28)	T2	
KELNOR 1/35 (28)	T2	
KELNOR 1/50 (28)	T2	
KURVELO (28)	T2	
KYLEENA	T4	
<i>l norgest/e.estradiol-e.estrad</i>	T2	
LARIN 1.5/30 (21)	T2	
LARIN 1/20 (21)	T2	
LARIN FE 1.5/30 (28)	T2	
LARIN FE 1/20 (28)	T2	
LAYOLIS FE	T4	
LEENA 28	T2	
LESSINA	T2	
LEVONEST (28)	T2	
<i>levonorgestrel-ethinyl estrad</i>	T2	
<i>levonorg-eth estrad triphasic</i>	T2	
LEVORA-28	T2	
LILETTA	T4	
LO LOESTRIN FE	T4	
LOESTRIN 1.5/30 (21)	T4	
LOESTRIN 1/20 (21)	T4	
LOESTRIN FE 1.5/30 (28-DAY)	T4	

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

Drug Name	Drug Tier	Requirements/Limits
LOESTRIN FE 1/20 (28-DAY)	T4	
LORYNA (28)	T2	
LOW-OGESTREL (28)	T2	
LUTERA (28)	T2	
LYLEQ	T2	
LYLLANA	T2	
LYZA	T2	
MARLISSA (28)	T2	
<i>medroxyprogesterone</i>	T2	
MENEST	T4	
MENOSTAR	T4	
MERZEE	T4	
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	T2	
MIBELAS 24 FE	T2	
MICONAZOLE-3 VAGINAL SUPPOSITORY	T2	
MICROGESTIN 1.5/30 (21)	T2	
MICROGESTIN 1/20 (21)	T2	
MICROGESTIN 24 FE	T4	
MICROGESTIN FE 1.5/30 (28)	T2	
MICROGESTIN FE 1/20 (28)	T2	
MILI	T2	
MIMVEY	T2	
MINIVELLE	T4	
MIRENA	T4	
MYFEMBREE	T5	PA; QL (31 EA per 31 days)
NATAZIA	T4	
NECON 0.5/35 (28)	T2	
NEXPLANON	T4	
NEXTSTELLIS	T4	
NIKKI (28)	T2	
NORA-BE	T2	
<i>norelgestromin-ethin.estradiol</i>	T2	
<i>noreth-ethinyl estradiol-iron</i>	T2	
<i>norethindrone (contraceptive)</i>	T2	
<i>norethindrone acetate</i>	T2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-20 mg-mcg, 1-5 mg-mcg</i>	T2	
<i>norethindrone-e.estradiol-iron oral capsule</i>	T4	
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1-20(5)/1-30(7) /1mg-35mcg (9)</i>	T2	
<i>norethindrone-e.estradiol-iron oral tablet, chewable</i>	T2	
<i>norgestimate-ethinyl estradiol</i>	T2	
NORTREL 0.5/35 (28)	T2	
NORTREL 1/35 (21)	T2	
NORTREL 1/35 (28)	T2	
NORTREL 7/7/7 (28)	T2	
NUVARING	T4	
NUVESSA	T4	
NYLIA 1/35 (28)	T2	
NYLIA 7/7/7 (28)	T2	
NYMYO	T2	
OCELLA	T2	
ORIAHNN	T5	PA; QL (56 EA per 28 days)
OSPHENA	T4	PA; QL (31 EA per 31 days)
PHEXXI	T4	
PIMTREA (28)	T2	
PORTIA 28	T2	
PREMARIN ORAL	T4	
PREMARIN VAGINAL	T3	
PREMPHASE	T4	
PREMPRO	T4	
<i>progesterone micronized</i>	T2	
PROMETRIUM	T4	
PROVERA	T4	
QUARTETTE	T4	
RECLIPSEN (28)	T2	
RIVELSA	T4	
SAFYRAL	T4	
SETLAKIN	T2	
SHAROBEL	T2	
SKYLA	T4	

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

Drug Name	Drug Tier	Requirements/Limits
SLYND	T4	
SPRINTEC (28)	T2	
SRONYX	T2	
SYEDA	T2	
TARINA 24 FE	T2	
TARINA FE 1-20 EQ (28)	T2	
<i>terconazole</i>	T2	
TILIA FE	T2	
<i>tranexamic acid oral</i>	T2	
TRI-ESTARYLLA	T2	
TRI-LEGEST FE	T2	
TRI-LO-ESTARYLLA	T2	
TRI-LO-SPRINTEC	T2	
TRI-MILI	T2	
TRI-NYMYO	T2	
TRI-SPRINTEC (28)	T2	
TRIVORA (28)	T2	
TRI-VYLIBRA	T2	
TRI-VYLIBRA LO	T2	
TURQOZ (28)	T2	
TYBLUME	T4	
TYDEMY	T2	
VAGIFEM	T4	
VANDAZOLE	T3	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VEOZAH	T4	PA; QL (31 EA per 31 days)
VESTURA (28)	T2	
VIENVA	T2	
VIVELLE-DOT	T4	
VYFEMLA (28)	T2	
VYLIBRA	T2	
WYMZYA FE	T2	
XACIATO	T4	
XULANE	T2	
YASMIN (28)	T4	
YAZ (28)	T4	
YUVAFEM	T4	

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

Drug Name	Drug Tier	Requirements/Limits
ZAFEMY	T2	
ZOVIA 1-35 (28)	T2	
Ophthalmology		
<i>acetazolamide</i>	T2	
ACULAR	T4	
ACULAR LS	T4	
ACUVAIL (PF)	T4	
ALOMIDE	T4	
ALPHAGAN P	T3	
ALREX	T4	
<i>apraclonidine</i>	T2	
<i>atropine ophthalmic (eye) drops 1 %</i>	T2	
AZASITE	T4	
<i>azelastine ophthalmic (eye)</i>	T2	
AZOPT	T4	
<i>bacitracin ophthalmic (eye)</i>	T2	
<i>bacitracin-polymyxin b</i>	T2	
<i>bepotastine besilate</i>	T4	
BEPREVE	T4	
BESIVANCE	T4	
<i>betaxolol ophthalmic (eye)</i>	T2	
BETIMOL	T4	
BETOPTIC S	T4	
<i>bimatoprost ophthalmic (eye)</i>	T2	
<i>brimonidine ophthalmic (eye) drops 0.1 %</i>	T3	
<i>brimonidine ophthalmic (eye) drops 0.15 %, 0.2 %</i>	T2	
<i>brimonidine-timolol</i>	T3	
<i>brinzolamide</i>	T4	
<i>bromfenac ophthalmic (eye) drops 0.07 %, 0.075 %</i>	T4	
<i>bromfenac ophthalmic (eye) drops 0.09 %</i>	T2	
BROMSITE	T4	
<i>carteolol</i>	T2	
CEQUA	T4	ST; QL (60 EA per 30 days)
CILOXAN OPHTHALMIC (EYE) OINTMENT	T3	

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

Drug Name	Drug Tier	Requirements/Limits
<i>ciprofloxacin hcl ophthalmic (eye)</i>	T1	
COMBIGAN	T3	
COSOPT	T4	
COSOPT (PF)	T4	
<i>cromolyn ophthalmic (eye)</i>	T2	
<i>cyclosporine ophthalmic (eye)</i>	T3	QL (60 EA per 30 days)
CYSTADROPS	T5	PA; QL (20 ML per 28 days)
CYSTARAN	T5	PA; QL (60 ML per 28 days)
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	T2	
<i>diclofenac sodium ophthalmic (eye)</i>	T1	
<i>difluprednate</i>	T4	
<i>dorzolamide</i>	T2	
<i>dorzolamide-timolol</i>	T2	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	T4	
DUREZOL	T4	
<i>epinastine</i>	T2	
<i>erythromycin ophthalmic (eye)</i>	T2	
EYSUVIS	T4	QL (8.3 ML per 30 days)
FLAREX	T4	
<i>fluorometholone</i>	T2	
<i>flurbiprofen sodium</i>	T2	
FML FORTE	T4	
FML LIQUIFILM	T4	
<i>gatifloxacin</i>	T3	
<i>gentamicin ophthalmic (eye) drops</i>	T1	
ILEVRO	T3	
INVELTYS	T4	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	T4	
ISTALOL	T4	
IYUZEH (PF)	T4	ST; QL (30 EA per 30 days)
<i>ketorolac ophthalmic (eye)</i>	T2	
<i>latanoprost</i>	T1	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	T1	
<i>levofloxacin ophthalmic (eye) drops 0.5 %</i>	T2	

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

Drug Name	Drug Tier	Requirements/Limits
LOTEMAX	T4	
LOTEMAX SM	T4	
<i>loteprednol etabonate</i>	T4	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
MAXIDEX	T4	
MAXITROL	T4	
<i>methazolamide</i>	T2	
MIEBO (PF)	T5	ST; QL (9 ML per 30 days)
<i>moxifloxacin ophthalmic (eye) drops</i>	T3	
NATACYN	T3	
<i>neomycin-bacitracin-poly-hc</i>	T2	
<i>neomycin-bacitracin-polymyxin</i>	T2	
<i>neomycin-polymyxin b-dexameth</i>	T2	
<i>neomycin-polymyxin-gramicidin</i>	T2	
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	T2	
NEO-POLYCIN	T2	
NEO-POLYCIN HC	T2	
NEVANAC	T4	
OCUFLOX	T4	
<i>ofloxacin ophthalmic (eye)</i>	T2	
OXERVATE	T5	PA; QL (112 ML per 56 days)
PHOSPHOLINE IODIDE	T5	PA; QL (5 ML per 25 days)
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T2	
POLYCIN	T2	
<i>polymyxin b sulf-trimethoprim</i>	T1	
PRED FORTE	T4	
PRED MILD	T4	
<i>prednisolone acetate</i>	T1	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	T2	
PROLENSA	T4	
RESTASIS	T3	QL (60 EA per 30 days)
RESTASIS MULTIDOSE	T3	QL (5.5 ML per 27 days)
RHOPRESSA	T4	ST
ROCKLATAN	T4	ST
SIMBRINZA	T4	

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

Drug Name	Drug Tier	Requirements/Limits
<i>sulfacetamide sodium ophthalmic (eye) drops</i>	T2	
<i>sulfacetamide sodium ophthalmic (eye) ointment</i>	T1	
<i>sulfacetamide-prednisolone</i>	T2	
<i>tafluprost (pf)</i>	T4	
<i>timolol maleate (pf)</i>	T4	
<i>timolol maleate ophthalmic (eye) drops</i>	T1	
<i>timolol maleate ophthalmic (eye) drops, once daily</i>	T2	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	T2	
TIMOPTIC OCUDOSE (PF)	T4	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
TOBRADEX ST	T3	
<i>tobramycin ophthalmic (eye)</i>	T1	
<i>tobramycin-dexamethasone</i>	T2	
TOBEX OPHTHALMIC (EYE) OINTMENT	T3	
TRAVATAN Z	T4	
<i>travoprost</i>	T3	
<i>trifluridine</i>	T2	
TYRVAYA	T4	ST; QL (8.4 ML per 30 days)
VERKAZIA	T5	PA; QL (120 EA per 30 days)
VEVYE	T4	ST; QL (2 ML per 50 days)
VIGAMOX	T4	
VUITY	T4	PA; QL (5 ML per 25 days)
VYZULTA	T4	ST; QL (5 ML per 31 days)
XALATAN	T4	
XDEMVIY	T5	PA; QL (10 ML per 42 days)
XELPROS	T4	
XIIDRA	T3	QL (60 EA per 30 days)
ZERVIAE	T4	
ZIOPTAN (PF)	T4	
ZIRGAN	T4	ST
ZYLET	T4	
Respiratory And Allergy		
<i>acetylcysteine</i>	T2	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
ADCIRCA	T5	PA; QL (62 EA per 31 days)
ADEMPAS	T5	PA; QL (93 EA per 31 days)
ADVAIR DISKUS	T4	QL (60 EA per 30 days)
ADVAIR HFA	T4	QL (12 GM per 30 days)
AIRDUO RESPICLICK	T4	QL (1 EA per 30 days)
AIRSUPRA	T4	ST; QL (32.1 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	T3	QL (17 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)</i>	T3	QL (13.4 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)</i>	T4	ST; QL (36 GM per 30 days)
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml</i>	T2	PA-BvD
<i>albuterol sulfate oral syrup</i>	T1	
<i>albuterol sulfate oral tablet</i>	T1	
ALVESCO	T4	QL (12.2 GM per 30 days)
ALYQ	T5	PA; QL (62 EA per 31 days)
<i>ambrisentan</i>	T5	PA; QL (31 EA per 31 days)
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
<i>arformoterol</i>	T4	PA-BvD
ARNUTY ELLIPTA	T4	QL (30 EA per 30 days)
ASMANEX HFA	T3	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	T3	QL (1 EA per 30 days)
ATROVENT HFA	T3	QL (25.8 GM per 30 days)
<i>azelastine-fluticasone</i>	T4	QL (23 GM per 30 days)
BERINERT INTRAVENOUS KIT	T5	PA
BEVESPI AEROSPHERE	T4	QL (10.7 GM per 30 days)
<i>bosentan</i>	T5	PA; QL (62 EA per 31 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BREYNA	T3	QL (10.3 GM per 30 days)
BREZTRI AEROSPHERE	T3	QL (10.7 GM per 30 days)
BRONCHITOL	T5	PA; QL (560 EA per 28 days)
BROVANA	T4	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
<i>budesonide inhalation</i>	T2	PA-BvD
<i>budesonide-formoterol</i>	T3	QL (10.2 GM per 30 days)
<i>carbinoxamine maleate oral liquid</i>	T4	PA
<i>carbinoxamine maleate oral tablet</i>	T4	PA
<i>cetirizine oral solution 1 mg/ml</i>	T1	QL (310 ML per 31 days)
CINRYZE	T5	PA; QL (20 EA per 28 days)
CLARINEX ORAL TABLET	T4	QL (31 EA per 31 days)
CLARINEX-D 12 HOUR	T4	
<i>clemastine oral syrup</i>	T2	PA
<i>clemastine oral tablet</i>	T2	
COMBIVENT RESPIMAT	T3	QL (4 GM per 30 days)
<i>cromolyn inhalation</i>	T5	PA-BvD
<i>cyproheptadine</i>	T2	PA
DALIRESP	T4	QL (31 EA per 31 days)
<i>desloratadine</i>	T2	QL (31 EA per 31 days)
DUAKLIR PRESSAIR	T5	QL (1 EA per 30 days)
DULERA	T4	QL (13 GM per 30 days)
DYMISTA	T4	ST; QL (23 GM per 30 days)
<i>epinephrine injection auto-injector</i>	T3	
EPIPEN 2-PAK	T4	
EPIPEN JR 2-PAK	T4	
ESBRIET ORAL CAPSULE	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET	T5	PA; QL (93 EA per 31 days)
FASENRA PEN	T5	PA; QL (1 ML per 56 days)
FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	T5	PA; QL (0.5 ML per 56 days)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	T5	PA; QL (1 ML per 56 days)
FIRAZYR	T5	PA; QL (18 ML per 30 days)
<i>flunisolide</i>	T2	QL (50 ML per 25 days)
<i>fluticasone furoate-vilanterol</i>	T4	ST; QL (60 EA per 30 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)

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

Drug Name	Drug Tier	Requirements/Limits
<i>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)
<i>fluticasone propion-salmeterol inhalation hfa aerosol inhaler</i>	T4	QL (12 GM per 30 days)
<i>formoterol fumarate</i>	T4	PA-BvD
HAEGARDA	T5	PA
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	T2	PA
<i>hydroxyzine hcl oral tablet</i>	T2	PA
<i>hydroxyzine pamoate</i>	T2	PA
<i>icatibant</i>	T5	PA; QL (18 ML per 30 days)
INCRUSE ELLIPTA	T4	ST; QL (30 EA per 30 days)
<i>ipratropium bromide inhalation</i>	T1	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 5.8 MG, 50 MG, 75 MG	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL GRANULES IN PACKET 25 MG	T5	PA; QL (62 EA per 31 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
LETAIRIS	T5	PA; QL (31 EA per 31 days)
<i>levalbuterol hcl</i>	T2	PA-BvD
<i>levalbuterol tartrate</i>	T3	QL (30 GM per 30 days)
<i>levocetirizine oral solution</i>	T2	QL (310 ML per 31 days)
<i>levocetirizine oral tablet</i>	T1	QL (31 EA per 31 days)
LIQREV	T5	PA; QL (744 ML per 31 days)
<i>mometasone nasal</i>	T3	QL (34 GM per 30 days)
<i>montelukast</i>	T2	QL (31 EA per 31 days)
NUCALA SUBCUTANEOUS AUTO-INJECTOR	T5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN	T5	PA; QL (3 EA per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.4 ML per 28 days)
OFEV	T5	PA; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
OHTUVAYRE	T5	PA; QL (150 ML per 30 days)
OMNARIS	T4	QL (12.5 GM per 30 days)
OPSUMIT	T5	PA; QL (31 EA per 31 days)
OPSYNVI	T5	PA; QL (31 EA per 31 days)
ORKAMBI ORAL GRANULES IN PACKET	T5	PA; QL (62 EA per 31 days)
ORKAMBI ORAL TABLET	T5	PA; QL (124 EA per 31 days)
ORLADEYO	T5	PA; QL (31 EA per 31 days)
PERFOROMIST	T4	PA-BvD
<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)
PROAIR RESPICLICK	T4	ST; QL (2 EA per 30 days)
<i>promethazine oral</i>	T2	PA
<i>promethazine rectal suppository 12.5 mg, 25 mg</i>	T2	
PROMETHEGAN RECTAL SUPPOSITORY 25 MG, 50 MG	T2	
PULMICORT	T4	PA-BvD
PULMICORT FLEXHALER	T4	QL (1 EA per 30 days)
PULMOZYME	T5	PA
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION	T4	QL (6.8 GM per 30 days)
QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION	T4	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	T3	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	T3	QL (21.2 GM per 30 days)
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	T5	PA; QL (784 ML per 31 days)
REVATIO ORAL TABLET	T5	PA; QL (372 EA per 31 days)
<i>roflumilast oral tablet 250 mcg</i>	T4	QL (31 EA per 31 days)
<i>roflumilast oral tablet 500 mcg</i>	T3	QL (31 EA per 31 days)
RUCONEST	T5	PA
RYALTRIS	T4	ST; QL (29 GM per 30 days)
RYCLORA	T4	
RYVENT	T4	PA
SAJAZIR	T5	PA; QL (18 ML per 30 days)
SEREVENT DISKUS	T3	QL (60 EA per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
<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)
SINGULAIR	T4	QL (31 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER	T3	QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T3	QL (4 GM per 30 days)
SYMBICORT	T4	ST; QL (10.2 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
<i>tadalafil (pulm. hypertension)</i>	T5	PA; QL (62 EA per 31 days)
TADLIQ	T5	PA; QL (310 ML per 31 days)
TAKHZYRO SUBCUTANEOUS SOLUTION	T5	PA; QL (4 ML per 28 days)
TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (2 ML per 28 days)
TAKHZYRO SUBCUTANEOUS SYRINGE 300 MG/2 ML (150 MG/ML)	T5	PA; QL (4 ML per 28 days)
<i>terbutaline oral</i>	T2	
THEO-24	T4	
<i>theophylline oral solution</i>	T2	
<i>theophylline oral tablet extended release 12 hr</i>	T2	
<i>theophylline oral tablet extended release 24 hr</i>	T2	
<i>tiotropium bromide</i>	T3	QL (30 EA per 30 days)
TRACLEER ORAL TABLET	T5	PA; QL (62 EA per 31 days)
TRACLEER ORAL TABLET FOR SUSPENSION	T5	PA; QL (124 EA per 31 days)
TRELEGY ELLIPTA	T3	QL (60 EA per 30 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	T5	PA; QL (56 EA per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	T5	PA; QL (84 EA per 28 days)
TUDORZA PRESSAIR	T4	ST; QL (1 EA per 30 days)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 32 MCG, 32-48 MCG, 48 MCG, 64 MCG	T5	PA
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16(112)-32(112) -48(28) MCG	T5	PA; QL (504 EA per 365 days)
VENTOLIN HFA	T3	QL (36 GM per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
VISTARIL ORAL CAPSULE 25 MG	T4	PA
WINREVAIR	T5	PA
WIXELA INHUB	T3	QL (60 EA per 30 days)
XHANCE	T4	QL (32 ML per 30 days)
XOLAIR	T5	PA
XOPENEX HFA	T4	ST; QL (30 GM per 30 days)
YUPELRI	T5	PA-BvD
<i>zafirlukast oral tablet 10 mg</i>	T2	QL (93 EA per 31 days)
<i>zafirlukast oral tablet 20 mg</i>	T2	QL (62 EA per 31 days)
<i>zileuton</i>	T5	PA; QL (124 EA per 31 days)
ZYFLO	T5	PA; QL (124 EA per 31 days)
Urologicals		
<i>alfuzosin</i>	T2	QL (31 EA per 31 days)
AVODART	T4	QL (31 EA per 31 days)
<i>bethanechol chloride</i>	T2	
CIALIS ORAL TABLET 2.5 MG	T4	PA; QL (62 EA per 31 days)
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T3	
<i>darifenacin</i>	T3	QL (31 EA per 31 days)
DETROL	T4	QL (62 EA per 31 days)
DETROL LA	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)
ELMIRON	T4	
ENTADFI	T4	PA; QL (31 EA per 31 days)
<i>fesoterodine</i>	T3	QL (31 EA per 31 days)
<i>finasteride oral tablet 5 mg</i>	T2	
<i>flavoxate</i>	T2	
FLOMAX	T4	
GEMTESA	T4	QL (31 EA per 31 days)
<i>mirabegron</i>	T4	ST; QL (31 EA per 31 days)
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON	T3	QL (300 ML per 30 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	T3	QL (31 EA per 31 days)
<i>oxybutynin chloride oral syrup</i>	T2	
<i>oxybutynin chloride oral tablet 5 mg</i>	T2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg</i>	T2	QL (31 EA per 31 days)
<i>oxybutynin chloride oral tablet extended release 24hr 15 mg</i>	T3	QL (62 EA per 31 days)
OXYTROL	T4	QL (8 EA per 28 days)
<i>potassium citrate oral tablet extended release</i>	T2	
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET	T5	PA
PROSCAR	T4	
RAPAFLO	T4	
RIVFLOZA SUBCUTANEOUS SOLUTION	T5	PA; QL (1 ML per 28 days)
RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML	T5	PA; QL (0.8 ML per 28 days)
RIVFLOZA SUBCUTANEOUS SYRINGE 160 MG/ML	T5	PA; QL (1 ML per 28 days)
<i>silodosin</i>	T4	
<i>solifenacin</i>	T3	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)
TOVIAZ	T4	QL (31 EA per 31 days)
<i>trospium oral capsule,extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>trospium oral tablet</i>	T2	QL (93 EA per 31 days)
UROCIT-K 10	T4	
UROCIT-K 15	T4	
UROCIT-K 5	T4	
UROXATRAL	T4	QL (31 EA per 31 days)
VESICARE	T4	QL (31 EA per 31 days)
VESICARE LS	T4	QL (310 ML per 31 days)
Vitamins, Hematinics / Electrolytes		
<i>calcium acetate(phosphat bind)</i>	T2	
CLINIMIX 5%/D15W SULFITE FREE	T4	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T4	PA-BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	T4	PA-BvD
CLINIMIX E 4.25%/D10W SUL FREE	T4	PA-BvD
CLINIMIX E 4.25%/D5W SULF FREE	T4	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
CLINIMIX E 5%/D15W SULFIT FREE	T4	PA-BvD
CLINIMIX E 5%/D20W SULFIT FREE	T4	PA-BvD
CLINISOL SF 15 %	T4	PA-BvD
DOJOLVI	T5	PA
<i>electrolyte-148</i>	T4	PA-BvD
<i>fluoride (sodium) oral tablet</i>	T2	
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	T4	PA-BvD
ISOLYTE S PH 7.4	T3	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T4	PA-BvD
KLOR-CON	T3	
KLOR-CON 10	T3	
KLOR-CON 8	T3	
KLOR-CON M10	T1	
KLOR-CON M15	T1	
KLOR-CON M20	T1	
<i>magnesium sulfate injection</i>	T2	
NUTRILIPID	T4	PA-BvD
PLASMA-LYTE 148	T4	PA-BvD
PLASMA-LYTE A	T4	PA-BvD
PLENAMINE	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>	T1	
<i>potassium chloride oral liquid</i>	T2	
<i>potassium chloride oral packet</i>	T2	
<i>potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq</i>	T1	
<i>potassium chloride oral tablet,er particles/crystals</i>	T1	

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

Drug Name	Drug Tier	Requirements/Limits
<i>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	
PREMASOL 10 %	T4	PA-BvD
PRENATAL VITAMIN PLUS LOW IRON	T2	PA
PROSOL 20 %	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	
TPN ELECTROLYTES	T4	
TRAVASOL 10 %	T3	PA-BvD
TROPHAMINE 10 %	T4	PA-BvD

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<i>abiraterone</i>	16	ADDERALL	25	ALTAVERA (28)	107
ABRILADA(CF)	103	ADDERALL XR	25	ALTOPREV	59
ABRILADA(CF) PEN	103	<i>adefovir</i>	3	ALTRENO	71
ABRYSVO (PF)	99	ADEMPAS	118	ALUNBRIG	16
ABSORICA	70	ADLARITY	25	ALVAIZ	59
ABSORICA LD	70	ADMELOG SOLOSTAR U-		ALVESCO	118
<i>acamprosate</i>	79	100 INSULIN	84	ALYACEN 1/35 (28)	107
ACANYA	70	ADMELOG U-100 INSULIN		ALYQ	118
<i>acarbose</i>	84	LISPRO	84	<i>amantadine hcl</i>	3
ACCUTANE	70	ADVAIR DISKUS	118	AMBIEN	26
<i>acebutolol</i>	59	ADVAIR HFA	118	AMBIEN CR	26
<i>acetaminophen-caff-dihydrocod</i> ..	25	ADZENYS XR-ODT	25	AMBISOME	3
<i>acetaminophen-codeine</i>	25	AEMCOLO	3	<i>ambrisentan</i>	118
<i>acetazolamide</i>	114	AFINITOR	16	<i>amcinonide</i>	71
<i>acetic acid</i>	83	AFINITOR DISPERZ	16	AMETHIA	107
<i>acetylcysteine</i>	117	AFREZZA	84	<i>amikacin</i>	3
ACIPHEX	92	AGAMREE	84	<i>amiloride</i>	59
<i>acitretin</i>	70	AGRYLIN	79	<i>amiloride-hydrochlorothiazide</i> ..	59
ACTEMRA	103	AIMOVIG AUTOINJECTOR	26	<i>amiodarone</i>	59
ACTEMRA ACTPEN	103	AIRDUO RESPICLICK	118	AMITIZA	93
ACTHAR	84	AIRSUPRA	118	<i>amitriptyline</i>	26
ACTHAR SELFJECT	84	AJOVY AUTOINJECTOR	26	<i>amitriptyline-chlordiazepoxide</i> ..	26
ACTHIB (PF)	99	AJOVY SYRINGE	26	AMJEVITA(CF)	104
ACTIMMUNE	99	AKEEGA	16	AMJEVITA(CF)	
ACTIVELLA	107	AKLIEF	70	AUTOINJECTOR	104
ACTONEL	103	ALA-CORT	71	<i>amlodipine</i>	59
ACTOPLUS MET	84	ALA-SCALP	71	<i>amlodipine-atorvastatin</i>	59
ACTOS	84	<i>albendazole</i>	3	<i>amlodipine-benazepril</i>	59
ACULAR	114	<i>albuterol sulfate</i>	118	<i>amlodipine-olmesartan</i>	59
ACULAR LS	114	<i>alclometasone</i>	71	<i>amlodipine-valsartan</i>	59
ACUVAIL (PF)	114	ALCOHOL PADS	84	<i>amlodipine-valsartan-hcthiazyd</i> ..	59
<i>acyclovir</i>	3, 70	ALDACTONE	59	<i>ammonium lactate</i>	71
<i>acyclovir sodium</i>	3	ALECENSA	16	AMNESTEEM	71
ACZONE	70	<i>alendronate</i>	104	<i>amoxapine</i>	26
ADACEL(TDAP		<i>alfuzosin</i>	123	<i>amoxicil-clarithromy-lansopraz</i> ..	93
ADOLESN/ADULT)(PF)	99	<i>aliskiren</i>	59	<i>amoxicillin</i>	3
<i>adalimumab-aacf</i>	103	ALKINDI SPRINKLE	84	<i>amoxicillin-pot clavulanate</i>	4
<i>adalimumab-aaty</i>	103	<i>allopurinol</i>	104	<i>amphetamine sulfate</i>	26
<i>adalimumab-adaz</i>	103	ALLZITAL	26	<i>amphotericin b</i>	4
<i>adalimumab-adbm</i>	103	<i>almotriptan malate</i>	26	<i>amphotericin b liposome</i>	4
		<i>alogliptin</i>	84	<i>ampicillin</i>	4

<i>ampicillin sodium</i>	4	<i>asenapine maleate</i>	27	<i>azithromycin</i>	4
<i>ampicillin-sulbactam</i>	4	ASHLYNA	108	AZOPT	114
AMPYRA	26	ASMANEX HFA	118	AZOR	60
AMRIX	26	ASMANEX TWISTHALER	118	AZSTARYS	28
AMZEEQ	71	<i>aspirin-dipyridamole</i>	59	<i>aztreonam</i>	4
ANAFRANIL	26	ASPRUZYO SPRINKLE	59	AZULFIDINE	93
<i>anagrelide</i>	79	ASSURE ID INSULIN		AZULFIDINE EN-TABS	93
<i>anastrozole</i>	16	SAFETY	103	<i>bacitracin</i>	114
ANCOBON	4	ASTAGRAF XL	16	<i>bacitracin-polymyxin b</i>	114
ANDROGEL	84	ATACAND	59	<i>baclofen</i>	28
ANGELIQ	107	ATACAND HCT	59	BACTRIM	4
ANNOVERA	108	<i>atazanavir</i>	4	BACTRIM DS	4
ANORO ELLIPTA	118	ATELVIA	104	BAFIERTAM	28
ANTIVERT	93	<i>atenolol</i>	59	BALCOLTRA	108
ANUSOL-HC	93	<i>atenolol-chlorthalidone</i>	60	<i>balsalazide</i>	93
ANZEMET	93	ATIVAN	27	BALVERSA	17
APEXICON E	71	<i>atomoxetine</i>	27	BALZIVA (28)	108
APIDRA SOLOSTAR U-100		ATORVALIQ	60	BANZEL	28
INSULIN	84	<i>atorvastatin</i>	60	BAQSIMI	84
APIDRA U-100 INSULIN	84	<i>atovaquone</i>	4	BARACLUDGE	4
APLENZIN	26	<i>atovaquone-proguanil</i>	4	BASAGLAR KWIKPEN U-	
APOKYN	26	ATRALIN	71	100 INSULIN	84
<i>apomorphine</i>	26	<i>atropine</i>	114	BASAGLAR TEMPO	
<i>apraclonidine</i>	114	ATROVENT HFA	118	PEN(U-100)INSLN	84
<i>aprepitant</i>	93	AUBAGIO	27	BAXDELA	4
APRI	108	AUBRA EQ	108	<i>bcg vaccine, live (pf)</i>	99
APRISO	93	AUGMENTIN	4	BELBUCA	28
APTENSIO XR	26	AUGMENTIN ES-600	4	BELSOMRA	28
APTIOM	26	AUGTYRO	16	<i>benazepril</i>	60
APTIVUS	4	AURYXIA	80	<i>benazepril-hydrochlorothiazide</i>	60
ARALAST NP	80	AUSTEDO	27	BENICAR	60
ARANELLE (28)	108	AUSTEDO XR	27	BENICAR HCT	60
ARANESP (IN		AUSTEDO XR TITRATION		BENLYSTA	104
POLYSORBATE)	99	KT(WK1-4)	28	BENZAMYCIN	71
ARAVA	104	AUVELITY	28	<i>benznidazole</i>	4
ARAZLO	71	AVALIDE	60	<i>benztropine</i>	28
ARCALYST	99	AVAPRO	60	<i>bepotastine besilate</i>	114
AREXVY (PF)	99	AVEED	84	BEPREVE	114
<i>arformoterol</i>	118	AVIANE	108	BERINERT	118
ARICEPT	27	AVODART	123	BESIVANCE	114
ARIKAYCE	4	AVONEX	99	BESREMI	99
ARIMIDEX	16	AVYCAZ	4	<i>betaine</i>	93
<i>aripiprazole</i>	27	AYVAKIT	16	<i>betamethasone dipropionate</i>	71
ARISTADA	27	AZACTAM	4	<i>betamethasone valerate</i>	71
ARISTADA INITIO	27	AZASAN	17	<i>betamethasone, augmented</i>	71
ARIXTRA	59	AZASITE	114	BETAPACE AF	60
<i>armodafinil</i>	27	<i>azathioprine</i>	17	BETASERON	99
ARNUITY ELLIPTA	118	<i>azelaic acid</i>	71	<i>betaxolol</i>	60, 114
AROMASIN	16	<i>azelastine</i>	83, 114	<i>bethanechol chloride</i>	123
ARTHROTEC 50	27	<i>azelastine-fluticasone</i>	118	BETHKIS	4
ARTHROTEC 75	27	AZELEX	71	BETIMOL	114
ASCOMP WITH CODEINE	27	AZILECT	28	BETOPTIC S	114

BEVESPI AEROSPHERE	118	<i>bupirone</i>	28	CAROSPIR	61
<i>bexarotene</i>	17	<i>butalbital-acetaminop-caf-cod</i>	29	<i>carteolol</i>	114
BEXSERO	99	<i>butalbital-acetaminophen</i>	29	CARTIA XT	61
BEYAZ	108	<i>butalbital-acetaminophen-caff</i>	29	<i>carvedilol</i>	61
<i>bicalutamide</i>	17	<i>butalbital-aspirin-caffeine</i>	29	<i>carvedilol phosphate</i>	61
BICILLIN C-R	4	<i>butorphanol</i>	29	CASODEX	17
BICILLIN L-A	4	BUTRANS	29	<i>casprofungin</i>	5
BIDIL	60	BYDUREON BCISE	84	CAYSTON	5
BIJUVA	108	BYETTA	84, 85	<i>cefaclor</i>	5
BIKTARVY	4	BYLVAY	93	<i>cefadroxil</i>	5
BILTRICIDE	5	BYSTOLIC	60	<i>cefazolin</i>	5
<i>bimatoprost</i>	114	<i>cabergoline</i>	85	<i>cefdinir</i>	5
BIMZELX	71	CABLIVI	60	<i>cefepime</i>	5
BIMZELX AUTOINJECTOR	71	CABOMETYX	17	<i>cefixime</i>	5
BINOSTO	104	CABTREO	71	<i>cefotetan</i>	5
<i>bismuth subcit k-metronidz-tcn</i> ...	93	CADUET	60	<i>cefoxitin</i>	5
<i>bisoprolol fumarate</i>	60	<i>calcipotriene</i>	71	<i>cefpodoxime</i>	5
<i>bisoprolol-hydrochlorothiazide</i> ..	60	<i>calcipotriene-betamethasone</i>	71	<i>cefprozil</i>	5
BIVIGAM	99	<i>calcitonin (salmon)</i>	85	<i>ceftazidime</i>	5
BLISOVI 24 FE	108	<i>calcitriol</i>	71, 85	<i>ceftriaxone</i>	5
BLISOVI FE 1.5/30 (28)	108	<i>calcium acetate(phosphat bind)</i>	124	<i>cefuroxime axetil</i>	5
BONJESTA	93	CALQUENCE	17	<i>cefuroxime sodium</i>	5
BOOSTRIX TDAP	99	CALQUENCE		CELEBREX	29
<i>bosentan</i>	118	(ACALABRUTINIB MAL).....	17	<i>celecoxib</i>	29
BOSULIF	17	CAMBIA	29	CELEXA	29
BRAFTOVI	17	CAMILA	108	CELLCEPT	17
BREO ELLIPTA	118	CAMRESE LO	108	CELONTIN	29
BREYNA	118	CAMZYOS	60	<i>cephalexin</i>	5
BREZTRI AEROSPHERE	118	CANASA	93	CEQUA	114
BRIELLYN	108	CANCIDAS	5	CERDELGA	85
BRILINTA	60	<i>candesartan</i>	60	<i>cetirizine</i>	119
<i>brimonidine</i>	71, 114	<i>candesartan-hydrochlorothiazid</i> .	60	CETRAXAL	83
<i>brimonidine-timolol</i>	114	CAPLYTA	29	<i>cevimeline</i>	80
<i>brinzolamide</i>	114	CAPRELSA	17	CHEMET	80
BRIVIACT	28	<i>captopril</i>	60	CHENODAL	93
<i>bromfenac</i>	114	CARAC	71	<i>chlordiazepoxide hcl</i>	29
<i>bromocriptine</i>	28	CARAFATE	93	<i>chlordiazepoxide-clidinium</i>	93
BROMSITE	114	CARBAGLU	80	<i>chlorhexidine gluconate</i>	83
BRONCHITOL	118	<i>carbamazepine</i>	29	<i>chloroquine phosphate</i>	5
BROVANA	118	CARBATROL	29	<i>chlorpromazine</i>	29
BRUKINSA	17	<i>carbidopa</i>	29	<i>chlorthalidone</i>	61
BRYHALI	71	<i>carbidopa-levodopa</i>	29	<i>chlorzoxazone</i>	29
<i>budesonide</i>	93, 119	<i>carbidopa-levodopa-entacapone</i>	29	CHOLBAM	93
<i>budesonide-formoterol</i>	119	<i>carbinoxamine maleate</i>	119	<i>cholestyramine (with sugar)</i>	61
<i>bumetanide</i>	60	CARDIZEM	60	CHOLESTYRAMINE	
BUPAP	28	CARDIZEM CD	60	LIGHT	61
BUPHENYL	80	CARDIZEM LA	60	CIALIS	123
<i>buprenorphine</i>	28	CARDURA	60	CIBINQO	71
<i>buprenorphine hcl</i>	28	CARDURA XL	61	<i>ciclopirox</i>	71, 72
<i>buprenorphine-naloxone</i>	28	<i>carglumic acid</i>	80	<i>cilostazol</i>	61
<i>bupropion hcl</i>	28	<i>carisoprodol</i>	29	CILOXAN	114
<i>bupropion hcl (smoking deter)</i>	80	CARNITOR	80	CIMDUO	5

<i>cimetidine</i>	93	CLINIMIX E 5%/D20W		COSENTYX	73
CIMZIA	93	SULFIT FREE	125	COSENTYX (2 SYRINGES) ...	73
CIMZIA POWDER FOR RECONST	93	CLINISOL SF 15 %	125	COSENTYX PEN (2 PENS)	73
<i>cinacalcet</i>	85	<i>clobazam</i>	30	COSENTYX UNOREADY PEN	73
CINRYZE	119	<i>clobetasol</i>	72	COSOPT	115
CIPRO	5	<i>clobetasol-emollient</i>	72	COSOPT (PF)	115
CIPRO HC	83	CLOBEX	72	COTELLIC	17
<i>ciprofloxacin hcl</i>	5, 83, 115	<i>clocortolone pivalate</i>	72	COTEMPLA XR-ODT	30
<i>ciprofloxacin in 5 % dextrose</i>	6	CLODAN	72	COZAAR	61
<i>ciprofloxacin-dexamethasone</i>	83	<i>clomipramine</i>	30	CREON	93
<i>ciprofloxacin-fluocinolone</i>	83	<i>clonazepam</i>	30	CRESEMBA	6
<i>citalopram</i>	29, 30	<i>clonidine</i>	61	CRESTOR	61
CLARAVIS	72	<i>clonidine hcl</i>	30, 61	CRINONE	108
CLARINEX	119	<i>clopidogrel</i>	61	<i>cromolyn</i>	93, 115, 119
CLARINEX-D 12 HOUR	119	<i>clorazepate dipotassium</i>	30	CROTAN	73
<i>clarithromycin</i>	6	<i>clotrimazole</i>	6, 73	CRYSELLE (28)	108
<i>clemastine</i>	119	<i>clotrimazole-betamethasone</i>	73	CUBICIN RF	6
CLENPIQ	93	<i>clozapine</i>	30	CUPRIMINE	104
CLEOCIN	6, 108	CLOZARIL	30	CUVPOSA	94
CLEOCIN HCL	6	COARTEM	6	CUVRIOR	80
CLEOCIN PEDIATRIC	6	<i>codeine sulfate</i>	30	<i>cyclobenzaprine</i>	31
CLEOCIN T	72	<i>codeine-butalbital-asa-caff</i>	30	<i>cyclophosphamide</i>	17
CLIMARA	108	COLAZAL	93	<i>cycloserine</i>	6
CLIMARA PRO	108	<i>colchicine</i>	104	CYCLOSET	85
CLINDACIN	72	COLCRYS	104	<i>cyclosporine</i>	17, 115
CLINDACIN ETZ	72	<i>colesevelam</i>	61	<i>cyclosporine modified</i>	17
CLINDAGEL	72	COLESTID	61	CYLTEZO(CF)	104
<i>clindamycin hcl</i>	6	<i>colestipol</i>	61	CYLTEZO(CF) PEN	104
<i>clindamycin in 5 % dextrose</i>	6	<i>colistin (colistimethate na)</i>	6	CYLTEZO(CF) PEN	105
CLINDAMYCIN PEDIATRIC	6	COMBIGAN	115	CROHN'S-UC-HS	105
<i>clindamycin phosphate</i> ... 6, 72, 108		COMBIPATCH	108	CYLTEZO(CF) PEN	105
<i>clindamycin-benzoyl peroxide</i>	72	COMBIVENT RESPIMAT ..	119	PSORIASIS-UV	105
<i>clindamycin-tretinoin</i>	72	COMBIVIR	6	CYMBALTA	31
CLINDESSE	108	COMETRIQ	17	<i>cyproheptadine</i>	119
CLINIMIX 5%/D15W SULFITE FREE	124	COMPLERA	6	CYRED EQ	108
CLINIMIX 4.25%/D10W SULF FREE	124	COMPRO	93	CYSTADANE	94
CLINIMIX 4.25%/D5W SULFIT FREE	80	COMTAN	30	CYSTADROPS	115
CLINIMIX 5%-D20W(SULFITE-FREE)	124	CONCERTA	30	CYSTAGON	123
CLINIMIX E 2.75%/D5W SULF FREE	80	CONDYLOX	73	CYSTARAN	115
CLINIMIX E 4.25%/D10W SUL FREE	124	CONSTULOSE	93	CYTOMEL	85
CLINIMIX E 4.25%/D5W SULF FREE	124	CONZIP	30	CYTOTEC	94
CLINIMIX E 5%/D15W SULFIT FREE	125	COPAXONE	30	<i>d10 %-0.45 % sodium chloride</i> ...80	
		COPIKTRA	17	<i>d2.5 %-0.45 % sodium chloride</i> ..80	
		CORDRAN	73	<i>d5 % and 0.9 % sodium chloride</i>	80
		CORDRAN TAPE LARGE ROLL	73	<i>d5 %-0.45 % sodium chloride</i>80	
		COREG	61	<i>dabigatran etexilate</i>	61
		COREG CR	61	<i>dalfampridine</i>	31
		CORGARD	61	DALIRESP	119
		CORLANOR	61	DALVANCE	6
		CORTEF	85	<i>danazol</i>	85
		CORTROPHIN GEL	85		

DANTRIUM	31	DETROL LA	123	<i>disopyramide phosphate</i>	62
<i>dantrolene</i>	31	DEXABLISS	85	<i>disulfiram</i>	80
<i>dapaglifloz propaned-metformin</i>	85	<i>dexamethasone</i>	85	DIURIL	62
<i>dapagliflozin propanediol</i>	85	<i>dexamethasone sodium</i>		<i>divalproex</i>	33
<i>dapsone</i>	6, 73	<i>phosphate</i>	115	DIVIGEL	108
DAPTACEL (DTAP		DEXEDRINE SPANSULE	31	<i>dofetilide</i>	62
PEDIATRIC) (PF)	99	DEXILANT	94	DOJOLVI	125
<i>daptomycin</i>	6	<i>dexlansoprazole</i>	94	DOLISHALE	108
DARAPRIM	6	<i>dexmethylphenidate</i>	31	<i>donepezil</i>	33
<i>darifenacin</i>	123	<i>dextroamphetamine sulfate</i> ...	31, 32	DOPTELET (10 TAB PACK) .	62
<i>darunavir</i>	6	<i>dextroamphetamine-</i>		DOPTELET (15 TAB PACK) .	62
DAURISMO	17	<i>amphetamine</i>	32	DOPTELET (30 TAB PACK) .	62
DAYBUE	31	<i>dextrose 10 % and 0.2 % nacl</i> ...	80	DORYX MPC	6
DAYPRO	31	<i>dextrose 10 % in water (d10w)</i> ..	80	<i>dorzolamide</i>	115
DAYTRANA	31	<i>dextrose 5 % in water (d5w)</i>	80	<i>dorzolamide-timolol</i>	115
DAYVIGO	31	<i>dextrose 5%-0.2 % sod chloride</i> .	80	<i>dorzolamide-timolol (pf)</i>	115
DDAVP	85	DHIVY	32	DOTTI	109
DEBLITANE	108	DIACOMIT	32	DOVATO	7
<i>deferiasirox</i>	80	<i>diazepam</i>	32	<i>doxazosin</i>	62
<i>deferiprone</i>	80	DIAZEPAM INTENSOL	32	<i>doxepin</i>	33, 73
<i>deflazacort</i>	85	<i>diazoxide</i>	85	<i>doxercalciferol</i>	85
DELESTROGEN	108	DIBENZYLINE	61	DOXY-100	7
DELSTRIGO	6	DICLEGIS	94	<i>doxycycline hyclate</i>	7
DELZICOL	94	<i>diclofenac epolamine</i>	32	<i>doxycycline monohydrate</i>	7
<i>demeclocycline</i>	6	<i>diclofenac potassium</i>	32	<i>doxylamine-pyridoxine (vit b6)</i> ...94	
DEMEROL	31	<i>diclofenac sodium</i>	32, 73, 115	DRIZALMA SPRINKLE	33
DEMEROL (PF)	31	<i>diclofenac-misoprostol</i>	32	<i>dronabinol</i>	94
DEMSEER	61	<i>dicloxacillin</i>	6	<i>drospirenone-e.estradiol-lm.fa</i> .	109
DENAVIR	73	<i>dicyclomine</i>	94	<i>drospirenone-ethinyl estradiol</i> ..109	
DEPAKOTE	31	DIFFERIN	73	DROXIA	17
DEPAKOTE ER	31	DIFICID	6	<i>droxidopa</i>	80
DEPAKOTE SPRINKLES	31	<i>diflorasone</i>	73	DUAKLIR PRESSAIR	119
DEPEN TITRATABS	105	DIFLUCAN	6	DUAVEE	109
DEPO-ESTRADIOL	108	<i>diflunisal</i>	32	DUETACT	85
DEPO-PROVERA	108	<i>difluprednate</i>	115	DULERA	119
DEPO-SUBQ PROVERA 104	108	<i>digoxin</i>	61	<i>duloxetine</i>	33
DEPO-TESTOSTERONE	85	<i>dihydroergotamine</i>	32	DUOBRII	73
DERMA-SMOOTHIE/FS		DILANTIN	33	DUOPA	33
SCALP OIL	73	DILANTIN EXTENDED	33	DUPIXENT PEN	74
DERMOTIC OIL	83	DILANTIN INFATABS	33	DUPIXENT SYRINGE	74
DESCOVY	6	DILANTIN-125	33	DUREZOL	115
<i>desipramine</i>	31	DILAUDID	33	<i>dutasteride</i>	123
<i>desloratadine</i>	119	<i>diltiazem hcl</i>	62	<i>dutasteride-tamsulosin</i>	123
<i>desmopressin</i>	85	DILT-XR	62	DUVYZAT	80
<i>desog-e.estradiol/e.estradiol</i>	108	<i>dimethyl fumarate</i>	33	DYANAVEL XR	33
<i>desogestrel-ethinyl estradiol</i>	108	DIOVAN	62	DYMISTA	119
<i>desonide</i>	73	DIOVAN HCT	62	DYRENIUM	62
DESOWEN	73	DIPENTUM	94	E.E.S. 400	7
<i>desoximetasone</i>	73	<i>diphenoxylate-atropine</i>	94	E.E.S. GRANULES	7
<i>desvenlafaxine</i>	31	DIPROLENE		<i>econazole</i>	74
<i>desvenlafaxine succinate</i>	31	(AUGMENTED)	73	EDARBI	62
DETROL	123	<i>dipyridamole</i>	62	EDARBYCLOR	62

EDECIN	62	ENTRESTO	62	ESTROGEL	109
EDLUAR	34	ENTRESTO SPRINKLE	63	<i>eszopiclone</i>	34
EDURANT	7	ENTYVIO PEN	94	<i>ethacrynic acid</i>	63
<i>efavirenz</i>	7	ENULOSE	94	<i>ethambutol</i>	8
<i>efavirenz-emtricitabin-tenofov</i>	7	ENVARUS XR	18	<i>ethosuximide</i>	34
<i>efavirenz-lamivu-tenofov disop</i>	7	EPCLUSA	7, 8	<i>ethynodiol diac-eth estradiol</i>	109
EFFEXOR XR	34	EPIDIOLEX	34	<i>etodolac</i>	34
EFFIENT	62	EPIDUO	74	<i>etonogestrel-ethinyl estradiol</i> ...	109
EFUDEX	74	EPIDUO FORTE	74	<i>etravirine</i>	8
EGRIFTA SV	99	<i>epinastine</i>	115	EUCRISA	74
<i>electrolyte-148</i>	125	<i>epinephrine</i>	119	EUTHYROX	85
ELESTRIN	109	EIPEN 2-PAK	119	EVAMIST	109
<i>eletriptan</i>	34	EIPEN JR 2-PAK	119	EVEKEO	34
ELIDEL	74	EPITOL	34	EVENITY	105
ELIGARD	17	EPIVIR	8	<i>everolimus (antineoplastic)</i>	18
ELIGARD (3 MONTH)	17	<i>eplerenone</i>	63	<i>everolimus</i>	
ELIGARD (4 MONTH)	18	EPOGEN	100	<i>(immunosuppressive)</i>	18
ELIGARD (6 MONTH)	18	EPRONTIA	34	EVISTA	105
ELIQUIS	62	EPSOLAY	74	EVOTAZ	8
ELIQUIS DVT-PE TREAT		EPZICOM	8	EVOXAC	80
30D START	62	EQUETRO	34	EVRYSDI	34
ELMIRON	123	ERAXIS(WATER DILUENT) ..	8	EXELDERM	74
ELURYNG	109	<i>ergoloid</i>	34	EXELON PATCH	34
ELYXYB	34	<i>ergotamine-caffeine</i>	34	<i>exemestane</i>	18
EMEND	94	ERIVEDGE	18	EXFORGE	63
EMFLAZA	85	ERLEADA	18	EXFORGE HCT	63
EMGALITY PEN	34	<i>erlotinib</i>	18	EXJADE	80
EMGALITY SYRINGE	34	ERMEZA	85	EXSERVAN	80
EMSAM	34	ERRIN	109	EYSUVIS	115
<i>emtricitabine</i>	7	ERTACZO	74	EZALLOR SPRINKLE	63
<i>emtricitabine-tenofovir (tdf)</i>	7	<i>ertapenem</i>	8	<i>ezetimibe</i>	63
EMTRIVA	7	ERY PADS	74	<i>ezetimibe-simvastatin</i>	63
EMVERM	7	ERYGEL	74	FABHALTA	81
<i>enalapril maleate</i>	62	ERYPED 200	8	FABIOR	74
<i>enalapril-hydrochlorothiazide</i>	62	ERYPED 400	8	FALMINA (28)	109
ENBREL	105	ERY-TAB	8	<i>famciclovir</i>	8
ENBREL MINI	105	ERYTHROCIN	8	<i>famotidine</i>	94
ENBREL SURECLICK	105	<i>erythromycin</i>	8, 115	FANAPT	34, 35
ENDARI	80	<i>erythromycin ethylsuccinate</i>	8	FARESTON	18
ENDOCET	34	<i>erythromycin with ethanol</i>	74	FARXIGA	86
ENGERIX-B (PF)	99	<i>erythromycin-benzoyl peroxide</i> ...74		FASENRA	119
ENGERIX-B PEDIATRIC		ESBRIET	119	FASENRA PEN	119
(PF)	100	<i>escitalopram oxalate</i>	34	<i>febuxostat</i>	105
ENILLORING	109	ESGIC	34	<i>felbamate</i>	35
<i>enoxaparin</i>	62	<i>esomeprazole magnesium</i>	94	FELBATOL	35
ENPRESSE	109	ESTARYLLA	109	<i>felodipine</i>	63
ENSKYCE	109	<i>estazolam</i>	34	FEMARA	18
ENSPRYNG	18	ESTRACE	109	FEMRING	109
ENSTILAR	74	<i>estradiol</i>	109	<i>fenofibrate</i>	63
<i>entacapone</i>	34	<i>estradiol valerate</i>	109	<i>fenofibrate micronized</i>	63
ENTADFI	123	<i>estradiol-norethindrone acet</i>	109	<i>fenofibrate nanocrystallized</i>	63
<i>entecavir</i>	7	ESTRING	109	<i>fenofibric acid (choline)</i>	63

FENOGLIDE	63	<i>fluoxetine</i>	36	GASTROCROM	94
<i>fenoprofen</i>	35	<i>fluoxetine (pmd)</i>	36	<i>gatifloxacin</i>	115
<i>fentanyl</i>	35	<i>fluphenazine decanoate</i>	36	GATTEX 30-VIAL	94
<i>fentanyl citrate</i>	35	<i>fluphenazine hcl</i>	36	GAUZE PAD	103
FENTORA	36	<i>flurandrenolide</i>	75	GAVILYTE-C	94
FERRIPROX	81	<i>flurazepam</i>	36	GAVILYTE-G	94
FERRIPROX (2 TIMES A DAY)	81	<i>flurbiprofen</i>	36	GAVRETO	18
<i>fesoterodine</i>	123	<i>flurbiprofen sodium</i>	115	<i>gefitinib</i>	18
FETZIMA	36	<i>fluticasone furoate-vilanterol</i> ... 119		<i>gemfibrozil</i>	64
FEXMID	36	<i>fluticasone propionate</i> 75, 119, 120		GEMMILY	109
FIASP FLEXTOUCH U-100 INSULIN	86	<i>fluticasone propion-salmeterol</i> 120		GEMTESA	123
FIASP PENFILL U-100 INSULIN	86	<i>fluvastatin</i>	63	GENERLAC	94
FIASP U-100 INSULIN	86	<i>fluvoxamine</i>	36	GENGRAF	18
FILSPARI	63	FML FORTE	115	GENOTROPIN	100
FILSUVEZ	74	FML LIQUIFILM	115	GENOTROPIN MINIQUICK	100
FINACEA	74	FOCALIN	36	<i>gentamicin</i>	9, 75, 115
<i>finasteride</i>	123	FOCALIN XR	37	<i>gentamicin in nacl (iso-osm)</i>	9
<i>fingolimod</i>	36	<i>fondaparinux</i>	63	GENVOYA	9
FINTEPLA	36	FORFIVO XL	37	GEODON	37
FINZALA	109	<i>formoterol fumarate</i>	120	GILENYA	37
FIORICET	36	FORTEO	105	GILOTRIF	18
FIORICET WITH CODEINE	36	FOSAMAX	105	GIMOTI	94
FIRAZYR	119	FOSAMAX PLUS D	105	GLASSIA	81
FIRDAPSE	36	<i>fosamprenavir</i>	8	<i>glatiramer</i>	37
FIRMAGON KIT W DILUENT SYRINGE	18	<i>fosfomycin tromethamine</i>	8	GLATOPA	37
FIRVANQ	8	<i>fosinopril</i>	63	GLEEVEC	18
FLAC OTIC OIL	83	<i>fosinopril-hydrochlorothiazide</i> ... 63		GLEOSTINE	18
FLAGYL	8	FOSRENOL	81	<i>glimepiride</i>	86
FLAREX	115	FOTIVDA	18	<i>glipizide</i>	86
<i>flavoxate</i>	123	FRAGMIN	63	<i>glipizide-metformin</i>	86
<i>flecainide</i>	63	FROVA	37	GLOPERBA	105
FLECTOR	36	<i>frovatriptan</i>	37	GLUCAGON EMERGENCY KIT (HUMAN)	86
FLEQSUVY	36	FRUZAQLA	18	GLUCOTROL XL	86
FLOLIPID	63	FULPHILA	100	GLUMETZA	86
FLOMAX	123	FUROSCIX	63	<i>glutamine (sickle cell)</i>	81
<i>fluconazole</i>	8	<i>furosemide</i>	63, 64	<i>glyburide</i>	86
<i>fluconazole in nacl (iso-osm)</i>	8	FUZEON	9	<i>glyburide micronized</i>	86
<i>flucytosine</i>	8	FYAVOLV	109	<i>glyburide-metformin</i>	86
<i>fludrocortisone</i>	86	FYCOMPA	37	GLYCATE	94
<i>flunisolide</i>	119	FYLNETRA	100	<i>glycopyrrolate</i>	94, 95
<i>fluocinolone</i>	74	<i>gabapentin</i>	37	GLYXAMBI	86
<i>fluocinolone acetonide oil</i>	83	GALAFOLD	86	GOCOVRI	37
<i>fluocinolone and shower cap</i>	74	<i>galantamine</i>	37	GOLYTELY	95
<i>fluocinonide</i>	74, 75	GAMMAGARD LIQUID	100	GRALISE	37
<i>fluocinonide-emollient</i>	75	GAMMAGARD S-D (IGA < 1 MCG/ML)	100	<i>granisetron hcl</i>	95
<i>fluoride (sodium)</i>	125	GAMMAKED	100	GRANIX	100
<i>fluorometholone</i>	115	GAMMAPLEX	100	GRASTEK	100
<i>fluorouracil</i>	75	GAMMAPLEX (WITH SORBITOL)	100	<i>griseofulvin microsize</i>	9
		GAMUNEX-C	100	<i>griseofulvin ultramicrosize</i>	9
		GARDASIL 9 (PF)	100	<i>guanfacine</i>	38, 64

GVOKE	86	HUMIRA(CF)	105	IBSRELA	95
GVOKE HYPOPEN 2-PACK	86	HUMIRA(CF) PEN	105	IBU	39
GVOKE PFS 1-PACK		HUMIRA(CF) PEN		<i>ibuprofen</i>	39
SYRINGE	86	CROHNS-UC-HS	105	<i>ibuprofen-famotidine</i>	39
GYNAZOLE-1	109	HUMIRA(CF) PEN		<i>icatibant</i>	120
HADLIMA	105	PEDIATRIC UC	105	ICLEVIA	109
HADLIMA PUSH TOUCH	105	HUMIRA(CF) PEN PSOR-		ICLUSIG	19
HADLIMA(CF)	105	UV-ADOL HS	105	<i>icosapent ethyl</i>	64
HADLIMA(CF)		HUMULIN 70/30 U-100		IDACIO(CF)	106
PUSH TOUCH	105	INSULIN	86	IDACIO(CF) PEN	106
HAEGARDA	120	HUMULIN 70/30 U-100		IDACIO(CF) PEN CROHN-	
HAILEY 24 FE	109	KWIKPEN	86	UC STARTR	106
<i>halcinonide</i>	75	HUMULIN N NPH INSULIN		IDACIO(CF) PEN	
HALCION	38	KWIKPEN	86	PSORIASIS START	106
HALDOL DECANOATE	38	HUMULIN N NPH U-100		IDHIFA	19
<i>halobetasol propionate</i>	75	INSULIN	86	ILEVRO	115
HALOETTE	109	HUMULIN R REGULAR U-		ILUMYA	75
HALOG	75	100 INSULN	87	<i>imatinib</i>	19
<i>haloperidol</i>	38	HUMULIN R U-500 (CONC)		IMBRUVICA	19
<i>haloperidol decanoate</i>	38	INSULIN	87	<i>imipenem-cilastatin</i>	9
<i>haloperidol lactate</i>	38	HUMULIN R U-500 (CONC)		<i>imipramine hcl</i>	39
HARVONI	9	KWIKPEN	87	<i>imipramine pamoate</i>	39
HAVRIX (PF)	100	<i>hydralazine</i>	64	<i>imiquimod</i>	75
HEATHER	109	HYDREA	18	IMITREX	39
HELIDAC	95	<i>hydrochlorothiazide</i>	64	IMITREX STATDOSE PEN ..	39
HEMADY	86	<i>hydrocodone bitartrate</i>	38	IMITREX STATDOSE	
<i>heparin (porcine)</i>	64	<i>hydrocodone-acetaminophen</i>	38	REFILL	39
HEPLISAV-B (PF)	100	<i>hydrocodone-ibuprofen</i>	38	IMOVAX RABIES	
HETLIOZ	38	<i>hydrocortisone</i>	75, 87, 95	VACCINE (PF)	100
HETLIOZ LQ	38	<i>hydrocortisone butyrate</i>	75	IMPAVIDO	9
HIBERIX (PF)	100	<i>hydrocortisone valerate</i>	75	IMURAN	19
HIPREX	9	<i>hydrocortisone-acetic acid</i>	83	IMVEXXY MAINTENANCE	
HORIZANT	38	<i>hydrocortisone-pramoxine</i>	95	PACK	109
HULIO(CF)	105	<i>hydromorphone</i>	38	IMVEXXY STARTER PACK	
HULIO(CF) PEN	105	<i>hydromorphone (pf)</i>	38	110
HUMALOG JUNIOR		<i>hydroxychloroquine</i>	9	INBRIJA	39
KWIKPEN U-100	86	<i>hydroxyurea</i>	18	INCASSIA	110
HUMALOG KWIKPEN		<i>hydroxyzine hcl</i>	120	INCRELEX	81
INSULIN	86	<i>hydroxyzine pamoate</i>	120	INCRUSE ELLIPTA	120
HUMALOG MIX 50-50		HYFTOR	75	<i>indapamide</i>	64
KWIKPEN	86	HYRIMOZ PEN CROHN'S-		INDERAL LA	64
HUMALOG MIX 75-25		UC STARTER	105	INDOCIN	39
KWIKPEN	86	HYRIMOZ PEN PSORIASIS		<i>indomethacin</i>	39
HUMALOG MIX 75-25(U-		STARTER	105	INFANRIX (DTAP) (PF)	100
100)INSULN	86	HYRIMOZ(CF)	106	INGREZZA	39
HUMALOG TEMPO PEN(U-		HYRIMOZ(CF) PEDI		INGREZZA INITIATION	
100)INSULN	86	CROHN STARTER	105, 106	PK(TARDIV)	39
HUMALOG U-100 INSULIN ..	86	HYRIMOZ(CF) PEN	106	INGREZZA SPRINKLE	39
HUMATIN	9	HYSINGLA ER	38, 39	INLYTA	19
HUMATROPE	100	HYZAAR	64	INNOPRAN XL	64
HUMIRA	105	<i>ibandronate</i>	106	INPEFA	87
HUMIRA PEN	105	IBRANCE	18	INQOVI	19

INREBIC	19	IXCHIQ (PF)	100	KINERET	106
INSPIRA	64	IXIARO (PF)	100	KINRIX (PF)	101
<i>insulin asp prt-insulin aspart</i>	87	IYUZEH (PF)	115	KIONEX (WITH	
<i>insulin aspart u-100</i>	87	JADENU	81	SORBITOL)	81
<i>insulin degludec</i>	87	JADENU SPRINKLE	81	KIPROFEN	40
<i>insulin glargine u-300 conc</i>	87	JAKAFI	19	KISQALI	19
<i>insulin glargine-yfgn</i>	87	JANTOVEN	64	KISQALI FEMARA CO-	
<i>insulin lispro</i>	87	JANUMET	87	PACK	19
<i>insulin lispro protamin-lispro</i>	87	JANUMET XR	87	KITABIS PAK	10
<i>insulin syringe-needle u-100</i>	103	JANUVIA	87	KLARON	76
INTELENCE	9	JARDIANCE	87	KLISYRI	19
INTRALIPID	125	JASMIEL (28)	110	KLONOPIN	40
INTRAROSA	110	JATENZO	87	KLOR-CON	125
INTROVALE	110	JAVYGTOR	87	KLOR-CON 10	125
INTUNIV ER	39	JAYPIRCA	19	KLOR-CON 8	125
INVANZ	9	JENTADUETO	87	KLOR-CON M10	125
INVEGA	39	JENTADUETO XR	87, 88	KLOR-CON M15	125
INVEGA HAFYERA	39	JINTELI	110	KLOR-CON M20	125
INVEGA SUSTENNA	40	JOENJA	81	KLOXXADO	40
INVEGA TRINZA	40	JORNAY PM	40	KONVOMEPI	95
INVELTYS	115	JOYEAUX	110	KORLYM	88
INVOKAMET	87	JUBLIA	75	KOSELUGO	19
INVOKAMET XR	87	JULEBER	110	KOURZEQ	83
INVOKANA	87	JULUCA	9	KRAZATI	19
IOPIDINE	115	JUNEL 1.5/30 (21)	110	KRINTAFEL	10
IPOL	100	JUNEL 1/20 (21)	110	KRISTALOSE	95
<i>ipratropium bromide</i>	83, 120	JUNEL FE 1.5/30 (28)	110	KURVELO (28)	110
<i>ipratropium-albuterol</i>	120	JUNEL FE 1/20 (28)	110	KUVAN	88
IQIRVO	95	JUNEL FE 24	110	KYLEENA	110
<i>irbesartan</i>	64	JUXTAPID	64	<i>l norgest/e.estradiol-e.estradiol</i>	110
<i>irbesartan-hydrochlorothiazide</i> ..	64	JYLAMVO	19	<i>labetalol</i>	64
IRESSA	19	JYNARQUE	88	<i>lacosamide</i>	40
ISENTRESS	9	JYNNEOS (PF)	100	<i>lactulose</i>	95
ISENTRESS HD	9	KAITLIB FE	110	LAGEVRIO (EUA)	10
ISIBLOOM	110	KALETRA	9	LAMICTAL	41
ISOLYTE S PH 7.4	125	KALYDECO	120	LAMICTAL ODT	41
ISOLYTE-P IN 5 %		KARIVA (28)	110	LAMICTAL STARTER	
DEXTROSE	125	KATERZIA	64	(BLUE) KIT	41
<i>isoniazid</i>	9	KAZANO	88	LAMICTAL STARTER	
ISORDIL	64	KELNOR 1/35 (28)	110	(GREEN) KIT	41
ISORDIL TITRADOSE	64	KELNOR 1/50 (28)	110	LAMICTAL STARTER	
<i>isosorbide dinitrate</i>	64	KENALOG	75	(ORANGE) KIT	41
<i>isosorbide mononitrate</i>	64	KEPPRA	40	LAMICTAL XR	41
<i>isosorbide-hydralazine</i>	64	KEPPRA XR	40	LAMICTAL XR STARTER	
<i>isotretinoin</i>	75	KERENDIA	64	(BLUE)	41
<i>isradipine</i>	64	KESIMPTA PEN	40	LAMICTAL XR STARTER	
ISTALOL	115	<i>ketoconazole</i>	9, 75	(GREEN)	41
ISTURISA	87	KETODAN	75	LAMICTAL XR STARTER	
<i>itraconazole</i>	9	<i>ketoprofen</i>	40	(ORANGE)	41
<i>ivabradine</i>	64	<i>ketorolac</i>	40, 115	<i>lamivudine</i>	10
<i>ivermectin</i>	9, 75	KEVEYIS	40	<i>lamivudine-zidovudine</i>	10
IWILFIN	19	KEVZARA	106	<i>lamotrigine</i>	41

LAMPIT	10	LIALDA	95	<i>lorazepam</i>	42
LANOXIN	64, 65	LIBERVANT	41	LORAZEPAM INTENSOL	42
<i>lansoprazole</i>	95	LIBRAX (WITH		LORBRENA	20
<i>lanthanum</i>	81	CLIDINIUM)	95	LOREEV XR	42
LANTUS SOLOSTAR U-100		LICART	41	LORYNA (28)	111
INSULIN	88	<i>lidocaine</i>	76	LORZONE	42
LANTUS U-100 INSULIN	88	<i>lidocaine hcl</i>	76	<i>losartan</i>	65
<i>lapatinib</i>	19	LIDOCAINE VISCOUS	76	<i>losartan-hydrochlorothiazide</i>	65
LARIN 1.5/30 (21)	110	<i>lidocaine-prilocaine</i>	76	LOTEMAX	116
LARIN 1/20 (21)	110	LIDOCAN III	76	LOTEMAX SM	116
LARIN FE 1.5/30 (28)	110	LIDODERM	76	LOTENSIN	65
LARIN FE 1/20 (28)	110	LILETTA	110	<i>loteprednol etabonate</i>	116
LASIX	65	<i>linezolid</i>	10	LOTREL	65
<i>latanoprost</i>	115	<i>linezolid in dextrose 5%</i>	10	LOTRONEX	95
LATUDA	41	LINZESS	95	<i>lovastatin</i>	65
LAYOLIS FE	110	<i>liothyronine</i>	88	LOVAZA	65
<i>ledipasvir-sofosbuvir</i>	10	LIPITOR	65	LOVENOX	65
LEENA 28	110	LIPOFEN	65	LOW-OGESTREL (28)	111
<i>leflunomide</i>	106	LIQREV	120	<i>loxapine succinate</i>	42
<i>lenalidomide</i>	19	<i>liraglutide</i>	88	<i>lubiprostone</i>	95
LENVIMA	20	<i>lisdexamfetamine</i>	42	LUCEMYRA	42
LESCOL XL	65	<i>lisinopril</i>	65	<i>luliconazole</i>	76
LESSINA	110	<i>lisinopril-hydrochlorothiazide</i>	65	LUMAKRAS	20
LETAIRIS	120	LITFULO	81	LUMIGAN	116
<i>letrozole</i>	20	<i>lithium carbonate</i>	42	LUMRYZ	42
<i>leucovorin calcium</i>	20	<i>lithium citrate</i>	42	LUNESTA	42
LEUKERAN	20	LITHOBID	42	LUPKYNIS	20
LEUKINE	101	LITHOSTAT	81	LUPRON DEPOT	20
<i>leuprolide</i>	20	LIVALO	65	LUPRON DEPOT (3	
<i>leuprolide (3 month)</i>	20	LIVMARLI	95	MONTH)	20
<i>levabuterol hcl</i>	120	LIVTENCITY	10	LUPRON DEPOT (4	
<i>levabuterol tartrate</i>	120	LO LOESTRIN FE	110	MONTH)	20
<i>levamlodipine</i>	65	LOCOID	76	LUPRON DEPOT (6	
LEVEMIR FLEXPEN	88	LOCOID LIPOCREAM	76	MONTH)	20
LEVEMIR U-100 INSULIN	88	LODINE	42	LUPRON DEPOT-PED	20
<i>levetiracetam</i>	41	LODOCO	65	LUPRON DEPOT-PED (3	
<i>levobunolol</i>	115	LODOSYN	42	MONTH)	20
<i>levocarnitine</i>	81	LOESTRIN 1.5/30 (21)	110	<i>lurasidone</i>	42
<i>levocarnitine (with sugar)</i>	81	LOESTRIN 1/20 (21)	110	LUTERA (28)	111
<i>levocetirizine</i>	120	LOESTRIN FE 1.5/30 (28-		LUZU	76
<i>levofloxacin</i>	10, 115	DAY)	110	LYBALVI	42
<i>levofloxacin in d5w</i>	10	LOESTRIN FE 1/20 (28-		LYLEQ	111
LEVONEST (28)	110	DAY)	111	LYLLANA	111
<i>levonorgestrel-ethinyl estrad</i>	110	LOFENA	42	LYNPARZA	20
<i>levonorg-eth estrad triphasic</i>	110	LOKELMA	81	LYRICA	42
LEVORA-28	110	LOMOTIL	95	LYRICA CR	42
<i>levorphanol tartrate</i>	41	LONSURF	20	LYSODREN	20
<i>levothyroxine</i>	88	<i>loperamide</i>	95	LYTGOBI	20
LEVOXYL	88	LOPID	65	LYUMJEV KWIKPEN U-100	
LEXAPRO	41	<i>lopinavir-ritonavir</i>	10	INSULIN	88
LEXETTE	76	LOPRESSOR	65	LYUMJEV KWIKPEN U-200	
LEXIVA	10	LOPROX	76	INSULIN	88

LYUMJEV TEMPO PEN(U-100)INSULN	88	<i>meloxicam</i>	43	MIBELAS 24 FE	111
LYUMJEV U-100 INSULIN	88	<i>meloxicam submicronized</i>	43	<i>micafungin</i>	10
LYVISPAH	42	<i>memantine</i>	43	MICARDIS	65
LYZA	111	MENACTRA (PF)	101	MICARDIS HCT	65
MACROBID	10	MENEST	111	MICONAZOLE-3	111
MACRODANTIN	10	MENOSTAR	111	MICROGESTIN 1.5/30 (21) ..	111
<i>mafenide acetate</i>	76	MENQUADFI (PF)	101	MICROGESTIN 1/20 (21)	111
<i>magnesium sulfate</i>	125	MENVEO A-C-Y-W-135-DIP (PF)	101	MICROGESTIN 24 FE	111
MALARONE	10	<i>meperidine</i>	43	MICROGESTIN FE 1.5/30 (28)	111
MALARONE PEDIATRIC	10	<i>meperidine (pf)</i>	43	MICROGESTIN FE 1/20 (28)
<i>malathion</i>	76	<i>meprobamate</i>	43	111
<i>maraviroc</i>	10	MEPRON	10	<i>midodrine</i>	81
MARINOL	95	<i>mercaptapurine</i>	21	MIEBO (PF)	116
MARLISSA (28)	111	<i>meropenem</i>	10	<i>mifepristone</i>	89
MARPLAN	42	MERZEE	111	MIGERGOT	44
MATULANE	20	<i>mesalamine</i>	95, 96	<i>miglitol</i>	89
MATZIM LA	65	MESNEX	21	<i>miglustat</i>	89
MAVENCLAD (10 TABLET PACK)	42	MESTINON	43	MIGRANAL	44
MAVENCLAD (4 TABLET PACK)	42	MESTINON TIMESPAN	43	MILI	111
MAVENCLAD (5 TABLET PACK)	42	METADATE CD	43	MIMVEY	111
MAVENCLAD (6 TABLET PACK)	42	<i>metaxalone</i>	43	MINIVELLE	111
MAVENCLAD (6 TABLET PACK)	42	<i>metformin</i>	88	<i>minocycline</i>	11
MAVENCLAD (7 TABLET PACK)	42	<i>methadone</i>	43	<i>minoxidil</i>	65
MAVENCLAD (8 TABLET PACK)	42	<i>methamphetamine</i>	43	<i>mirabegron</i>	123
MAVENCLAD (9 TABLET PACK)	42	<i>methazolamide</i>	116	MIRENA	111
MAVENCLAD (8 TABLET PACK)	42	<i>methenamine hippurate</i>	10	<i>mirtazapine</i>	44
MAVENCLAD (9 TABLET PACK)	42	<i>methimazole</i>	89	MIRVASO	76
MAVYRET	10	METHITEST	89	<i>misoprostol</i>	96
MAXALT	43	<i>methocarbamol</i>	43	MITIGARE	106
MAXALT-MLT	43	<i>methotrexate sodium</i>	21	M-M-R II (PF)	101
MAXIDEX	116	<i>methotrexate sodium (pf)</i>	21	<i>modafinil</i>	44
MAXITROL	116	<i>methoxsalen</i>	76	<i>moexipril</i>	65
MAYZENT	43	<i>methscopolamine</i>	96	<i>molindone</i>	44
MAYZENT STARTER(FOR 1MG MAINT)	43	<i>methsuximide</i>	43	<i>mometasone</i>	76, 120
MAYZENT STARTER(FOR 2MG MAINT)	43	METHYLIN	43	<i>montelukast</i>	120
<i>meclizine</i>	95	<i>methylphenidate</i>	43	<i>morphine</i>	44, 45
<i>meclofenamate</i>	43	<i>methylphenidate hcl</i>	44	<i>morphine concentrate</i>	44
MEDROL	88	<i>methylprednisolone</i>	89	MOTEGRITY	96
MEDROL (PAK)	88	<i>methyltestosterone</i>	89	MOTPOLY XR	45
<i>medroxyprogesterone</i>	111	<i>metoclopramide hcl</i>	96	MOUNJARO	89
<i>mefenamic acid</i>	43	<i>metolazone</i>	65	MOVANTIK	96
<i>mefloquine</i>	10	<i>metoprolol succinate</i>	65	MOVIPREP	96
<i>megestrol</i>	20	<i>metoprolol ta-hydrochlorothiaz</i> ..	65	<i>moxifloxacin</i>	11, 116
MEKINIST	20	<i>metoprolol tartrate</i>	65	<i>moxifloxacin-sod.chloride(iso)</i> ... 11	
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		METROGEL	76	MULPLETA	66
		METROLOTION	76	MULTAQ	66
		<i>metronidazole</i>	10, 76, 111	<i>mupirocin</i>	76
		<i>metronidazole in nacl (iso-os)</i>	10	<i>mupirocin calcium</i>	76
		<i>metryrosine</i>	65	MYALEPT	89
		<i>mexiletine</i>	65	MYCAMINE	11

MYCAPSSA	21	NEO-SYNALAR	76	NORGESIC	46
MYCOBUTIN	11	NERLYNX	21	NORGESIC FORTE	46
<i>mycophenolate mofetil</i>	21	NESINA	89	<i>norgestimate-ethinyl estradiol</i> ..	112
<i>mycophenolate sodium</i>	21	NEUAC	76	NORITATE	77
MYDAYIS	45	NEULASTA	101	NORLIQVA	66
MYFEMBREE	111	NEUPOGEN	101	NORPACE	66
MYFORTIC	21	NEUPRO	46	NORPACE CR	66
MYHIBBIN	21	NEURONTIN	46	NORPRAMIN	46
MYRBETRIQ	123	NEVANAC	116	NORTHERA	81
MYSOLINE	45	<i>nevirapine</i>	11	NORTREL 0.5/35 (28)	112
MYTESI	96	NEXAVAR	21	NORTREL 1/35 (21)	112
<i>nabumetone</i>	45	NEXICLON XR	66	NORTREL 1/35 (28)	112
<i>nadolol</i>	66	NEXIUM	96	NORTREL 7/7/7 (28)	112
<i>nafcillin</i>	11	NEXIUM PACKET	96	<i>nortriptyline</i>	46
<i>naftifine</i>	76	NEXLETOL	66	NORVASC	66
NAFTIN	76	NEXLIZET	66	NORVIR	11
NALFON	45	NEXPLANON	111	NOURIANZ	46
NALOCET	45	NEXTSTELLIS	111	NOVOLIN 70/30 U-100	
<i>naloxone</i>	45	NGENLA	101	INSULIN	89
<i>naltrexone</i>	45	<i>niacin</i>	66	NOVOLIN 70-30 FLEXPEN	
NAMENDA TITRATION		NIACOR	66	U-100	89
PAK	45	<i>nicardipine</i>	66	NOVOLIN N FLEXPEN	89
NAMENDA XR	45	NICOTROL	81	NOVOLIN N NPH U-100	
NAMZARIC	45	NICOTROL NS	81	INSULIN	89
NAPRELAN CR	45	<i>nifedipine</i>	66	NOVOLIN R FLEXPEN	89
NAPROSYN	45	NIKKI (28)	111	NOVOLIN R REGULAR	
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<i>naproxen sodium</i>	45, 46	<i>nilutamide</i>	21	NOVOLOG FLEXPEN U-100	
<i>naproxen-esomeprazole</i>	46	<i>nimodipine</i>	66	INSULIN	89
<i>naratriptan</i>	46	NINLARO	21	NOVOLOG MIX 70-30 U-100	
NARDIL	46	<i>nisoldipine</i>	66	INSULN	89
NATACYN	116	<i>nitazoxanide</i>	11	NOVOLOG MIX 70-	
NATAZIA	111	<i>nitisinone</i>	81	30FLEXPEN U-100	89
<i>nateglinide</i>	89	NITRO-BID	66	NOVOLOG PENFILL U-100	
NATESTO	89	NITRO-DUR	66	INSULIN	89
NATROBA	76	<i>nitrofurantoin</i>	11	NOVOLOG U-100 INSULIN	
NAYZILAM	46	<i>nitrofurantoin macrocrystal</i>	11	ASPART	89
<i>nebivolol</i>	66	<i>nitrofurantoin monohyd/m-cryst</i> ..	11	NOXAFIL	11
NEBUPENT	11	<i>nitroglycerin</i>	66, 96	NUBEQA	21
NECON 0.5/35 (28)	111	NITROLINGUAL	66	NUCALA	120
<i>nefazodone</i>	46	NITROSTAT	66	NUCYNTA	46
<i>neomycin</i>	11	NITYR	81	NUCYNTA ER	46
<i>neomycin-bacitracin-poly-hc</i>	116	NIVESTYM	101	NUEDEXTA	46
<i>neomycin-bacitracin-polymyxin</i> ..	116	<i>nizatidine</i>	96	NUPLAZID	46
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<i>dexameth</i>	116	NORDITROPIN FLEXPRO ..	101	NUTRILIPID	125
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<i>neomycin-polymyxin-hc</i>	83, 116	<i>noreth-ethinyl estradiol-iron</i>	111	NUVARING	112
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NYVEPRIA	101	TITRATION KT	67	<i>mesylate(menop.sym)</i>	48
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OCELLA	112	ORGOVYX	22	PAXIL CR	48
OCTAGAM	101	ORIAHNN	112	PAXLOVID	12
<i>octreotide acetate</i>	21	ORLISSA	89	<i>pazopanib</i>	22
OCUFLOX	116	ORKAMBI	121	PEDIARIX (PF)	101
ODACTRA	101	ORLADEYO	121	PEDVAX HIB (PF)	101
ODEFSEY	11	ORMALVI	47	<i>peg 3350-electrolytes</i>	96
ODOMZO	21	<i>orphenadrine citrate</i>	47	<i>peg3350-sod sul-nacl-kcl-asb-c</i>	96
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OGSIVEO	21	<i>oseltamivir</i>	12	PEMAZYRE	22
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OJEMDA	21	OSMOLEX ER	47	PENBRAYA (PF)	101
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<i>olanzapine</i>	46	OTEZLA	106	<i>penicillamine</i>	106
<i>olanzapine-fluoxetine</i>	47	OTEZLA STARTER	106	<i>penicillin g pot in dextrose</i>	12
<i>olmesartan</i>	66	OTOVEL	83	<i>penicillin g potassium</i>	12
<i>olmesartan-amlodipin-hcthiazid</i>	66	OTREXUP (PF)	106	<i>penicillin g sodium</i>	12
<i>olmesartan-hydrochlorothiazide</i>	66	OVIDE	77	<i>penicillin v potassium</i>	12
<i>olopatadine</i>	83	<i>oxacillin</i>	12	PENNSAID	48
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OLUMIANT	106	<i>oxaprozin</i>	47	PENTAM	12
<i>omega-3 acid ethyl esters</i>	67	<i>oxazepam</i>	47	<i>pentamidine</i>	12
<i>omeprazole</i>	96	OXBRYTA	82	PENTASA	97
<i>omeprazole-sodium bicarbonate</i>	96	<i>oxcarbazepine</i>	47	<i>pentazocine-naloxone</i>	48
OMNARIS	121	OXERVATE	116	<i>pentoxifylline</i>	67
OMNITROPE	101	<i>oxiconazole</i>	77	PEPCID	97
OMVOH	96	OXISTAT	77	PERCOCET	48
OMVOH PEN	96	OXTELLAR XR	47	PERFOROMIST	121
<i>ondansetron</i>	96	<i>oxybutynin chloride</i>	123, 124	<i>perindopril erbumine</i>	67
<i>ondansetron hcl</i>	96	<i>oxycodone</i>	47	PERIOGARD	84
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ONGENTYS	47	<i>oxymorphone</i>	48	<i>perphenazine-amitriptyline</i>	48
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ONZETRA XSAIL	47	OZEMPIC	89	PERTZYE	97
OPSUMIT	121	OZOBAX DS	48	PHEBURANE	82
OPSYNVI	121	PACERONE	67	<i>phenelzine</i>	48
OPVEE	47	<i>paliperidone</i>	48	<i>phenobarbital</i>	48
OPZELURA	77	PALYNZIQ	89	<i>phenoxybenzamine</i>	67
ORACEA	12	PAMELOR	48	PHENYTEK	48
ORALAIR	101	PANCREAZE	96	<i>phenytoin</i>	48
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<i>pilocarpine hcl</i>	82, 116	PRED MILD	116	PROMETHEGAN	121
<i>pimecrolimus</i>	77	<i>prednisolone</i>	90	PROMETRIUM	112
<i>pimozide</i>	49	<i>prednisolone acetate</i>	116	<i>propafenone</i>	68
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<i>pindolol</i>	67	90, 116	<i>propylthiouracil</i>	90
<i>pioglitazone</i>	90	<i>prednisone</i>	90	PROQUAD (PF)	102
<i>pioglitazone-glimepiride</i>	90	PREDNISON INTENSOL	90	PROSCAR	124
<i>pioglitazone-metformin</i>	90	<i>pregabalin</i>	49	PROSOL 20 %	126
<i>piperacillin-tazobactam</i>	12	PREHEVBRIO (PF)	101	PROTONIX	97
PIQRAY	22	PREMARIN	112	<i>protriptyline</i>	49
<i>pirfenidone</i>	121	PREMASOL 10 %	126	PROVERA	112
<i>piroxicam</i>	49	PREMPHASE	112	PROVIGIL	49
<i>pitavastatin calcium</i>	67	PREMPRO	112	PROZAC	49
PLAQUENIL	12	PRENATAL VITAMIN		PRUDOXIN	77
PLASMA-LYTE 148	125	PLUS LOW IRON	126	PULMICORT	121
PLASMA-LYTE A	125	<i>pretomanid</i>	12	PULMICORT FLEXHALER	121
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PLEGRIDY	101	PREVACID SOLUTAB	97	PURIXAN	22
PLENAMINE	125	PREVALITE	67	PYLERA	97
PLENVU	97	PREVYMIS	12	<i>pyrazinamide</i>	13
PLIAGLIS	77	PREZCOBIX	12	<i>pyridostigmine bromide</i>	49
<i>podofilox</i>	77	PREZISTA	12	<i>pyrimethamine</i>	13
POLYCYN	116	PRIFTIN	12	PYRUKYND	82
<i>polymyxin b sulfate</i>	12	PRIOSEC	97	QBRELIS	68
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PONVORY	49	<i>primidone</i>	49	QELBREE	49
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<i>posaconazole</i>	12	PROAIR RESPICLICK	121	QUADRACEL (PF)	102
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<i>0.45%nacl</i>	125	<i>probenecid-colchicine</i>	106	QUARTETTE	112
<i>potassium chloride</i>	125	PROCARDIA XL	67	QUDEXY XR	49
<i>potassium chloride in 0.9%nacl</i>	125	PROCENTRA	49	QUESTRAN	68
<i>potassium chloride in 5 % dex</i> ..	125	<i>prochlorperazine</i>	97	QUESTRAN LIGHT	68
<i>potassium chloride in lr-d5</i>	125	<i>prochlorperazine maleate</i>	97	<i>quetiapine</i>	49, 50
<i>potassium chloride in water</i>	125	PROCRIT	102	QUILLICHEW ER	50
<i>potassium chloride-0.45 % nacl</i>	126	PROCTOFOAM HC	97	QUILLIVANT XR	50
<i>potassium chloride-d5-</i>		PROCTO-MED HC	97	<i>quinapril</i>	68
<i>0.2%nacl</i>	126	PROCTOSOL HC	97	<i>quinidine gluconate</i>	68
<i>potassium chloride-d5-</i>		PROCTOZONE-HC	97	<i>quinidine sulfate</i>	68
<i>0.9%nacl</i>	126	PROCYSBI	124	<i>quinine sulfate</i>	13
<i>potassium citrate</i>	124	<i>progesterone micronized</i>	112	QULIPTA	50
PRADAXA	67	PROGLYCEM	90	QUVIVIQ	50
PRALUENT PEN	67	PROGRAF	22	QVAR REDHALER	121
<i>pramipexole</i>	49	PROLASTIN-C	82	RABAVERT (PF)	102
<i>prasugrel</i>	67	PROLATE	49	<i>rabeprazole</i>	97
<i>pravastatin</i>	67	PROLENSA	116	RADICAVA ORS STARTER	
<i>praziquantel</i>	12	PROLIA	106	KIT SUSP	50

<i>raloxifene</i>	106	REZVOGLAR KWIKPEN	90	SAMSCA	90
<i>ramelteon</i>	50	RHOPRESSA	116	SANDIMMUNE	22
<i>ramipril</i>	68	<i>ribavirin</i>	13	SANDOSTATIN	22
<i>ranolazine</i>	68	RIDAURA	107	SANTYL	77
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RAPAMUNE	22	<i>rifampin</i>	13	<i>sapropterin</i>	90
<i>rasagiline</i>	50	<i>riluzole</i>	82	SAVAYSA	68
RASUVO (PF)	107	<i>rimantadine</i>	13	SAVELLA	107
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RAYALDEE	90	<i>risedronate</i>	82, 107	<i>saxagliptin-metformin</i>	90
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REGLAN	97	<i>rivastigmine tartrate</i>	51	SEMGLEE(INSULIN	
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RELPAK	50	ROCKLATAN	116	SEROQUEL XR	52
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REMERON	50	<i>ropinirole</i>	51	<i>sertraline</i>	52
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REYVOW	50	SABRIL	51	SINGULAIR	122
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SKYTROFA	102	STALEVO 200	52	SYMPROIC	98
SLYND	113	STALEVO 50	52	SYMTUZA	14
SOAAZ	68	STALEVO 75	52	SYNALAR	78
<i>sodium chloride</i>	82	STEGLATRO	91	SYNAREL	91
<i>sodium chloride 0.45 %</i>	126	STEGLUJAN	91	SYNDROS	98
<i>sodium chloride 0.9 %</i>	82	STELARA	78	SYNJARDY	91
<i>sodium chloride 3 % hypertonic</i>	126	STIMUFEND	102	SYNJARDY XR	91
<i>sodium chloride 5 % hypertonic</i>	126	STIOLTO RESPIMAT	122	SYNTHROID	91
<i>sodium oxybate</i>	52	STIVARGA	23	SYPRINE	82
<i>sodium phenylbutyrate</i>	82	STRATTERA	52	TABLOID	23
<i>sodium polystyrene sulfonate</i>	82	<i>streptomycin</i>	13	TABRECTA	23
<i>sodium,potassium,mag sulfates</i> ..	98	STRIBILD	13	TACLONEX	78
<i>sofosbuvir-velpatasvir</i>	13	STRIVERDI RESPIMAT	122	<i>tacrolimus</i>	23, 78
SOGROYA	102	STROMECTOL	14	<i>tadalafil</i>	124
SOHONOS	82	SUBOXONE	52	<i>tadalafil (pulm. hypertension)</i> ..	122
<i>solifenacin</i>	124	SUBVENITE	52	TADLIQ	122
SOLQUA 100/33	91	SUBVENITE STARTER (BLUE) KIT	52	TAFINLAR	23
SOLODYN	13	SUBVENITE STARTER (GREEN) KIT	52	<i>tafluprost (pf)</i>	117
SOLOSEC	13	SUBVENITE STARTER (ORANGE) KIT	53	TAGRISO	23
SOLTAMOX	23	SUCRAID	98	TAKHZYRO	122
SOMA	52	<i>sucralfate</i>	98	TALICIA	98
SOMAVERT	91	SUFLAVE	98	TALTZ AUTOINJECTOR	78
SOOLANTRA	78	SULAR	68	TALTZ SYRINGE	78
<i>sorafenib</i>	23	<i>sulfacetamide sodium</i>	117	TALZENNA	23
SORILUX	78	<i>sulfacetamide sodium (acne)</i>	78	TAMIFLU	14
SORINE	68	<i>sulfacetamide-prednisolone</i>	117	<i>tamoxifen</i>	23
<i>sotalol</i>	68	<i>sulfadiazine</i>	14	<i>tamsulosin</i>	124
SOTALOL AF	68	<i>sulfamethoxazole-trimethoprim</i> ..	14	TAPERDEX	91
SOTYKTU	78	SULFAMYLON	78	TARGADOX	14
SOTYLIZE	68	<i>sulfasalazine</i>	98	TARGRETIN	23
SOVALDI	13	<i>sulindac</i>	53	TARINA 24 FE	113
SOVUNA	13	<i>sumatriptan</i>	53	TARINA FE 1-20 EQ (28)	113
SPEVIGO	78	<i>sumatriptan succinate</i>	53	TARPEYO	91
<i>spinosad</i>	78	<i>sumatriptan-naproxen</i>	53	TASCENSO ODT	53
SPIRIVA RESPIMAT	122	<i>sunitinib malate</i>	23	TASIGNA	23
SPIRIVA WITH HANDIHALER	122	SUNLENCA	14	<i>tasimelteon</i>	53
<i>spironolactone</i>	68	SUNOSI	53	TASMAR	53
<i>spironolacton-hydrochlorothiaz.</i>	68	SUPREP BOWEL PREP KIT	98	<i>tavaborole</i>	78
SPORANOX	13	SUTAB	98	TAVALISSE	68
SPRINTEC (28)	113	SUTENT	23	TAVNEOS	82
SPRITAM	52	SYEDA	113	<i>tazarotene</i>	78
SPRIX	52	SYMBICORT	122	TAZICEF	14
SPRYCEL	23	SYMBYAX	53	TAZORAC	78
SPS (WITH SORBITOL)	82	SYMDEKO	122	TAZVERIK	23

TEGLUTIK	82	<i>tiotropium bromide</i>	122	TRELSTAR	23
TEGRETOL	53	TIROSINT	91	TREMFYA	78
TEGRETOL XR	53	TIROSINT-SOL	91	TRESIBA FLEXTOUCH U-	
TEGSEDI	53	TIVICAY	14	100	92
TEKTURNA	68	TIVICAY PD	14	TRESIBA FLEXTOUCH U-	
<i>telmisartan</i>	68	<i>tizanidine</i>	54	200	92
<i>telmisartan-amlodipine</i>	68	TLANDO	91	TRESIBA U-100 INSULIN	92
<i>telmisartan-hydrochlorothiazid</i> ..	68	TOBI	14	<i>tretinoin</i>	79
<i>temazepam</i>	53	TOBI PODHALER	14	<i>tretinoin (antineoplastic)</i>	23
TENCON	53	TOBRADEX	117	<i>tretinoin microspheres</i>	79
TENIVAC (PF)	102	TOBRADEX ST	117	TREXALL	23
<i>tenofovir disoproxil fumarate</i>	14	<i>tobramycin</i>	14, 117	TREXIMET	54
TENORETIC 100	68	<i>tobramycin in 0.225 % nacl</i>	14	TREZIX	54
TENORETIC 50	68	<i>tobramycin sulfate</i>	14	<i>triamcinolone acetonide</i>	79, 84
TENORMIN	69	<i>tobramycin-dexamethasone</i>	117	<i>triamterene</i>	69
TEPMETKO	23	TOBREX	117	<i>triamterene-hydrochlorothiazid</i> ..	69
<i>terazosin</i>	69	<i>tolcapone</i>	54	<i>triazolam</i>	54
<i>terbinafine hcl</i>	14	TOLECTIN 600	54	TRIBENZOR	69
<i>terbutaline</i>	122	<i>tolmetin</i>	54	TRICOR	69
<i>terconazole</i>	113	TOLSURA	14	TRIDACAINE II	79
<i>teriflunomide</i>	53	<i>tolterodine</i>	124	TRIDERM	79
<i>teriparatide</i>	107	<i>tolvaptan</i>	92	<i>trientine</i>	83
TESTIM	91	TOPAMAX	54	TRI-ESTARYLLA	113
<i>testosterone</i>	91	TOPICORT	78	<i>trifluoperazine</i>	54
<i>testosterone cypionate</i>	91	<i>topiramate</i>	54	<i>trifluridine</i>	117
<i>testosterone enanthate</i>	91	TOPROL XL	69	<i>trihexyphenidyl</i>	54
<i>tetanus, diphtheria tox ped(pf)</i> ...	102	<i>toremifene</i>	23	TRIJARDY XR	92
<i>tetrabenazine</i>	53	TORPENZ	23	TRIKAFTA	122
<i>tetracycline</i>	14	<i>torseamide</i>	69	TRI-LEGEST FE	113
TEXACORT	78	TOSYMRA	54	TRILEPTAL	54
THALITONE	69	TOUJEO MAX U-300		TRILIPIX	69
THALOMID	23	SOLOSTAR	92	TRI-LO-ESTARYLLA	113
THEO-24	122	TOUJEO SOLOSTAR U-300		TRI-LO-SPRINTEC	113
<i>theophylline</i>	122	INSULIN	92	<i>trimethobenzamide</i>	98
THIOLA	82	TOVET EMOLLIENT	78	<i>trimethoprim</i>	14
THIOLA EC	82	TOVIAZ	124	TRI-MILI	113
<i>thioridazine</i>	53	TPN ELECTROLYTES	126	<i>trimipramine</i>	54
<i>thiothixene</i>	54	TRACLEER	122	TRINTELLIX	55
THYQUIDITY	91	TRADJENTA	92	TRI-NYMYO	113
TIADYL ER	69	<i>tramadol</i>	54	TRI-SPRINTEC (28)	113
<i>tiagabine</i>	54	<i>tramadol-acetaminophen</i>	54	TRIUMEQ	14
TIAZAC	69	<i>trandolapril</i>	69	TRIUMEQ PD	14
TIBSOVO	23	<i>trandolapril-verapamil</i>	69	TRIVORA (28)	113
TICOVAC	102	<i>tranexamic acid</i>	113	TRI-VYLIBRA	113
<i>tigecycline</i>	14	TRANSDERM-SCOP	98	TRI-VYLIBRA LO	113
TIKOSYN	69	<i>tranylcypramine</i>	54	TRIZIVIR	14
TILIA FE	113	TRAVASOL 10 %	126	TROKENDI XR	55
<i>timolol maleate</i>	69, 117	TRAVATAN Z	117	TROPHAMINE 10 %	126
<i>timolol maleate (pf)</i>	117	<i>travoprost</i>	117	<i>trospium</i>	124
TIMOPTIC OCUDOSE (PF)	117	<i>trazodone</i>	54	TRUDHESA	55
<i>tinidazole</i>	14	TRECTOR	14	TRULANCE	98
<i>tiopronin</i>	82	TRELEGY ELLIPTA	122	TRULICITY	92

TRUMENBA	102	<i>vancomycin</i>	15	VIMOVO	56
TRUQAP	24	VANFLYTA	24	VIMPAT	56
TRUVADA	14	VANOS	79	VIOKACE	98
TUDORZA PRESSAIR	122	VAQTA (PF)	102	VIRACEPT	15
TUKYSA	24	<i>varenicline</i>	83	VIREAD	15
TURALIO	24	VARIVAX (PF)	102	VISTARIL	123
TURQOZ (28)	113	VARUBI	98	VITRAKVI	24
TWINRIX (PF)	102	VASCEPA	69	VIVELLE-DOT	113
TWYNEO	79	VASERETIC	69	VIVITROL	56
TYBLUME	113	VASOTEC	69	VIVJOA	15
TYBOST	15	VECAMEYL	69	VIZIMPRO	24
TYDEMY	113	VECTICAL	79	VOGELXO	92
TYENNE	107	VELIVET TRIPHASIC		VONJO	24
TYENNE AUTOINJECTOR	107	REGIMEN (28)	113	VOQUEZNA	98
TYGACIL	15	VELPHORO	83	VOQUEZNA DUAL PAK	98
TYKERB	24	VELSIPITY	98	VOQUEZNA TRIPLE PAK	98
TYMLOS	107	VELTASSA	83	<i>voriconazole</i>	15
TYPHIM VI	102	VELTIN	79	VOSEVI	15
TYRVAYA	117	VELMIDY	15	VOTRIENT	24
TYVASO DPI	122	VENCLEXTA	24	VOWST	98
UBRELVY	55	VENCLEXTA STARTING		VOXZOGO	92
UCERIS	98	PACK	24	VRAYLAR	56
UDENYCA	102	<i>venlafaxine</i>	56	VTAMA	79
UDENYCA		<i>venlafaxine besylate</i>	55	VUITY	117
AUTOINJECTOR	102	VENTOLIN HFA	122	VUMERITY	56
ULORIC	107	VEOZAH	113	VYFEMLA (28)	113
ULTRAVATE	79	<i>verapamil</i>	69	VYLIBRA	113
UNASYN	15	VERDESO	79	VYNDAMAX	69
UNITHROID	92	VEREGEN	79	VYNDAQEL	70
UPTRAVI	69	VERELAN	69	VYTORIN 10-10	70
UROCIT-K 10	124	VERELAN PM	69	VYTORIN 10-20	70
UROCIT-K 15	124	VERKAZIA	117	VYTORIN 10-40	70
UROCIT-K 5	124	VERQUVO	69	VYTORIN 10-80	70
UROXATRAL	124	VERSACLOZ	56	VYVANSE	56
URSO 250	98	VERZENIO	24	VYZULTA	117
URSO FORTE	98	VESICARE	124	WAINUA	56
<i>ursodiol</i>	98	VESICARE LS	124	WAKIX	56
UZEDY	55	VESTURA (28)	113	<i>warfarin</i>	70
VABOMERE	15	VEVYE	117	WEGOVY	83
VAGIFEM	113	VFEND	15	WELCHOL	70
<i>valacyclovir</i>	15	VFEND IV	15	WELIREG	24
VALCHLOR	79	VIBERZI	98	WELLBUTRIN SR	56
VALCYTE	15	VICTOZA 3-PAK	92	WELLBUTRIN XL	56
<i>valganciclovir</i>	15	VIENVA	113	WINLEVI	79
VALIUM	55	<i>vigabatrin</i>	56	WINREVAIR	123
<i>valproic acid</i>	55	VIGADRONE	56	WIXELA INHUB	123
<i>valproic acid (as sodium salt)</i>	55	VIGAMOX	117	WYMZYA FE	113
<i>valsartan</i>	69	VIGPODER	56	XACIATO	113
<i>valsartan-hydrochlorothiazide</i> ...	69	VIIBRYD	56	XALATAN	117
VALTOCO	55	VIJOICE	24	XALKORI	24
VALTREX	15	<i>vilazodone</i>	56	XANAX	56
VANCOCIN	15			XANAX XR	56

XARELTO.....	70	ZARONTIN.....	57	<i>zolpidem</i>	58
XARELTO DVT-PE TREAT 30D START.....	70	ZARXIO.....	103	ZOMACTON.....	103
XATMEP.....	24	ZAVESCA.....	92	ZOMIG.....	58
XCOPRI.....	57	ZAVZPRET.....	57	ZONALON.....	79
XCOPRI MAINTENANCE PACK.....	57	ZEGALOGUE AUTOINJECTOR.....	92	ZONEGRAN.....	58
XCOPRI TITRATION PACK.....	57	ZEGALOGUE SYRINGE.....	92	ZONISADE.....	58
XDEMVI.....	117	ZEGERID.....	98	<i>zonisamide</i>	58
XELJANZ.....	107	ZEJULA.....	25	ZONTIVITY.....	70
XELJANZ XR.....	107	ZELAPAR.....	57	ZORTRESS.....	25
XELPROS.....	117	ZELBORAF.....	25	ZORYVE.....	79
XELSTRYM.....	57	ZEMAIRA.....	83	ZOSYN IN DEXTROSE (ISO-OSM).....	16
XENAZINE.....	57	ZEMBRACE SYMTOUCH.....	57	ZOVIA 1-35 (28).....	114
XERESE.....	79	ZEMDRI.....	15	ZOVIRAX.....	79
XERMELO.....	24	ZEMPLAR.....	92	ZTALMY.....	58
XGEVA.....	24	ZENATANE.....	79	ZTLIDO.....	79
XHANCE.....	123	ZENPEP.....	99	ZUBSOLV.....	58
XIFAXAN.....	15	ZENZEDI.....	57	ZURZUVAE.....	58
XIGDUO XR.....	92	ZEPATIER.....	15	ZYCLARA.....	79
XIIDRA.....	117	ZEPOSIA.....	57	ZYDELIG.....	25
XOFLUZA.....	15	ZEPOSIA STARTER KIT (28-DAY).....	57	ZYFLO.....	123
XOLAIR.....	123	ZEPOSIA STARTER PACK (7-DAY).....	57	ZYKADIA.....	25
XOLREMDI.....	102	ZERBAXA.....	15	ZYLET.....	117
XOPENEX HFA.....	123	ZERVIAE.....	117	ZYMFENTRA.....	99
XOSPATA.....	24	ZESTORETIC.....	70	ZYPITAMAG.....	70
XPOVIO.....	24	ZESTRIL.....	70	ZYPREXA.....	58
XTAMPZA ER.....	57	ZETIA.....	70	ZYPREXA RELPREVV.....	59
XTANDI.....	25	ZIAC.....	70	ZYPREXA ZYDIS.....	59
XULANE.....	113	ZIAGEN.....	15	ZYTIGA.....	25
XULTOPHY 100/3.6.....	92	ZIANA.....	79	ZYVOX.....	16
XURIDEN.....	83	<i>zidovudine</i>	15		
XYOSTED.....	92	ZIEXTENZO.....	103		
XYREM.....	57	ZILBRYSQ.....	57, 58		
XYWAV.....	57	<i>zileuton</i>	123		
YARGESA.....	92	ZILXI.....	79		
YASMIN (28).....	113	ZIMHI.....	58		
YAZ (28).....	113	ZIOPTAN (PF).....	117		
YF-VAX (PF).....	103	<i>ziprasidone hcl</i>	58		
YONSA.....	25	<i>ziprasidone mesylate</i>	58		
YUFLYMA(CF).....	107	ZIPSOR.....	58		
YUFLYMA(CF) AI CROHN'S-UC-HS.....	107	ZIRGAN.....	117		
YUFLYMA(CF) AUTOINJECTOR.....	107	ZITHROMAX.....	16		
YUPELRI.....	123	ZITHROMAX TRI-PAK.....	16		
YUSIMRY(CF) PEN.....	107	ZITHROMAX Z-PAK.....	16		
YUVAFEM.....	113	ZITUVIO.....	92		
ZAFEMY.....	114	ZOCOR.....	70		
<i>zafirlukast</i>	123	ZOKINVY.....	83		
<i>zaleplon</i>	57	ZOLINZA.....	25		
ZANAFLEX.....	57	<i>zolmitriptan</i>	58		
		ZOLOFT.....	58		

Acitretin

Products Affected

- *acitretin*

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

Actemra

Products Affected

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

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

Acthar H.P.

Products Affected

- ACTHAR
- ACTHAR SELFJECT

PA Criteria	Criteria Details
Exclusion Criteria	Acthar Gel SelfJect used for the treatment of infantile spasms.
Required Medical Information	Covered for the following indications: 1. Infantile spasms (West syndrome) in children less than 2 years of age (vial only) 2. Acute exacerbations of multiple sclerosis (MS) for patients receiving concurrent immunomodulator therapy (e.g., interferon beta, glatiramer acetate, dimethyl fumarate, fingolimod, teriflunomide) 3. Rheumatic disorders for patients receiving maintenance therapy with at least one NSAID, DMARD (e.g. leflunomide) or biologic (e.g. adalimumab) 4. Collagen diseases for members receiving maintenance therapy with at least one antimalarial (e.g. hydroxychloroquine) or immunosuppressant (e.g. azathioprine) 5. Dermatologic diseases 6. Allergic states (i.e. serum sickness and transfusion reaction due to serum protein reaction 7. Ophthalmic diseases 8. Respiratory diseases 9. Gout and unable to take first-line therapies. 10. Pediatric acquired epileptic aphasia. 11. Proteinuria in nephrotic syndrome and trial/failure or contraindication to two therapies from any of the following different classes: corticosteroids (e.g., cortisone or dexamethasone), calcineurin inhibitors (e.g., cyclosporine or tacrolimus, per DRUGDEX). For covered indications 2 through 10, limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (i.e. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month

PA Criteria	Criteria Details
Other Criteria	For reauthorization, the following (1. 2. and 3.) must be met. 1) Prescriber attestation that the member cannot use corticosteroids (e.g. IV methylprednisolone, high dose oral corticosteroids) due to unsatisfactory response, intolerance (e.g. severe anaphylaxis) or experienced a severe adverse event to corticosteroids (e.g. psychosis). 2) If the reauthorization is for the treatment of multiple sclerosis, a rheumatic disorder, dermatologic disease, or nephrotic syndrome, the prescriber attests that H.P. Acthar is being used for a new acute exacerbation and not on a routine basis to prevent an exacerbation as supported by Compendia. 3) If the reauthorization is for treatment of multiple sclerosis, a rheumatic disorder, or collagen disease, the member continues to receive maintenance therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Gout, Epileptic Aphasia
Part B Prerequisite	No

Actimmune

Products Affected

- ACTIMMUNE

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

Adalimumab

Products Affected

- **ABRILADA(CF)**
- **ABRILADA(CF) PEN**
- *adalimumab-aacf subcutaneous pen injector kit*
- *adalimumab-aaty*
- *adalimumab-fkjp subcutaneous pen injector kit*
- *adalimumab-fkjp subcutaneous syringe kit*
- *adalimumab-ryvk subcutaneous auto-injector, kit*
- **AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML, 40 MG/0.8 ML, 80 MG/0.8 ML**
- **AMJEVITA(CF) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML, 20 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.4 ML, 40 MG/0.8 ML**
- **HADLIMA**
- **HADLIMA PUSHTOUCH**
- **HADLIMA(CF)**
- **HADLIMA(CF) PUSHTOUCH**
- **HULIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT**
- **HULIO(CF) SUBCUTANEOUS SYRINGE KIT**
- **IDACIO(CF)**
- **IDACIO(CF) PEN CROHN-UC STARTR**
- **IDACIO(CF) PEN PSORIASIS START**
- **IDACIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT**
- **SIMLANDI(CF) AUTOINJECTOR**
- **YUFLYMA(CF)**
- **YUFLYMA(CF) AI CROHN'S-UC-HS**
- **YUFLYMA(CF) AUTOINJECTOR**
- **YUSIMRY(CF) PEN**

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

PA Criteria	Criteria Details
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, and Ankylosing Spondylitis or less than 12 years of age for Hidradenitis Suppurative or Less than 6 years of age for Crohn's disease or Less than 5 years of age for Ulcerative Colitis or less than 2 years of age for Juvenile Idiopathic Arthritis and Uveitis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Therapeutic failure or intolerance to 2 of the following preferred products is required: Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm. 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: preferred adalimumab products include Humira with NDC starting 00074, Cyltezo with NDC starting 00597, Hyrimoz with NDC starting 61314, adalimumab-adaz with NDC starting 61314, and adalimumab-adbm with NDC starting 00597.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Adbry

Products Affected

- **ADBRY SUBCUTANEOUS SYRINGE**

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

ADHD Drugs

Products Affected

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

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

Adlarity

Products Affected

- ADLARITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- one of the following (1 or 2): 1) therapeutic failure or intolerance to donepezil tablets, 2) Unable to take daily oral donepezil due to impaired memory.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Afinitor

Products Affected

- **AFINITOR** *mg, 2.5 mg, 5 mg, 7.5 mg*
- **AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG** • *everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg*
- *everolimus (antineoplastic) oral tablet 10*

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

Agamree

Products Affected

- AGAMREE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Duchenne muscular dystrophy (DMD) with mutation of dystrophin gene -AND- One of the following: 1) Therapeutic failure, intolerance, or contraindication to prednisone, or 2) Growth delay or decline while on prednisone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Aimovig

Products Affected

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

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

Ajovy

Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

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

Akeega

Products Affected

- **AKEEGA**

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

Alecensa

Products Affected

- ALECENSA

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

Alkindi

Products Affected

- **ALKINDI SPRINKLE**

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

Alpha1-Proteinase Inhibitors

Products Affected

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

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

Alunbrig

Products Affected

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

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

Amlodipine Liquid

Products Affected

- **KATERZIA**
- **NORLIQVA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Inability to swallow amlodipine tablets
Age Restrictions	Deny if less than 6 years of age for Hypertension
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ampyra

Products Affected

- AMPYRA
- *dalfampridine*

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

Anabolic Steroids

Products Affected

- **METHITEST**
- *methyltestosterone oral capsule*

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

Apokyn

Products Affected

- **APOKYN**
- *apomorphine*

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

Arikayce

Products Affected

- ARIKAYCE

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

Aspruzyo Sprinkle

Products Affected

- ASPRUZYO SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic angina -AND- Therapeutic failure, contraindication, or intolerance to one beta-blocker (e.g., propranolol oral solution, metoprolol tartrate, propranolol immediate-release) -AND- Inability to swallow generic ranolazine tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ATTR-CM drugs

Products Affected

- VYNDAMAX
- VYNDAQEL

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

Atypical Antipsychotics

Products Affected

- **ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET WITH SENSOR AND STRIP 15 MG, 2 MG, 20 MG, 30 MG, 5 MG**
- **ABILIFY MYCITE STARTER KIT**
- **ORAL TABLET WITH SENSOR, STRIP, POD 10 MG**
- **ABILIFY ORAL TABLET**
- *aripiprazole*
- **REXULTI ORAL TABLET**

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

Aubagio

Products Affected

- **AUBAGIO**
- *teriflunomide*

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

Augtyro

Products Affected

- AUGTYRO

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

Auryxia

Products Affected

- AURYXIA

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

Austedo

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 6 MG (14)-12 MG (14)-24 MG (14)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3) 1) Chorea associated with Huntington's disease 2) In patients with comorbid depression, attestation of adequate treatment for depression is required. 3) Attestation that patient is not actively suicidal. -OR- 4) Tardive Dyskinesia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Auvelity

Products Affected

- AUVELITY

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

Ayvakit

Products Affected

- **AYVAKIT**

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

Baclofen Solution

Products Affected

- *baclofen oral solution 10 mg/5 ml (2 mg/ml)*
- **OZOBAX DS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- the member has an inability to swallow generic baclofen tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Bafiertam

Products Affected

- **BAFIERTAM**

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

Balversa

Products Affected

- BALVERSA

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

Banzel

Products Affected

- **BANZEL**
- *rufinamide*

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

Benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

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

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

Benznidazole

Products Affected

- *benznidazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	Deny if less than 2 years of age.
Prescriber Restrictions	
Coverage Duration	2 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Berinert

Products Affected

- **BERINERT INTRAVENOUS KIT**

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

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

Besremi

Products Affected

- **BESREMI**

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

Bimzelx

Products Affected

- **BIMZELX**
- **BIMZELX AUTOINJECTOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- documentation of member weight and prescribed dose. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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, Enbrel and Skyrizi SC. Must follow recommended dosing guidelines based upon weight. Induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Bonjesta

Products Affected

- **BONJESTA**
- **DICLEGIS**
- *doxylamine-pyridoxine (vit b6)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	9 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Bosulif

Products Affected

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

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

Braftovi

Products Affected

- BRAFTOVI

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

Bronchitol

Products Affected

- BRONCHITOL

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

Brukinsa

Products Affected

- BRUKINSA

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

Buphenyl

Products Affected

- **BUPHENYL**
- *sodium phenylbutyrate*

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

Bylvay

Products Affected

- **BYLVAY ORAL CAPSULE 1,200 MCG, 400 MCG**
- **BYLVAY ORAL PELLETT 200 MCG, 600 MCG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of pruritis with progressive familial intrahepatic cholestasis or cholestatic pruritus with Alagille syndrome -AND- The member does not have cirrhosis, portal hypertension, or history of hepatic decompensation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial, 12 months reauthorization
Other Criteria	For reauthorization, attestation of improvement in pruritis -AND- attestation that the member has not progressed to any of the following (1-3): 1) portal hypertension, 2) cirrhosis, or 3) experienced a hepatic decompensation event.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cablivi

Products Affected

- CABLIVI INJECTION KIT

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

Cabometyx

Products Affected

- CABOMETYX

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

Calquence

Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

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

Camzyos

Products Affected

- CAMZYOS

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

Caplyta

Products Affected

- CAPLYTA

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

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

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

Carac

Products Affected

- CARAC

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

Carbaglu

Products Affected

- **CARBAGLU**
- *carglumic acid*

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

Carbinoxamine

Products Affected

- *carbinoxamine maleate oral liquid*
- *carbinoxamine maleate oral tablet*
- **RYVENT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Failure, contraindication or intolerance to 2 antihistamines indicated for diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cayston

Products Affected

- CAYSTON

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

Cerdelga

Products Affected

- CERDELGA

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

CF drugs

Products Affected

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

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

Chenodal

Products Affected

- CHENODAL

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

Cholbam

Products Affected

- CHOLBAM

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

Cialis

Products Affected

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

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

Cibinqo

Products Affected

- CIBINQO

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

Cimzia

Products Affected

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

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

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

Cinryze

Products Affected

- CINRYZE

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Citalopram Capsule

Products Affected

- *citalopram oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder -AND- citalpram 20 mg has been received for greater than or equal to 7 days -AND- Therapeutic failure or intolerance to generic citalopram tablets -AND- Therapeutic failure, intolerance or contraindication to at least one other antidepressant (e.g. SNRI, SSRI, TCA, MAOI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Clemastine Syrup

Products Affected

- *clemastine oral syrup*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of allergic rhinitis or mild, uncomplicated allergic skin manifestations of urticaria and angioedema -AND- Therapeutic failure, contraindication or intolerance to one generic antihistamine product - AND- Therapeutic failure or intolerance to generic clemastine fumarate tablets or an inability to swallow tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cometriq

Products Affected

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

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

Copiktra

Products Affected

- **COPIKTRA**

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

Corlanor

Products Affected

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

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

Cosentyx

Products Affected

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

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

Cotellic

Products Affected

- COTELLIC

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

Cresemba

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of invasive aspergillosis infection -AND- therapeutic failure, contraindication, or intolerance to voriconazole -OR- Documentation of invasive mucormycosis infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of presence of continued indicators of active disease (e.g. histopathology, fungal culture).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Crinone

Products Affected

- CRINONE

PA Criteria	Criteria Details
Exclusion Criteria	Use to promote fertility
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

Cuvrior

Products Affected

- CUVRIOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of stable Wilson's disease -AND- Previously tolerated one penicillamine product used for de-coppering (e.g., generic penicillamine tablet or capsule, Depen) -AND- Therapeutic failure or intolerance to generic trientine hydrochloride
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cysteamine Ophthalmic Drops

Products Affected

- CYSTADROPS
- CYSTARAN

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

Daraprim

Products Affected

- **DARAPRIM**
- *pyrimethamine*

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

Daurismo

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

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

Daybue

Products Affected

- DAYBUE

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

Daytrana

Products Affected

- **DAYTRANA**
- *methylphenidate*

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

Deferasirox

Products Affected

- *deferasirox*
- **EXJADE**
- **JADENU**
- **JADENU SPRINKLE**

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

Diacomit

Products Affected

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

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

Dihydroergotamine

Products Affected

- *dihydroergotamine nasal*
- **MIGRANAL**
- **TRUDHESA**

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

Dojolvi

Products Affected

- DOJOLVI

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

Doptelet

Products Affected

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

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

Doxepin Cream

Products Affected

- *doxepin topical*
- **PRUDOXIN**
- **ZONALON**

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

Drizalma

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- inability to swallow tablets/capsules. For fibromyalgia, members must also have widespread bilateral pain above and below the waist for greater than 3 months duration -AND- At least 1 fibromyalgia-related symptom (e.g., cognitive impairment, fatigue, sleep disturbance, neurologic symptoms, exercise intolerance).
Age Restrictions	Deny if less than 18 years of age in the treatment of fibromyalgia, major depressive disorder, diabetic peripheral neuropathy and chronic musculoskeletal pain -OR- if less than 7 years of age in generalized anxiety disorder
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Duexis2

Products Affected

- *ibuprofen-famotidine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) Trial/failure of ibuprofen used in combination with famotidine. -AND- 2) Trial/failure of one additional generic formulary NSAID (other than ibuprofen) used in combination with another generic formulary H2-receptor blocker (other than famotidine).
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

Duobrii

Products Affected

- DUOBRII

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

Dupixent

Products Affected

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

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

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

Duvyzat

Products Affected

- DUVYZAT

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

EGFR Tyrosine Kinase Inhibitors

Products Affected

- *erlotinib*
- **GILOTRIF**

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

Egrifta

Products Affected

- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of HIV and lipodystrophy, member must actively be receiving antiretroviral therapy including protease inhibitors, nucleoside reverse transcriptase inhibitors, or non-nucleoside reverse transcriptase inhibitors
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Elyxyb

Products Affected

- **ELYXYB**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of migraine diagnosis -AND- trial/failure or intolerance to 2 generic NSAIDs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of reduction in migraine symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Emflaza

Products Affected

- *deflazacort*
- **EMFLAZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Duchenne muscular dystrophy (DMD) with mutation of dystrophin gene -AND- onset of weakness or history of DMD starting before age 5 -AND- One of the following (1, 2, or 3). 1) Documented trial/failure, intolerance or contraindication to prednisone. 2) Documented trial of prednisone has resulted in intolerable adverse events (e.g. diabetes, hypertension that is difficult to manage, Cushingoid features, truncal obesity, greater than or equal to 10 percent increase in body weight over a 6 month period). 3) Documented severe behavioral adverse event while on prednisone that warrants prednisone dose reduction impacting efficacy for management of DMD (i.e. abnormal behavior, aggression, irritability, disturbance in mood)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Emflaza tablets and 5 years of age or older, therapeutic failure or intolerance to generic deflazacort tablets is required. For brand Emflaza suspension and 5 years of age or older, therapeutic failure or intolerance to generic deflazacort tablets or inability to swallow tablets is required, and therapeutic failure or intolerance to generic deflazacort suspension. For generic deflazacort suspension and 5 years of age or older, therapeutic failure or intolerance to generic deflazacort tablets or inability to swallow tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Emgality

Products Affected

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

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Enbrel

Products Affected

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

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

Endari

Products Affected

- **ENDARI**
- *glutamine (sickle cell)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Sickle Cell Disease with 2 or more sickle cell acute complications (e.g. vaso-occlusive crisis, acute anemia, acute chest syndrome, etc.) -AND- documentation of concurrent use, therapeutic failure, contraindication, or intolerance to hydroxyurea.
Age Restrictions	Deny if less than 5 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Endari, initial authorization requires documentation of trial and failure of generic prescription L-glutamine and reauthorization requires failure of generic prescription L-glutamine if not previously trialed. For reauthorization, attestation of stability in sickle cell acute complications or decrease in number of sickle cell acute complications is required (e.g. vaso-occlusive crisis, acute anemia, acute chest syndrome, etc.)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Enspryng

Products Affected

- ENSPRYNG

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

Entadfi

Products Affected

- ENTADFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of use for the initial treatment of benign prostatic hyperplasia (BPH) -AND- Trial/failure of finasteride used in combination with tadalafil.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For reauthorization, attestation that the member is reinitiating treatment for BPH.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Entresto Sprinkle

Products Affected

- ENTRESTO SPRINKLE

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

Entyvio

Products Affected

- ENTYVIO PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation of clinical response or remission following at least 2 doses of IV Entyvio at least 6 weeks before initiating therapy with Entyvio SC.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For moderate to severe ulcerative colitis, 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), Rinvoq, Xeljanz/Xeljanz XR, and Stelara SC. For moderate to severe active Crohn's disease, 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), Rinvoq, Skyrizi SC, and Stelara SC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Epclusa

Products Affected

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

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

Epidiolex

Products Affected

- EPIDIOLEX

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

Eprontia

Products Affected

- **EPRONTIA**

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

Ergotamine

Products Affected

- *ergotamine-caffeine*

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

Erivedge

Products Affected

- ERIVEDGE

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

Erleada

Products Affected

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

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

Eucrisa

Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1 and 2): 1) mild to moderate atopic dermatitis 2) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- documentation of facial or anogenital involvement
Age Restrictions	Deny if less than 3 months of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	If 2 years of age or older, therapeutic failure of one of the following is required: topical tacrolimus -OR- topical pimecrolimus. Reauthorization or continuation of therapy will be approved when documentation of improvement or response to therapy is provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Evekeo

Products Affected

- *amphetamine sulfate*
- EVEKEO

PA Criteria	Criteria Details
Exclusion Criteria	Obesity
Required Medical Information	Documentation of diagnosis. For narcolepsy the following are required: 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.
Age Restrictions	Deny if less than 6 years of age for narcolepsy or 3 years of age for ADHD
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For narcolepsy, trial and failure, intolerance to 2 of the following generic alternatives is required: immediate release amphetamine/dextroamphetamine, dextroamphetamine, and methylphenidate. For ADHD, trial/failure or intolerance to 2 unique generic stimulants (e.g. methylphenidate) is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Evenity

Products Affected

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

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

Evrysdi

Products Affected

- EVRYSDI

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

Fabhalta

Products Affected

- FABHALTA

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

PA Criteria	Criteria Details
Part B Prerequisite	No

Fasenra

Products Affected

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

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Fecal Microbiota Products

Products Affected

- VOWST

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

Ferriprox

Products Affected

- *deferiprone*
- **FERRIPROX**
- **FERRIPROX (2 TIMES A DAY)**

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

Fetzima

Products Affected

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

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

Filspari

Products Affected

- FILSPARI

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

Filsuvez

Products Affected

- **FILSUVEZ**

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

Fintepla

Products Affected

- FINTEPLA

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

Firazyr

Products Affected

- **FIRAZYR**
- *icatibant*
- **SAJAZIR**

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Firdapse

Products Affected

- **FIRDAPSE**

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

Flector

Products Affected

- *diclofenac epolamine*
- **FLECTOR**
- **LICART**

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

Fleqsuvy

Products Affected

- *baclofen oral suspension*
- **FLEQSUVY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- the member has an inability to swallow generic baclofen tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Forteo

Products Affected

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

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

Fotivda

Products Affected

- FOTIVDA

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

Fruzaqla

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

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

Furoscix

Products Affected

- **FUROSCIX**

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

Gabapentin

Products Affected

- *gabapentin oral capsule 100 mg, 300 mg, 400 mg*
- *gabapentin oral solution 250 mg/5 ml*
- *gabapentin oral tablet 600 mg, 800 mg*
- **NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG**
- **NEURONTIN ORAL SOLUTION**
- **NEURONTIN ORAL TABLET 600 MG, 800 MG**

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

Galafold

Products Affected

- GALAFOLD

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

Gattex

Products Affected

- GATTEX 30-VIAL

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

Gavreto

Products Affected

- GAVRETO

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

Gilenya

Products Affected

- *fingolimod*
- GILENYA

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as teriflunomide, interferons, Copaxone, Tysabri
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	Brand Gilenya requires therapeutic failure or intolerance to generic fingolimod. For Brand Gilenya 0.25mg, failure of generic is not required if age is between 10-17 years old and weight is less than or equal to 40kg.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gimoti

Products Affected

- GIMOTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute or recurrent diabetic gastroparesis -AND- Attestation of no signs or symptoms of tardive dyskinesia -AND- Therapeutic failure or intolerance to generic metoclopramide (tablets, orally disintegrating tablets, or solution) or not a candidate for oral dosage forms -AND- If over 65 years of age, member was titrated to a stable does of metoclopramide tablets or solution at 10mg four times a day before switching to Gimoti therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	For reauthorization, treatment is for a new episode of diabetic gastroparesis -AND- There has been a 2 week drug holiday without Gimoti since its last administration -AND- Attestation of no signs or symptoms of tardive dyskinesia -AND- Attestation that extended therapy with Gimoti outweighs risk of developing tardive dyskinesia.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Glatiramer

Products Affected

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

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

Gleevec

Products Affected

- **GLEEVEC ORAL TABLET 100 MG, 400 MG**
- *imatinib oral tablet 100 mg, 400 mg*

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

Gleostine

Products Affected

- GLEOSTINE

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

GLP1

Products Affected

- **BYDUREON BCISE**
- **BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML, 5 MCG/DOSE (250 MCG/ML) 1.2 ML**
- *liraglutide*
- **MOUNJARO**
- **OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)**
- **RYBELSUS**
- **TRULICITY**
- **VICTOZA 3-PAK**

PA Criteria	Criteria Details
Exclusion Criteria	Obesity or use for weight loss
Required Medical Information	Documentation of diabetes mellitus type 2
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Bydureon Bcise, Byetta, and liraglutide, therapeutic failure or intolerance to two, or contraindication to all of the following: Mounjaro, Ozempic, Rybelsus, Trulicity, or Victoza.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Glycate

Products Affected

- **GLYCATE**
- *glycopyrrolate oral tablet 1.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- using as an adjunctive treatment for peptic ulcer disease -AND- Therapeutic failure or intolerance to both generic glycopyrrolate 1mg tablet AND 2 mg tablet
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of positive clinical response to therapy - AND- Additional courses of therapy are required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gocovri

Products Affected

- **GOCOVRI ORAL
CAPSULE,EXTENDED RELEASE 24HR
137 MG, 68.5 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For dyskinesia associated with Parkinson's disease, documentation of concurrent levodopa-based therapy -AND- trial and failure, contraindication, or intolerance to immediate-release amantadine. For off-episodes of Parkinson's disease, documentation of concurrent carbidopa/levodopa therapy -AND- trial and failure, contraindication, or intolerance to immediate-release amantadine -AND- trial and failure, contraindication, or intolerance to one (1) of the following agents: entacapone, pramipexole, rasagiline, ropinirole, or selegiline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gralise

Products Affected

- *gabapentin oral tablet extended release 24 hr 300 mg, 600 mg* **MG, 750 MG, 900 MG**
- **GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 450 MG, 600**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of postherpetic neuralgia (PHN) -AND- Trial and failure or intolerance to generic immediate-release gabapentin. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Grastek

Products Affected

- **GRASTEK**

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

Growth Hormone

Products Affected

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

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

Haegarda

Products Affected

- HAEGARDA

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Harvoni

Products Affected

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

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

Hemady

Products Affected

- **HEMADY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of multiple myeloma -AND- used in combination with other anti-myeloma agents -AND- therapeutic failure or intolerance to generic dexamethasone.
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

Hetlioz

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Non-24 Sleep-Wake disorder in patient that is totally blind -AND- evidenced by all the following (1 through 4): 1) history of insomnia, excessive daytime sleepiness, or both alternating with asymptomatic episodes 2) symptoms persistent for at least 3 months 3) daily sleep logs for at least 1 month demonstrating a sleep/wake pattern that delays each day 4) sleep disturbances are not better explained by another current disorder or medication/substance use -OR- Documented diagnosis of Smith-Magenis Syndrome as confirmed by chromosome analysis -AND- patient is experiencing nighttime sleep disturbances (e.g. difficulty falling asleep, shortened sleep cycles, inability to enter REM sleep, or frequent awaking during the night and early in the morning)
Age Restrictions	Deny if less than 16 years of age for nighttime sleep disturbances in Smith-Magenis Syndrome or deny if less than 18 years of age for Non-24 Hour Sleep-Wake Disorder
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For brand Hetlioz, documentation of trial and failure of generic tasimelteon is required. For reauthorization, attestation of increased total nighttime sleep or decreased daytime nap duration for Non-24 Sleep-Wake disorder -OR- attestation of positive clinical response to therapy with minimal side effects for Smith-Magenis Syndrome
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Hetlioz LQ

Products Affected

- HETLIOZ LQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Smith-Magenis Syndrome as confirmed by chromosome analysis -AND- patient is experiencing nighttime sleep disturbances (e.g. difficulty falling asleep, shortened sleep cycles, inability to enter REM sleep, or frequent awaking during the night and early in the morning)
Age Restrictions	Deny if less than 3 or greater than 15 years of age.
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of positive clinical response to therapy with minimal side effects for Smith-Magenis Syndrome -AND- member is between 3 and 15 years of age
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

High-risk meds

Products Affected

- *amitriptyline*
- *amitriptyline-chlordiazepoxide*
- **ANAFRANIL**
- *benztropine oral*
- *carisoprodol*
- *chlorzoxazone*
- *clomipramine*
- *cycloheptadine*
- *doxepin oral capsule*
- *doxepin oral concentrate*
- *doxepin oral tablet*
- *ergoloid*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate*
- *imipramine hcl*
- *imipramine pamoate*
- **LORZONE**
- *metaxalone*
- **NORGESIC**
- **NORGESIC FORTE**
- *orphenadrine citrate oral*
- *orphenadrine-asa-caffeine oral tablet 25-385-30 mg*
- *perphenazine-amitriptyline*
- *promethazine oral*
- **SILENOR**
- **SOMA**
- *trimipramine*
- **VISTARIL ORAL CAPSULE 25 MG**

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

High-risk meds phenobarbital

Products Affected

- *phenobarbital*

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

Homozygous FH

Products Affected

- JUXTAPID

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

Horizant

Products Affected

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

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

Humira

Products Affected

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

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

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

Hyftor

Products Affected

- **HYFTOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of tuberous sclerosis complex with facial angiofibromas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of positive clinical response to therapy (e.g. decrease in size of facial angiofibromas, decrease in redness of facial angiofibromas)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ibrance

Products Affected

- **IBRANCE**

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

Ibsrela

Products Affected

- **IBSRELA**

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

Iclusig

Products Affected

- ICLUSIG

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

Idhifa

Products Affected

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

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

IG

Products Affected

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

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

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

Ilumya

Products Affected

- ILUMYA

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

Imbruvica

Products Affected

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

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

Inbrija

Products Affected

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

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

Increlex

Products Affected

- INCRELEX

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

PA Criteria	Criteria Details
Part B Prerequisite	No

Ingrezza

Products Affected

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

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

Inlyta

Products Affected

- INLYTA

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

Inqovi

Products Affected

- INQOVI

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

Inrebic

Products Affected

- **INREBIC**

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

Interferon Alfa

Products Affected

- PEGASYS

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

Interferon Beta

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT
- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8MCG/0.2ML-22 MCG/0.5ML (6)
- REBIF TITRATION PACK

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

Interleukin-1b Blockers

Products Affected

- ARCALYST

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

Intrarosa

Products Affected

- INTRAROSA

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

IPF Agents

Products Affected

- **ESBRIET ORAL CAPSULE**
- **ESBRIET ORAL TABLET**
- **OFEV**
- *pirfenidone oral capsule*
- *pirfenidone oral tablet*

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Iqirvo

Products Affected

- IQIRVO

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

Iressa

Products Affected

- *gefitinib*
- **IRESSA**

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

Isturisa

Products Affected

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

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

Itraconazole

Products Affected

- *itraconazole*
- SPORANOX

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

Ivermectin Oral

Products Affected

- *ivermectin oral*
- **STROMEKTOL**

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

Iwilfin

Products Affected

- IWILFIN

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

Jakafi

Products Affected

- JAKAFI

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

Jaypirca

Products Affected

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

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

Joenja

Products Affected

- JOENJA

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

Jynarque

Products Affected

- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL

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

Kalydeco

Products Affected

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

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

Kerendia

Products Affected

- **KERENDIA**

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

Kesimpta

Products Affected

- **KESIMPTA PEN**

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

Keveyis

Products Affected

- KEVEYIS
- ORMALVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of one of the following: 1. Primary hyperkalemic periodic paralysis 2. Primary hypokalemic periodic paralysis 3. Related variants of primary periodic paralysis
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	2 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation the number of muscle weakness attacks per week has decreased from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kevzara

Products Affected

- KEVZARA

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

PA Criteria	Criteria Details
Part B Prerequisite	No

Kineret

Products Affected

- KINERET

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

Kisqali

Products Affected

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

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

Klisyri

Products Affected

- **KLISYRI**

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

Korlym

Products Affected

- **KORLYM**
- *mifepristone oral tablet 300 mg*

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

Koselugo

Products Affected

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

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

Krazati

Products Affected

- KRAZATI

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

Kuvan

Products Affected

- **JAVYGTOR**
- **KUVAN**
- *sapropterin*

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

Lampit

Products Affected

- LAMPIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Weight of at least 2.5 kg
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Latuda

Products Affected

- **LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG**
- *lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg*

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

Lenvima

Products Affected

- LENVIMA

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

Leukine

Products Affected

- LEUKINE INJECTION RECON SOLN

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

Leukotriene Modifiers

Products Affected

- *zileuton*
- **ZYFLO**

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

Libervant

Products Affected

- **LIBERVANT**

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

Lidoderm

Products Affected

- *lidocaine topical adhesive patch, medicated 5 %* • **TRIDACAIN E II**
- **LIDOCAN III**
- **LIDODERM**

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

Litfulo

Products Affected

- LITFULO

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

Livmarli

Products Affected

- **LIVMARLI ORAL SOLUTION 9.5 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Cholestatic Pruritus -AND- Documentation of one of the following diagnoses (1-2): 1) Alagille syndrome, 2) progressive familial intrahepatic cholestasis confirmed by genetic testing that is not PFIC type 2 with a ABCB11 variant resulting in nonfunctional or absent bile salt export pump (BSEP) protein -AND- Documentation that the member does not have any of the following diagnoses (3-5): 3) decompensated cirrhosis, 4) portal hypertension, 5) history of a hepatic decompensation event.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial, 12 months reauthorization
Other Criteria	For reauthorization, attestation of improvement in pruritus -AND- attestation that the member has not progressed to any of the following (1-3): 1) portal hypertension, 2) cirrhosis, or 3) experienced a hepatic decompensation event.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Livtency

Products Affected

- LIVTENCITY

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

Lodoco

Products Affected

- LODOCO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of established atherosclerotic disease (e.g., ASCVD, experienced CV event) or multiple risk factors for cardiovascular disease (e.g., high cholesterol, high blood pressure, obesity, diabetes, smoking) - AND- being used to reduce the risk of myocardial infarction, stroke, coronary revascularization, or cardiovascular death -AND- trial and failure of maximally tolerated statin or documentation of statin intolerance.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lokelma

Products Affected

- **LOKELMA**

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

Lonsurf

Products Affected

- LONSURF

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

Lorbrena

Products Affected

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

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

Lotronex

Products Affected

- *alosetron oral tablet 0.5 mg, 1 mg*
- **LOTROXEX ORAL TABLET 0.5 MG, 1 MG**

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

Lovaza

Products Affected

- LOVAZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For hypertriglyceridemia, triglycerides greater than or equal to 500mg/dL indicating sever hypertriglyceridemia -AND- Therapeutic failure or intolerance to a prescription, generic omega 3 acid ethyl ester capsules
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, reduction in triglyceride levels from baseline for hypertriglyceridemia
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lumakras

Products Affected

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

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

Lumryz

Products Affected

- LUMRYZ

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

Lupkynis

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of active lupus nephritis -AND- Documented positive ANA titer (greater than or equal to 1:80) or anti-dsDNA greater than or equal to 30 IU/mL -AND- Trial, contraindication, intolerance, or inadequate response to at least 2 of the following standard of care drug classes: 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate) -AND- Member will continue to receive concomitant standard of care treatment with corticosteroids (e.g. prednisone) and mycophenolate mofetil.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	24 weeks initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of disease stability or disease improvement -AND- member will continue to receive concomitant standard of care treatment with corticosteroids (e.g. prednisone) and mycophenolate mofetil.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lupron Depot Ped

Products Affected

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

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

Lybalvi

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of schizophrenia or bipolar I disorder -AND- One of the following (1 or 2): 1) Therapeutic failure, intolerance or contraindication to generic risperidone and generic quetiapine 2) Currently stable and responding to olanzapine but experiencing weight gain from the medication
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

Lynparza

Products Affected

- LYNPARZA

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

Lyrica

Products Affected

- LYRICA CR
 - LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG
 - LYRICA ORAL SOLUTION
- *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg*
 - *pregabalin oral solution*
 - *pregabalin oral tablet extended release 24 hr*

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

Lytgobi

Products Affected

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

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

Lyvispah

Products Affected

- LYVISPAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- the member has an inability to swallow generic baclofen tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Mavenclad

Products Affected

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

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

Mavyret

Products Affected

- MAVYRET ORAL PELLETS IN PACKET
- MAVYRET ORAL TABLET

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

Mayzent

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG
- MAYZENT STARTER(FOR 1MG MAINT)
- MAYZENT STARTER(FOR 2MG MAINT)

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Mayzent and other disease modifying agents such as interferons, Copaxone, Tysabri.
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- Testing for CYP2C9 variants has confirmed member does not have CYP2C9*3/*3 genotype
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Megace

Products Affected

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

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

Mekinist

Products Affected

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

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

Mekinist Suspension

Products Affected

- MEKINIST ORAL RECON SOLN

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

Mektovi

Products Affected

- MEKTOVI

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

Methamphetamine

Products Affected

- *methamphetamine*

PA Criteria	Criteria Details
Exclusion Criteria	Obesity
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For ADHD, trial/failure or intolerance to 2 of the following generic medications: methylphenidate, atomoxetine, or dextroamphetamine/amphetamine is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Metyrosine

Products Affected

- **DEMSER**
- *metyrosine*

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

Motegrity

Products Affected

- **MOTTEGRITY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic idiopathic constipation -AND- Therapeutic failure, contraindication or intolerance to Linzess and lubiprostone.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Motpoly XR

Products Affected

- **MOTPOLY XR ORAL
CAPSULE,EXTENDED RELEASE 24HR
100 MG, 150 MG, 200 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of partial onset seizures or adjunctive therapy for the treatment of primary generalized tonic-clonic seizures -AND- weight greater than or equal to 50kg.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Therapeutic failure or intolerance to generic lacosamide tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MTX Injection

Products Affected

- OTREXUP (PF)
- RASUVO (PF)

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

Mulpleta

Products Affected

- MULPLETA

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

Myalept

Products Affected

- MYALEPT

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

Myasthenia Gravis

Products Affected

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

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

Mycapssa

Products Affected

- MYCAPSSA

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

Myfembree

Products Affected

- MYFEMBREE

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Namenda

Products Affected

- **NAMENDA TITRATION PAK**
- **NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR 14 MG, 21 MG, 28 MG**

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

Namzarin

Products Affected

- NAMZARIC

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

Nayzilam

Products Affected

- NAYZILAM

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

Nerlynx

Products Affected

- **NERLYNX**

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

Nexavar

Products Affected

- **NEXAVAR**
- *sorafenib*

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

Nexletol

Products Affected

- NEXLETOL
- NEXLIZET

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

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

Ninlaro

Products Affected

- NINLARO

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

Nitisinone

Products Affected

- *nitisinone*
- **NITYR**
- **ORFADIN**

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

Northera

Products Affected

- *droxidopa oral capsule 100 mg, 200 mg, 300 mg*
- **NORTHERA 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 brand Northera, initial authorization requires documentation of trial and failure of generic droxidopa and reauthorization requires failure of generic droxidopa if not previously trialed. For reauthorization, attestation of increase from baseline of systolic or diastolic blood pressure upon standing -OR- attestation of decrease from baseline of neurogenic orthostatic hypotension symptoms upon standing (e.g., dizziness, feeling faint, etc.).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nourianz

Products Affected

- NOURIANZ

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

Nubeqa

Products Affected

- NUBEQA

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

Nucala

Products Affected

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

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

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

Nuedexta

Products Affected

- NUEDEXTA

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

Nuplazid

Products Affected

- NUPLAZID

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

Nurtec

Products Affected

- NURTEC ODT

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

Nuvigil

Products Affected

- *armodafinil*
- NUVIGIL

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

PA Criteria	Criteria Details
Other Criteria	For reauthorization, provider attestation of improvement in daytime sleepiness is required. For brand Nuvigil, documentation of failure on modafinil (generic Provigil).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ocaliva

Products Affected

- OCALIVA

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

Octreotide

Products Affected

- *octreotide acetate injection solution*
- **SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML**

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

Odactra

Products Affected

- ODACTRA

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

Odomzo

Products Affected

- ODOMZO

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

Ogsiveo

Products Affected

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

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

Ohtuvayre

Products Affected

- OHTUVAYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of chronic obstructive pulmonary disease (COPD) -AND- Inadequate symptom control despite regular treatment for at least 3 months of at least two maintenance COPD controllers (e.g. LABA/LAMA, LAMA/LABA/ICS), or intolerance/contraindication to these agents.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Ohtuvayre covered under Part B when using via nebulizer in the home setting.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ojemda

Products Affected

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

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

Ojjaara

Products Affected

- OJJAARA

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

Olpruva

Products Affected

- **OLPRUVA ORAL PELLETS IN PACKET 2 GRAM, 3 GRAM, 4 GRAM, 5 GRAM, 6 GRAM, 6.67 GRAM**

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of acute hyperammonemia in urea cycle disorders
Required Medical Information	Documentation of chronic management of urea cycle disorders involving deficiencies of carbamylphosphate synthetase, argininosuccinic acid synthetase, or ornithine transcarbamylase -AND- use as an adjunctive therapy to dietary management.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure of generic sodium phenylbutyrate is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Olumiant

Products Affected

- OLUMIANT

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

OmvoH

Products Affected

- OMVOH PEN
- OMVOH SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation of clinical response or remission following 3 doses of IV Omvoh within 3 months of initiating therapy with Omvoh SC.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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), Rinvoq, Xeljanz/Xeljanz XR, and Stelara SC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Onfi

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- **ONFI ORAL SUSPENSION**
- **ONFI ORAL TABLET**

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

Ongentys

Products Affected

- **ONGENTYS**

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

Onureg

Products Affected

- ONUREG

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

Opzelura

Products Affected

- OPZELURA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-4): 1) mild to moderate atopic dermatitis (AD), 2) attestation of up to 20 percent of body surface area (excluding scalp) with AD involvement, 3) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- documentation of facial or anogenital involvement, 4) trial & failure, intolerance, or contraindication to topical generic tacrolimus or topical generic pimecrolimus -OR- Documentation of all of the following (5-7): 5) Nonsegmental vitiligo, 6) body surface area with vitiligo involvement does not exceed 10%, 7) trial & failure or intolerance to at least 1 generic, formulary high or ultrahigh potency topical corticosteroid -OR- vitiligo with facial or anogenital involvement
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	Initial authorization: 8 weeks for AD, 24 weeks for vitiligo. Reauthorization: 12 months
Other Criteria	For reauthorization, attestation of positive clinical response to therapy for atopic dermatitis -OR- meaningful repigmentation of affected areas for vitiligo
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Oralair

Products Affected

- **ORALAIR SUBLINGUAL TABLET 300
INDX REACTIVITY**

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

Orencia

Products Affected

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

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Orgovyx

Products Affected

- ORGOVYX

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

Oriahnn

Products Affected

- **ORIAHNN**

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

Orilissa

Products Affected

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

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

Orkambi

Products Affected

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

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

Orladeyo

Products Affected

- ORLADEYO

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

PA Criteria	Criteria Details
Part B Prerequisite	No

Orserdu

Products Affected

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

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

Osmolex

Products Affected

- **OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease or drug-induced extrapyramidal symptoms -AND- trial and failure, contraindication, or intolerance to immediate-release amantadine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Osphena

Products Affected

- OSPHENA

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

OTEZLA

Products Affected

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

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

Oxbryta

Products Affected

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

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

Oxbryta for Suspension

Products Affected

- **OXBRYTA ORAL TABLET FOR SUSPENSION**

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

Oxervate

Products Affected

- **OXERVATE**

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

Palynziq

Products Affected

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

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

Panretin

Products Affected

- PANRETIN

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

Pemazyre

Products Affected

- PEMAZYRE

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

Pheburane

Products Affected

- PHEBURANE

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

Phenoxybenzamine

Products Affected

- **DIBENZYLINE**
- *phenoxybenzamine*

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

Phospholine Iodide

Products Affected

- PHOSPHOLINE IODIDE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For diagnosis of elevated intraocular pressure (IOP), the following criteria apply (1 and 2): therapeutic failure or intolerance to generic latanoprost, 2) therapeutic failure, contraindication, or intolerance to one generic ophthalmic alternative that lowers IOP (a. through f.): a) prostaglandin analog, b) ophthalmic beta-blocker, c) alpha-adrenergic agonist, d) carbonic anhydrase inhibitor, e) ophthalmic cholinergic agonist, f) combination products of these classes
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Piqray

Products Affected

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

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

Pomalyst

Products Affected

- POMALYST

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

Ponvory

Products Affected

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

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

Posaconazole Powder Packet

Products Affected

- NOXAFIL ORAL SUSP, DELAYED
RELEASE FOR RECON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	Deny if less than 2 years of age or greater than 17 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Posaconazole Suspension

Products Affected

- **NOXAFIL ORAL SUSPENSION**
- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For aspergillus or candida infection prophylaxis, high risk of developing invasive Aspergillosis or Candidiasis infection due to being severely immunocompromised (e.g., hematopoietic stem cell transplant recipients with graft versus host disease, those with hematologic malignancies with prolonged neutropenia from chemotherapy) -AND- weight less than or equal to 40 kg. For oropharyngeal candidiasis treatment, trial/failure or intolerance to generic fluconazole or generic itraconazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of failure on generic posaconazole delayed-release tablets or an inability to swallow tablets is required when being utilized for the same FDA approved indication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Posaconazole Tablet

Products Affected

- **NOXAFIL ORAL TABLET,DELAYED RELEASE (DR/EC)**
- *posaconazole oral*

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

Praluent

Products Affected

- PRALUENT PEN

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

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

Prenatal Vitamins

Products Affected

- **PRENATAL VITAMIN PLUS LOW IRON**

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

Prescription Drug Combo

Products Affected

- *acetaminophen-caff-dihydrocod*
- *acetaminophen-codeine oral solution 120-12 mg/5 ml*
- *acetaminophen-codeine oral tablet*
- **ALPRAZOLAM INTENSOL**
- *alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg*
- *alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- **AMBIEN**
- **AMBIEN CR**
- **ASCOMP WITH CODEINE**
- **ATIVAN ORAL TABLET 0.5 MG, 1 MG, 2 MG**
- **BELBUCA**
- *buprenorphine*
- *butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg*
- **BUTRANS**
- *chlordiazepoxide hcl*
- *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*
- *codeine sulfate*
- *codeine-bitalbital-asa-caff*
- **CONZIP**
- **DEMEROL (PF) INJECTION SYRINGE 25 MG/ML**
- **DEMEROL INJECTION**
- **DIAZEPAM INTENSOL**
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*
- *diazepam oral tablet*
- **DILAUDID ORAL LIQUID**
- **DILAUDID ORAL TABLET**
- **EDLUAR**
- **ENDOCET**
- *estazolam*
- *eszopiclone*
- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr, 87.5 mcg/hour*
- **FIORICET WITH CODEINE**
- *flurazepam*
- **HALCION ORAL TABLET 0.25 MG**
- *hydrocodone bitartrate oral capsule, oral only, er 12hr*
- *hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr*
- *hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml*
- *hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg*
- *hydrocodone-ibuprofen*
- *hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml*
- *hydromorphone oral liquid*
- *hydromorphone oral tablet*
- *hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg*
- **HYSINGLA ER**
- **KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG**
- *levorphanol tartrate*
- **LORAZEPAM INTENSOL**
- *lorazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- **LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1 MG, 1.5 MG, 2 MG, 3 MG**
- **LUNESTA**
- *meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*
- *meperidine oral solution*
- *meperidine oral tablet 50 mg*
- *methadone oral solution 10 mg/5 ml, 5 mg/5 ml*
- *methadone oral tablet 10 mg, 5 mg*
- *morphine concentrate oral solution*
- *morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg*
- *morphine oral capsule,extend.release pellets*

- 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg
- *morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)*
- *morphine oral tablet*
- *morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg*
- **MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 15 MG, 200 MG, 30 MG, 60 MG**
- **NALOCET**
- **NUCYNTA**
- **NUCYNTA ER**
- *oxazepam*
- *oxycodone oral capsule*
- *oxycodone oral concentrate*
- *oxycodone oral solution*
- *oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg*
- *oxycodone oral tablet, oral only, ext. rel. 12 hr 10 mg, 20 mg*
- *oxycodone-acetaminophen oral solution 5-325 mg/5 ml*
- *oxycodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg*
- **OXYCONTIN ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG**
- *oxymorphone oral tablet*
- *oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg, 7.5 mg*
- **PERCOCET**
- **PROLATE ORAL SOLUTION**
- **PROLATE ORAL TABLET**
- **QDOLO**
- **RESTORIL**
- **ROXICODONE ORAL TABLET 15 MG, 30 MG**
- **ROXYBOND**
- **SEGLENTIS**
- *temazepam*
- *tramadol oral capsule, er biphasic 24 hr 17-83*
- *tramadol oral capsule, er biphasic 24 hr 25-75 100 mg, 200 mg*
- *tramadol oral solution*
- *tramadol oral tablet 100 mg, 25 mg, 50 mg*
- *tramadol oral tablet extended release 24 hr*
- *tramadol oral tablet, er multiphasic 24 hr*
- *tramadol-acetaminophen*
- **TREZIX**
- *triazolam*
- **VALIUM**
- **XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG**
- **XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 0.5 MG, 1 MG, 2 MG, 3 MG**
- **XTAMPZA ER**
- *zaleplon oral capsule 10 mg, 5 mg*
- *zolpidem*

PA Criteria	Criteria Details
Exclusion Criteria	

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

PA Criteria	Criteria Details
Part B Prerequisite	No

Pretomanid

Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of extensively drug resistant, treatment intolerant or nonresponsive multidrug resistant tuberculosis -AND- Used as part of a combination regimen with bedaquiline and linezolid -AND- Therapeutic failure, contraindication or intolerance to both of the following (1 and 2): 1) A fluoroquinolone antibiotic or amikacin, kancamycin, or capreomycin 2) isoniazid, rifampin, rifabutin, or rifapentine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	26 weeks
Other Criteria	For reauthorization, additional therapy required due to doses of the regimen being missed for safety reasons
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Procysbi

Products Affected

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

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

Prolia

Products Affected

- PROLIA

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

Provigil

Products Affected

- *modafinil*
- **PROVIGIL**

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

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

Pulmonary Arterial Hypertension

Products Affected

- **ADCIRCA**
- **ADEMPAS**
- **ALYQ**
- *ambrisentan*
- *bosentan*
- **LETAIRIS**
- **LIQREV**
- **OPSUMIT**
- **OPSYNVI**
- **ORENITRAM MONTH 1 TITRATION KT**
- **ORENITRAM MONTH 2 TITRATION KT**
- **ORENITRAM MONTH 3 TITRATION KT**
- **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG**
- **REVATIO ORAL SUSPENSION FOR RECONSTITUTION**
- **REVATIO ORAL TABLET**
- *sildenafil (pulm.hypertension) oral suspension for reconstitution*
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*
- **TADLIQ**
- **TRACLEER ORAL TABLET**
- **TRACLEER ORAL TABLET FOR SUSPENSION**
- **TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 32-48 MCG, 48 MCG, 64 MCG**
- **UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**
- **UPTRAVI ORAL TABLETS,DOSE PACK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>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 (i.e. Revatio) 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.</p>
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Adcirca, trial and failure of generic tadalafil or Alyq is required. For brand Letairis, trial and failure of generic ambrisentan is required. For brand Revatio, trial and failure of generic sildenafil is required. For brand Tracleer 62.5mg and 125mg, trial and failure of generic bosentan is required. For brand Tadliq, trial and failure of generic tadalafil or Alyq - OR- Inability to swallow tablets is required. For Liquev, trial and failure of generic sildenafil for oral suspension is required. For Opsynvi, therapeutic failure, contraindication, or intolerance to a generic endothelin-1 receptor antagonist, phosphodiesterase type 5 inhibitor and soluble guanylate cyclase stimulator.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Pulmozyme

Products Affected

- PULMOZYME

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

Purified Cortrophin Gel

Products Affected

- CORTROPHIN GEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Covered for the following indications: 1. Acute exacerbations of multiple sclerosis (MS) for patients receiving concurrent immunomodulator therapy 2. Rheumatic disorders for patients receiving maintenance therapy 3. Collagen diseases for members receiving maintenance therapy 4. Dermatologic diseases, if using for severe psoriasis, then the member is concurrently receiving maintenance therapy 5. Allergic states (i.e. serum sickness and transfusion reaction due to serum protein reaction), if using for atopic dermatitis, then the member is concurrently receiving maintenance therapy 6. Ophthalmic diseases 7. Respiratory diseases 8. Gout and unable to take first-line therapies. 9. Pediatric acquired epileptic aphasia. 10. Proteinuria in nephrotic syndrome and trial/failure or contraindication to two therapies from any of the following different classes: corticosteroids (e.g., cortisone or dexamethasone), calcineurin inhibitors (e.g., cyclosporine or tacrolimus, per DRUGDEX). For covered indications 1 through 9, limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (i.e. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month

PA Criteria	Criteria Details
Other Criteria	For reauthorization, the following (1. 2. and 3.) must be met. 1) Prescriber attestation that the member cannot use corticosteroids (e.g. IV methylprednisolone, high dose oral corticosteroids) due to unsatisfactory response, intolerance (e.g. severe anaphylaxis) or experienced a severe adverse event to corticosteroids (e.g. psychosis). 2) If the reauthorization is for the treatment of multiple sclerosis, a rheumatic disorder, dermatologic disease, or nephrotic syndrome, the prescriber attests that Cortrophin is being used for a new acute exacerbation and not on a routine basis to prevent an exacerbation as supported by Compendia. 3) If the reauthorization is for treatment of multiple sclerosis, a rheumatic disorder, or collagen disease, the member continues to receive maintenance therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Epileptic Aphasia
Part B Prerequisite	No

Pyrukynd

Products Affected

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

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

Qelbree

Products Affected

- **QELBREE ORAL
CAPSULE,EXTENDED RELEASE 24HR
100 MG, 150 MG, 200 MG**

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

Qinlock

Products Affected

- QINLOCK

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

Quinine

Products Affected

- **QUALAQUIN**
- *quinine sulfate*

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

Qulipta

Products Affected

- QULIPTA

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

Radicava ORS

Products Affected

- **RADICAVA ORS STARTER KIT SUSP**

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

Ravicti

Products Affected

- RAVICTI

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

Recorlev

Products Affected

- **RECORLEV**

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

Regranex

Products Affected

- **REGRANEX**

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

Relistor

Products Affected

- **RELISTOR ORAL**

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

Relistor SC

Products Affected

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

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

Repatha

Products Affected

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

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

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

Retevmo

Products Affected

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

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

Revlimid

Products Affected

- *lenalidomide*
- **REVLIMID**

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

Rezdiffra

Products Affected

- REZDIFFRA

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

Rezlidhia

Products Affected

- **REZLIDHIA**

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

Rezurock

Products Affected

- **REZUROCK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic graft-versus-host disease (cGVHD) -AND- therapeutic failure or intolerance to 2 lines of systemic therapy
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Riluzole

Products Affected

- **EXSERVAN**
- **TEGLUTIK**

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

Rinvoq

Products Affected

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

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

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

Rivfloza

Products Affected

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

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

Rozlytrek

Products Affected

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

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

Rubraca

Products Affected

- RUBRACA

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

Ruconest

Products Affected

- RUCONEST

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Rydapt

Products Affected

- RYDAPT

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

Sabril

Products Affected

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

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

Samsca

Products Affected

- SAMSCA
- *tolvaptan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic hypervolemic or euvoletic hyponatremia evidenced by (1. or 2.): 1.) Serum Na less than 125 mEq/L -OR- 2.) Serum NA less than 135mEq/L with symptoms (e.g. nausea, malaise, lethargy, headache, seizures)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	Doses must be initiated in the hospital setting to closely monitor serum sodium. Treatment should be limited to 30 days to minimize risk of liver injury. For brand Samsca, initial authorization requires a trial and failure of generic tolvaptan and reauthorization requires failure of generic tolvaptan if not previously trialed. For reauthorization, treatment is for a new episode of a clinically significant euvoletic or hypervolemic hyponatremia -AND- on of the following (1. or 2.) 1.) Serum Na less than 125 mEq/L -OR- 2.) Serum NA less than 135mEq/L with symptoms (e.g. nausea, malaise, lethargy, headache, seizures)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Saphris

Products Affected

- *asenapine maleate*
- **SAPHRIS**

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

Savella

Products Affected

- SAVELLA

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

Scemblix

Products Affected

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

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

Secuado

Products Affected

- **SECUADO**

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

Sertraline Capsule

Products Affected

- *sertraline oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder or obsessive-compulsive disorder -AND- Sertraline 100mg or sertraline 125mg has been received for greater than or equal to 7 days -AND- Therapeutic failure or intolerance to generic sertraline immediate release tablets -AND- Therapeutic failure, intolerance or contraindication to at least one other antidepressant (e.g. SNRI, SSRI, TCA, MAOI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Seysara

Products Affected

- SEYSARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of inflammatory lesions of non-nodular moderate to severe acne -AND- trial and failure or intolerance of at least 1 generic topical acne medication (e.g. adapalene, clindamycin, sulfacetamide, erythromycin) -AND- trial and failure or intolerance of at least 1 generic oral acne antibiotic (e.g. minocycline, azithromycin, trimethoprim)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Signifor

Products Affected

- SIGNIFOR

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

Siliq

Products Affected

- SILIQ

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

Simponi

Products Affected

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

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

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

Sirturo

Products Affected

- **SIRTURO**

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

Skyclarys

Products Affected

- SKYCLARYS

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

Skyrizi

Products Affected

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

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

Skytrofa

Products Affected

- SKYTROFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis, growth chart, bone age, growth velocity, response to stimulation test, when applicable to meet standard diagnostic criteria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of growth velocity and bone age, as applicable to meet standard continuation of therapy guidelines.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sogroya

Products Affected

- SOGROYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis, growth chart, bone age, growth velocity, response to stimulation test, when applicable to meet standard diagnostic criteria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of growth velocity and bone age, as applicable to meet standard continuation of therapy guidelines.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sohonos

Products Affected

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

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

Solaraze

Products Affected

- *diclofenac sodium topical gel 3 %*

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

Somavert

Products Affected

- SOMAVERT

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

Sotyktu

Products Affected

- SOTYKTU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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, Enbrel and Skyrizi.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sovaldi

Products Affected

- SOVALDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member has a contraindication to or is otherwise not a candidate for all regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
Age Restrictions	Deny if less than 3 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Spevigo SC

Products Affected

- **SPEVIGO SUBCUTANEOUS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of generalized pustular psoriasis (GPP) -AND- Previous GPP flares have been experienced -AND- A flare is not currently being experienced -AND- Prevention for future GPP flares is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sprycel

Products Affected

- **SPRYCEL**

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

Statin Liquid

Products Affected

- ATORVALIQ
- FLOLIPID

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

Stelara

Products Affected

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

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

Stivarga

Products Affected

- STIVARGA

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

Sucraid

Products Affected

- SUCRAID

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

Sunosi

Products Affected

- SUNOSI

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

PA Criteria	Criteria Details
Part B Prerequisite	No

Sutent

Products Affected

- *sunitinib malate*
- SUTENT

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

Symdeko

Products Affected

- SYMDEKO

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

Sympazan

Products Affected

- SYMPAZAN

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

Symproic

Products Affected

- SYMPROIC

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

Synarel

Products Affected

- SYNAREL

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

Syndros

Products Affected

- SYNDROS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of one of the following (1 or 2): 1) anorexia associated with weight loss in patients with AIDS -and- trial and failure, contraindication, or intolerance to generic dronabinol capsules -OR- 2) nausea and vomiting associated with cancer chemotherapy in adults who have trial and failure, contraindication, or intolerance to a conventional antiemetic treatment (e.g., metoclopramide, promethazine, ondansetron, perphenazine, etc.) -and- trial and failure, contraindication, or intolerance to generic dronabinol capsules
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Covered under Part B when the following are met: 1) used for chemotherapy-induced nausea and vomiting. 2) used as full replacement for IV anti-emetic therapy. 3) using within 48 hours of receiving chemotherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tabrecta

Products Affected

- **TABRECTA**

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

Tafinlar for Suspension

Products Affected

- **TAFINLAR ORAL TABLET FOR SUSPENSION**

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

Tagrisso

Products Affected

- TAGRISSO

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

Takhzyro

Products Affected

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

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

PA Criteria	Criteria Details
Part B Prerequisite	No

Taltz

Products Affected

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

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

Talzenna

Products Affected

- **TALZENNA**

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

Targretin

Products Affected

- *bexarotene oral*
- *bexarotene topical*
- **TARGRETIN ORAL**
- **TARGRETIN TOPICAL**

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

Tarpeyo

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- one (1) of the following (A or B): A) Used in combination with one (1) of the following (1 or 2): 1) angiotensin-converting enzyme inhibitor (ACE-I), or 2) angiotensin II receptor blocker (ARB), -OR- B) Intolerance or contraindication to both of the following (3 and 4): 3) ACE-I, and 4) ARB.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	10 months
Other Criteria	For reauthorizations, documentation of diagnosis -AND- member requires re-continuation of therapy with Tarpeyo -AND- one of the following (A or B): A) Used in combination with one of the following (1 or 2): 1) angiotensin-converting enzyme inhibitor (ACE-I), or 2) angiotensin II receptor blocker (ARB), -OR- B) Intolerance or contraindication to both of the following (3 and 4): 3) ACE-I, and 4) ARB
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tascenso ODT

Products Affected

- TASCENSO ODT

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

Tasigna

Products Affected

- TASIGNA

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

Tasimelteon

Products Affected

- *tasimelteon*

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

Tavalisse

Products Affected

- TAVALISSE

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

Tavneos

Products Affected

- TAVNEOS

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

Tazarotene

Products Affected

- **ARAZLO**
- **FABIOR**
- *tazarotene topical foam*

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

Tazorac

Products Affected

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

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

Tazverik

Products Affected

- TAZVERIK

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

Tecfidera

Products Affected

- *dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg* **CAPSULE, DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG**
- **TECFIDERA ORAL**

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

Tegsedi

Products Affected

- TEGSEDI

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

Tepmetko

Products Affected

- **TEPMETKO**

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

Testosterone (androgens)

Products Affected

- **ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP**
- **AVEED**
- **DEPO-TESTOSTERONE**
- **JATENZO ORAL CAPSULE 158 MG, 198 MG, 237 MG**
- **NATESTO**
- **TESTIM**
- *testosterone cypionate*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump*
- *testosterone transdermal gel in packet*
- *testosterone transdermal solution in metered pump w/app*
- **TLANDO**
- **VOGELXO TRANSDERMAL GEL**
- **VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP**
- **XYOSTED**

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

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	HIV Wasting
Part B Prerequisite	No

Thalomid

Products Affected

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

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

Thiola

Products Affected

- **THIOLA**
- **THIOLA EC**
- *tiopronin*

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

Thrombopoiesis Stimulating Agents

Products Affected

- ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG
- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG

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

Tibsovo

Products Affected

- TIBSOVO

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

Tigan

Products Affected

- *trimethobenzamide oral*

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

Tolsura

Products Affected

- TOLSURA

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

Topical Lidocaine

Products Affected

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

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

Torpenz

Products Affected

- TORPENZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced, hormone receptor-positive, HER2-negative breast cancer -AND- member is a postmenopausal woman -AND- member is using Torpenz in combination with exemestane -AND- member has experienced therapeutic failure or intolerance to prior treatment with letrozole or anastrozole. Documentation of renal angiomyolipoma and tuberous sclerosis complex (TSC) -AND- the member does not require immediate surgery. Documentation of TSC with subependymal giant cell astrocytoma -AND- the member is not a candidate for curative surgical resection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Torpenz, documentation of failure on generic everolimus tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Transmucosal Fentanyl Citrate

Products Affected

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

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

Tremfya

Products Affected

- TREMFYA SUBCUTANEOUS AUTO-INJECTOR
- TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML

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

Tretinoin

Products Affected

- *adapalene topical cream*
- *adapalene topical gel 0.3 %*
- *adapalene topical swab*
- *adapalene-benzoyl peroxide*
- **AKLIEF**
- **ALTRENO**
- **ATRALIN**
- **CABTREO**
- *clindamycin-tretinoin*
- **DIFFERIN TOPICAL CREAM**
- **DIFFERIN TOPICAL GEL WITH PUMP**
- **DIFFERIN TOPICAL LOTION**
- **EPIDUO FORTE**
- **EPIDUO TOPICAL GEL WITH PUMP**
- **RETIN-A**
- **RETIN-A MICRO**
- **RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %**
- *tretinoin*
- *tretinoin microspheres topical gel*
- *tretinoin microspheres topical gel with pump 0.08 %*
- **TWYNEO**
- **VELTIN**
- **WINLEVI**
- **ZIANA**

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

Trientine

Products Affected

- *trientine oral capsule 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Wilson's Disease -AND- intolerant of penicillamine (e.g., generic penicillamine capsule or tablet).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Therapeutic failure or intolerance to generic trientine hydrochloride 250mg capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Trikafta

Products Affected

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

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

Truqap

Products Affected

- TRUQAP

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

Tukysa

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

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

Turalio

Products Affected

- TURALIO ORAL CAPSULE 125 MG

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

Tyenne

Products Affected

- **TYENNE AUTOINJECTOR**
- **TYENNE SUBCUTANEOUS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For rheumatoid arthritis, patients must have an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide). For giant cell arteritis, patients must have therapeutic failure or intolerance to one systemic corticosteroid (e.g., prednisone). For polyarticular juvenile idiopathic arthritis, patients must have an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. Documentation of systemic juvenile idiopathic arthritis.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis and Giant Cell Arteritis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Systemic Juvenile Idiopathic Arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Therapeutic failure or intolerance to preferred Actemra. For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tykerb

Products Affected

- *lapatinib*
- **TYKERB**

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

Tymlos

Products Affected

- TYMLOS

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

Ubrelvy

Products Affected

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

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

Uloric

Products Affected

- *febuxostat*
- **ULORIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of chronic management of hyperuricemia due to gout -And- trial/failure, intolerance or contraindication to allopurinol.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Valchlor

Products Affected

- VALCHLOR

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

Valtoco

Products Affected

- VALTOCO

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

Vancomycin

Products Affected

- **VANCOGIN ORAL CAPSULE 125 MG, 250 MG**
- *vancomycin oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For brand Vancocin, trial and failure of generic vancomycin capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vanflyta

Products Affected

- VANFLYTA

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

Velsipity

Products Affected

- VELSIPITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- inadequate response or intolerance to one systemic therapy (e.g. corticosteroids, azathioprine, cyclophosphamide).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patients must have therapeutic failure or intolerance to 2 of the following preferred products Humira, Rinvoq, Xeljanz/Xeljanz XR and Stelara SC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Veltassa

Products Affected

- VELTASSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hyperkalemia as defined by serum potassium level between 5.1 and 6.4 mmol/L on at least two (2) screenings -AND- Modification of medications to reduce serum potassium levels were not successful, when applicable.
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in serum potassium levels following Veltassa administration and continued treatment for hyperkalemia is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Venbysi XR

Products Affected

- *venlafaxine besylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- venlafaxine extended-release product at a total daily dose greater than or equal to 75 mg has been received for greater than or equal to 4 days.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Venclexta

Products Affected

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

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

Veozah

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of moderate to severe vasomotor symptoms due to menopause -AND- one of the following (1 or 2): 1) therapeutic failure, contraindication, or intolerance to a generic hormone therapy product, or 2) attestation that hormone therapy is not clinically appropriate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Verkazia

Products Affected

- VERKAZIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- therapeutic failure or intolerance to 2 of the following medication classes or all are contraindicated: 1) generic ophthalmic antihistamines (e.g., olopatadine), 2) generic ophthalmic mast cell stabilizers (e.g., cromolyn sodium), 3) Generic ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Verquvo

Products Affected

- VERQUVO

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

Verzenio

Products Affected

- VERZENIO

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

Viberzi

Products Affected

- **VIBERZI**

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

Vioice

Products Affected

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

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

Vimovo

Products Affected

- VIMOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) Trial/failure of ibuprofen/famotidine. -AND- 2) Trial/failure of naproxen/esomeprazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vimovo2

Products Affected

- *naproxen-esomeprazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) Trial/failure of naproxen used in combination with omeprazole. -AND- 2) Trial/failure of one additional generic formulary NSAID (other than naproxen) used in combination with another generic formulary PPI (other than omeprazole).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vittrakvi

Products Affected

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

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

Vivjoa

Products Affected

- VIVJOA

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

Vivlodex

Products Affected

- *meloxicam submicronized*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure or intolerance to generic meloxicam tablets and one additional generic NSAID
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vizimpro

Products Affected

- VIZIMPRO

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

Vonjo

Products Affected

- VONJO

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

Voquezna

Products Affected

- **VOQUEZNA ORAL TABLET 10 MG, 20 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For healing of erosive esophagitis (EE) and relief of heartburn associated with EE, therapeutic failure, contraindication, or intolerance to omeprazole and pantoprazole. For maintenance of EE healing and relief of heartburn associated with EE, therapeutic failure, contraindication, or intolerance to omeprazole and pantoprazole. For relief of heartburn associated with non-erosive gastroesophageal reflux disease (GERD), therapeutic failure, contraindication, or intolerance to omeprazole and pantoprazole. For treatment of H. pylori infection, used in combination with amoxicillin - OR- amoxicillin and clarithromycin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	H.pylori tx: 14 days. EE healing: 8 wks. EE Maintenance: 6 mo. Non-erosive GERD: 4 wks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Voquezna Combo Pak

Products Affected

- **VOQUEZNA DUAL PAK**
- **VOQUEZNA TRIPLE PAK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Voriconazole

Products Affected

- **VFEND IV**
- *voriconazole intravenous*

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

Vosevi

Products Affected

- VOSEVI

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

Votrient

Products Affected

- *pazopanib*
- **VOTRIENT**

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

Voxzogo

Products Affected

- VOXZOGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of achondroplasia as evidenced by an FGFR3 gene mutation detected by genetic testing -AND- all of the following (1-2): 1) baseline annualized growth velocity (AGV), 2) attestation that the member's epiphyses have not closed.
Age Restrictions	Deny if greater than 17 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of increase in annualized growth velocity (AGV) from baseline and attestation that the member's epiphyses have not closed are required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE

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

Vtama

Products Affected

- VTAMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3). 1) Documentation of plaque psoriasis -AND- 2) trial and failure or intolerance to at least one generic, formulary medium, high, or ultrahigh potency topical corticosteroid (e.g. fluocinonide, triamcinolone, betamethasone) -OR- psoriasis on facial or intertriginous areas -AND- 3) trial and failure, contraindication, or intolerance to one generic, formulary vitamin D analog (e.g., calcipotriene, calcitriol)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vuity

Products Affected

- VUITY

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

Vumerity

Products Affected

- VUMERITY

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

Wainua

Products Affected

- WAINUA

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

Wakix

Products Affected

- WAKIX

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

PA Criteria	Criteria Details
Part B Prerequisite	No

Wegovy

Products Affected

- **WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML**

PA Criteria	Criteria Details
Exclusion Criteria	Treatment to reduce body weight and maintain weight reduction
Required Medical Information	Documentation of use in combination with reduced calorie diet and increased physical activity to reduce the risk of major adverse cardiovascular (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight -AND- Baseline BMI is greater than or equal to 27 kg/m ² -AND- Will not be used in combination with GLP1 RA or GLP1 RA combinations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of continued use in combination with reduced calorie diet and increased physical activity for reduction of major adverse cardiovascular event risk -AND- Requested dose is 1.7mg or 2.4mg weekly.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Welireg

Products Affected

- WELIREG

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

Winrevair

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization (RHC), defined as a mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than or equal to 3 Wood units -AND- WHO Group -AND- Concomitant use of at least one of the following (1-4): 1) generic endothelin-1 receptor antagonist, 2) phosphodiesterase type 5 inhibitor, 3) soluble guanylate cyclase stimulator, 4) generic prostacyclin agent -AND- Background therapy with PAH-specific therapies will be continued while being treated with Winrevair.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xalkori

Products Affected

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

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

Xcopri

Products Affected

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

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

Xdemvy

Products Affected

- XDEMVI

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

Xeljanz

Products Affected

- XELJANZ ORAL TABLET
- XELJANZ XR

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

Xeljanz Solution

Products Affected

- XELJANZ ORAL SOLUTION

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

Xenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*
- **XENAZINE ORAL TABLET 12.5 MG, 25 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- if requesting brand Xenazine, trial and failure or intolerance to generic tetrabenazine has been documented - AND- attestation that the beneficiary is not actively suicidal
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	In patients with comorbid depression, attestation of adequate treatment for depression is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xermelo

Products Affected

- XERMELO

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

Xgeva

Products Affected

- XGEVA

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

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

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

Xolair

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<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>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

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

Xolremdi

Products Affected

- **XOLREMDI**

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

Xospata

Products Affected

- XOSPATA

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

Xpovio

Products Affected

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

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

Xtandi

Products Affected

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

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

Xuriden

Products Affected

- XURIDEN

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

Xyrem

Products Affected

- *sodium oxybate*
- **XYREM**

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

Xywav

Products Affected

- XYWAV

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

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

Yonsa

Products Affected

- YONSA

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

Zavesca

Products Affected

- *miglustat*
- YARGESA
- ZAVESCA

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

Zavzpret

Products Affected

- ZAVZPRET

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

Zejula

Products Affected

- ZEJULA ORAL TABLET

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

Zelboraf

Products Affected

- TAFINLAR ORAL CAPSULE
- ZELBORAF

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

Zepatier

Products Affected

- ZEPATIER

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

Zeposia

Products Affected

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

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

Zokinvy

Products Affected

- ZOKINVY

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

Zolinza

Products Affected

- ZOLINZA

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

Zolpidem Capsule

Products Affected

- *zolpidem*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of insomnia characterized by difficulties with sleep onset - AND- therapeutic failure or intolerance to 2 of the following (1-3): 1) eszopiclone, 2) zaleplon, 3) generic zolpidem tablets/zolpidem ER tablets. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators.
Age Restrictions	Deny if greater than 64 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zonisade

Products Affected

- ZONISADE

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

Zoryve

Products Affected

- ZORYVE TOPICAL CREAM 0.3 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3). 1) Documentation of plaque psoriasis -AND- 2) trial and failure or intolerance to at least one generic, formulary medium, high, or ultrahigh potency topical corticosteroid (e.g. fluocinonide, triamcinolone, betamethasone) -OR- psoriasis on facial or intertriginous areas -AND- 3) trial and failure, contraindication, or intolerance to one generic, formulary vitamin D analog (e.g., calcipotriene, calcitriol)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zoryve Foam

Products Affected

- ZORYVE TOPICAL FOAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3). 1) Documentation of seborrheic dermatitis -AND- 2) trial and failure or intolerance to at least one generic, formulary topical corticosteroid -OR- seborrheic dermatitis on facial or intertriginous areas -AND- 3) if the member is 12 years of age or older, trial and failure, contraindication, or intolerance to one generic, topical antifungal agent for seborrheic dermatitis (e.g., ketoconazole, ciclopirox).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ztalmy

Products Affected

- ZTALMY

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

ZTLido

Products Affected

- ZTLIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of postherpetic neuralgia (PHN) -AND- One of the following (1,2 or 3): 1) trial and failure of 1 other agent used to treat PHN (e.g. gabapentin) 2) Inability to swallow oral medication 3) Unable to take an oral medication due to potential adverse events (e.g. sedation)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patients must have therapeutic failure or contraindication to Lidoderm or lidocaine patch 5%.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zurzuvaе

Products Affected

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

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

Zydelig

Products Affected

- ZYDELIG

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

Zykadia

Products Affected

- ZYKADIA

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

Zymfentra

Products Affected

- ZYMFENTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation of clinical response or remission following at least 3 doses of IV infliximab at least 10 weeks before initiating therapy with Zymfentra.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For moderate to severe active ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Rinvoq, Xeljanz/Xeljanz XR, and Stelara SC. For moderate to severe active Crohn's disease, 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), Rinvoq, Skyrizi SC, and Stelara SC
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zytiga

Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*
- **ZYTIGA ORAL TABLET 250 MG, 500 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- concomitant therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Zytiga, trial and failure of generic abiraterone is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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LUPKYNIS	233	<i>meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml</i>	323
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LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)	234	<i>meperidine oral tablet 50 mg</i>	323
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LYBALVI	235	<i>methadone oral tablet 10 mg, 5 mg</i>	323
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MAVENCLAD (6 TABLET PACK)	240	<i>morphine concentrate oral solution</i>	323
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Brand ADHD

Products Affected

- **ADDERALL 20 MG TABLET**
- **ADDERALL 5 MG TABLET**
- **ADDERALL 7.5 MG TABLET**
- **ADDERALL XR 10 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 15 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 20 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 25 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 30 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 5 MG CAPSULE,EXTENDED RELEASE**
- **ADZENYS XR-ODT 12.5 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 15.7 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 18.8 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 3.1 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 6.3 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 9.4 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **APTENSIO XR 10 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 15 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 20 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 30 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 40 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 50 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 60 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **AZSTARYS 26.1 MG-5.2 MG CAPSULE**
- **AZSTARYS 39.2 MG-7.8 MG CAPSULE**
- **AZSTARYS 52.3 MG-10.4 MG CAPSULE**
- **CONCERTA 18 MG TABLET,EXTENDED RELEASE**
- **CONCERTA 27 MG TABLET,EXTENDED RELEASE**
- **CONCERTA 36 MG TABLET,EXTENDED RELEASE**
- **CONCERTA 54 MG TABLET,EXTENDED RELEASE**
- **COTEMPLA XR-ODT 17.3 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **COTEMPLA XR-ODT 25.9 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **COTEMPLA XR-ODT 8.6 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **DEXEDRINE SPANSULE 10 MG CAPSULE,EXTENDED RELEASE**
- *dextroamphetamine-amphetamine er 12.5 mg capsule, 3 bead, ext rel 24hr*
- *dextroamphetamine-amphetamine er 25 mg capsule,3 bead,ext release 24hr*
- *dextroamphetamine-amphetamine er 37.5 mg capsule, 3 bead, ext rel 24hr*
- *dextroamphetamine-amphetamine er 50 mg capsule,3 bead,ext release 24hr*
- **DYANAVEL XR 10 MG TABLET, EXTENDED RELEASE**

- **DYANAVEL XR 15 MG TABLET, EXTENDED RELEASE**
- **DYANAVEL XR 2.5 MG/ML ORAL 24 HR EXTENDED RELEASE SUSPENSION**
- **DYANAVEL XR 20 MG TABLET, EXTENDED RELEASE**
- **DYANAVEL XR 5 MG TABLET, EXTENDED RELEASE**
- **FOCALIN 10 MG TABLET**
- **FOCALIN 2.5 MG TABLET**
- **FOCALIN 5 MG TABLET**
- **FOCALIN XR 10 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 15 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 20 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 25 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 30 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 35 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 40 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 5 MG CAPSULE,EXTENDED RELEASE**
- **JORNAY PM 100 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 20 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 40 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 60 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 80 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **SPRINKLE**
- *lisdexamfetamine 10 mg capsule*
- *lisdexamfetamine 10 mg chewable tablet*
- *lisdexamfetamine 20 mg capsule*
- *lisdexamfetamine 20 mg chewable tablet*
- *lisdexamfetamine 30 mg capsule*
- *lisdexamfetamine 30 mg chewable tablet*
- *lisdexamfetamine 40 mg capsule*
- *lisdexamfetamine 40 mg chewable tablet*
- *lisdexamfetamine 50 mg capsule*
- *lisdexamfetamine 50 mg chewable tablet*
- *lisdexamfetamine 60 mg capsule*
- *lisdexamfetamine 60 mg chewable tablet*
- *lisdexamfetamine 70 mg capsule*
- **METADATE CD 10 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 20 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 30 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 40 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 50 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 60 MG CAPSULE,EXTENDED RELEASE**
- **METHYLIN 10 MG/5 ML ORAL SOLUTION**
- **METHYLIN 5 MG/5 ML ORAL SOLUTION**
- *methylphenidate er 45 mg tablet,extended release 24 hr*
- *methylphenidate er 63 mg tablet,extended release 24 hr*
- *methylphenidate er 72 mg tablet,extended release 24 hr*
- **MYDAYIS 12.5 MG CAPSULE EXTENDED RELEASE 24 HR**
- **MYDAYIS 25 MG CAPSULE EXTENDED RELEASE 24 HR**
- **MYDAYIS 37.5 MG CAPSULE EXTENDED RELEASE 24 HR**
- **MYDAYIS 50 MG CAPSULE EXTENDED RELEASE 24 HR**
- **QUILLICHEW ER 20 MG CHEWABLE TABLET, EXTENDED RELEASE**
- **QUILLICHEW ER 30 MG CHEWABLE**

- TABLET, EXTENDED RELEASE
- QUILLICHEW ER 40 MG CHEWABLE, EXTENDED RELEASE TABLET
- QUILLIVANT XR 5 MG/ML (25 MG/5 ML) ORAL SUSPENSION, EXTENDED RELEASE 24HR
- RELEXXII 18 MG TABLET, EXTENDED RELEASE
- RELEXXII 27 MG TABLET, EXTENDED RELEASE
- RELEXXII 36 MG TABLET, EXTENDED RELEASE
- RELEXXII 45 MG TABLET, EXTENDED RELEASE
- RELEXXII 63 MG TABLET, EXTENDED RELEASE
- RITALIN 10 MG TABLET
- RITALIN 20 MG TABLET
- RITALIN 5 MG TABLET
- RITALIN LA 10 MG CAPSULE, EXTENDED RELEASE
- RITALIN LA 20 MG CAPSULE, EXTENDED RELEASE
- RITALIN LA 30 MG CAPSULE, EXTENDED RELEASE
- RITALIN LA 40 MG CAPSULE, EXTENDED RELEASE
- STRATTERA 10 MG CAPSULE
- STRATTERA 100 MG CAPSULE
- STRATTERA 18 MG CAPSULE
- STRATTERA 25 MG CAPSULE
- STRATTERA 40 MG CAPSULE
- STRATTERA 60 MG CAPSULE
- STRATTERA 80 MG CAPSULE
- VYVANSE 10 MG CAPSULE
- VYVANSE 10 MG CHEWABLE TABLET
- VYVANSE 20 MG CAPSULE
- VYVANSE 20 MG CHEWABLE TABLET
- VYVANSE 30 MG CAPSULE
- VYVANSE 30 MG CHEWABLE TABLET
- VYVANSE 40 MG CAPSULE
- VYVANSE 40 MG CHEWABLE TABLET
- VYVANSE 50 MG CAPSULE
- VYVANSE 50 MG CHEWABLE TABLET
- VYVANSE 60 MG CAPSULE
- VYVANSE 60 MG CHEWABLE TABLET
- VYVANSE 70 MG CAPSULE
- XELSTRYM 13.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH
- XELSTRYM 18 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH
- XELSTRYM 4.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH
- XELSTRYM 9 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH

Details

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

Products Affected

- **AIRSUPRA 90 MCG-80 MCG/ACTUATION HFA AEROSOL INHALER**
albuterol sulfate hfa 90 mcg/actuation
- *aerosol inhaler (nda020983)*
- **PROAIR RESPICLICK 90 MCG/ACTUATION BREATH ACTIVATED**

Details

Criteria	Require a 1 month trial of albuterol (generic Proair HFA) in the last 90 days
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Brand Glaucoma

Products Affected

- **IYUZEH (PF) 0.005 % EYE DROPS IN A DROPPERETTE**
- **RHOPRESSA 0.02 % EYE DROPS**
- **ROCKLATAN 0.02 %-0.005 % EYE DROPS**
- **VYZULTA 0.024 % EYE DROPS**

Details

Criteria	Require a 1 month trial of generic latanoprost (Step 1 drug) plus one other preferred generic formulary glaucoma drug (Step 1 drug) in the last 180 days
-----------------	--

Brand Levalbuterol

Products Affected

- **XOPENEX HFA 45 MCG/ACTUATION
AEROSOL INHALER**

Details

Criteria	Require a 1 month trial of albuterol (generic Proair HFA) and generic levalbuterol in the last 180 days
-----------------	---

Breo Ellipta AG

Products Affected

- *fluticasone furoate 100 mcg-vilanterol 25 mcg/dose inhalation powder*
- *fluticasone furoate 200 mcg-vilanterol 25 mcg/dose inhalation powder*

Details

Criteria	Require a 1 month trial of Breo Ellipta (Step 1 drug) in the last 90 days
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Celecoxib

Products Affected

- **CELEBREX 100 MG CAPSULE**
 - **CELEBREX 200 MG CAPSULE**
 - **CELEBREX 400 MG CAPSULE**
 - **CELEBREX 50 MG CAPSULE**
- *celecoxib 100 mg capsule*
 - *celecoxib 200 mg capsule*
 - *celecoxib 400 mg capsule*
 - *celecoxib 50 mg capsule*

Details

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

Products Affected

- *clonidine hcl er 0.17 mg tablet, extended release 24 hr*
- **NEXICLON XR 0.17 MG TABLET, EXTENDED RELEASE**

Details

Criteria	Require a 1 month trial of generic clonidine IR tablet (Step 1 drug) in the last 90 days
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Conjupri

Products Affected

- *levamlodipine 2.5 mg tablet*
- *levamlodipine 5 mg tablet*

Details

Criteria	Require a trial of 2 of the following generic medications (Step 1 drug): amlodipine tablet, felodipine extended-release tablet, or nifedipine 24hr extended-release tablet in the last 180 days
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DPP4 Agents

Products Affected

- *alogliptin 12.5 mg tablet*
- *alogliptin 12.5 mg-metformin 1,000 mg tablet*
- *alogliptin 12.5 mg-metformin 500 mg tablet*
- *alogliptin 12.5 mg-pioglitazone 30 mg tablet*
- *alogliptin 25 mg tablet*
- *alogliptin 25 mg-pioglitazone 15 mg tablet*
- *alogliptin 25 mg-pioglitazone 30 mg tablet*
- *alogliptin 25 mg-pioglitazone 45 mg tablet*
- *alogliptin 6.25 mg tablet*
- **KAZANO 12.5 MG-1,000 MG TABLET**
- **KAZANO 12.5 MG-500 MG TABLET**
- **NESINA 12.5 MG TABLET**
- **NESINA 25 MG TABLET**
- **NESINA 6.25 MG TABLET**
- **OSENI 12.5 MG-30 MG TABLET**
- **OSENI 25 MG-15 MG TABLET**
- **OSENI 25 MG-30 MG TABLET**
- **OSENI 25 MG-45 MG TABLET**
- *saxagliptin 2.5 mg tablet*
- *saxagliptin 2.5 mg-metformin er 1,000 mg tablet,extend release 24hr mp*
- *saxagliptin 5 mg tablet*
- *saxagliptin 5 mg-metformin er 1,000 mg tablet,extend release 24hr mp*
- *saxagliptin 5 mg-metformin er 500 mg tablet,extend release 24hr mp*
- *sitagliptin 100 mg tablet*
- *sitagliptin 25 mg tablet*
- *sitagliptin 50 mg tablet*
- *sitagliptin 50 mg-metformin 1,000 mg tablet*
- *sitagliptin 50 mg-metformin 500 mg tablet*
- **ZITUVIO 100 MG TABLET**
- **ZITUVIO 25 MG TABLET**
- **ZITUVIO 50 MG TABLET**

Details

Criteria	Require a 1 month trial of a Januvia/Janumet/Janumet XR product and Tradjenta/Jentadueto/Jentadueto XR product in the last 180 days
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DPP4-SGLT2 Combo

Products Affected

- QTERN 10 MG-5 MG TABLET
- QTERN 5 MG-5 MG TABLET
- STEGLUJAN 15 MG-100 MG TABLET
- STEGLUJAN 5 MG-100 MG TABLET

Details

Criteria	Require a 1 month trial of Glyxambi and Trijardy the last 180 days
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Dry Eye

Products Affected

- **CEQUA 0.09 % EYE DROPS IN A DROPPERETTE**
- **MIEBO (PF) 100 % EYE DROPS**
- **TYRVAYA 0.03 MG/SPRAY NASAL SPRAY**
- **VEVYE 0.1 % EYE DROPS**

Details

Criteria	Require a 1 month trial of Xiidra and one of the following: Restasis or cyclosporine eye drop (i.e. generic Restasis), in the last 180 days
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Dymista

Products Affected

- **DYMISTA 137 MCG-50 MCG/SPRAY NASAL SPRAY**
- **RYALTRIS 665 MCG-25 MCG/SPRAY NASAL SPRAY**

Details

Criteria	Require a 1 month trial of generic azelastine/fluticasone spray in the last 90 days
-----------------	---

Erythroid Stimulants

Products Affected

- ARANESP 10 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE
- ARANESP 100 MCG/0.5 ML (IN POLYSORBATE) INJECTION SYRINGE
- ARANESP 100 MCG/ML (IN POLYSORBATE) INJECTION
- ARANESP 150 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE
- ARANESP 200 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE
- ARANESP 200 MCG/ML (IN POLYSORBATE) INJECTION
- ARANESP 25 MCG/0.42 ML (IN POLYSORBATE) INJECTION SYRINGE
- ARANESP 25 MCG/ML (IN POLYSORBATE) INJECTION
- ARANESP 300 MCG/0.6 ML (IN POLYSORBATE) INJECTION SYRINGE
- ARANESP 40 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE
- ARANESP 40 MCG/ML (IN POLYSORBATE) INJECTION
- ARANESP 500 MCG/ML (IN POLYSORBATE) INJECTION SYRINGE
- ARANESP 60 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE
- ARANESP 60 MCG/ML (IN POLYSORBATE) INJECTION
- EPOGEN 2,000 UNIT/ML INJECTION SOLUTION
- EPOGEN 20,000 UNIT/2 ML INJECTION SOLUTION
- EPOGEN 20,000 UNIT/ML INJECTION SOLUTION
- EPOGEN 3,000 UNIT/ML INJECTION SOLUTION
- EPOGEN 4,000 UNIT/ML INJECTION SOLUTION

Details

Criteria	Require a 1 month trial of Procrit and Retacrit (Step 1 drugs) in the last 180 days
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Filgrastim

Products Affected

- **GRANIX 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE**
- **GRANIX 300 MCG/ML SUBCUTANEOUS SOLUTION**
- **GRANIX 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE**
- **GRANIX 480 MCG/1.6 ML SUBCUTANEOUS SOLUTION**
- **NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE**
- **NEUPOGEN 300 MCG/ML INJECTION SOLUTION**
- **NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE**
- **NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION**
- **RELEUKO 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE**
- **RELEUKO 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE**

Details

Criteria	Require a 1 month trial of Zarxio and Nivestym (step 1 drugs) in the last 180 days
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Fortamet

Products Affected

- *metformin er 1,000 mg tablet, extended release 24hr (osmotic)*
- *metformin er 500 mg tablet, extended release 24hr (osmotic)*

Details

Criteria	Require a 1 month trial of generic metformin IR tablets and generic metformin ER (i.e. generic Glucophage XR) tablets in the last 180 days
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Glumetza

Products Affected

- **GLUMETZA 1,000 MG TABLET,EXTENDED RELEASE**
 - **GLUMETZA 500 MG TABLET,EXTENDED RELEASE**
- *metformin er 1,000 mg 24 hr tablet,extended release (gastric reten.)*
 - *metformin er 500 mg 24 hr tablet,extended release (gastric retention)*

Details

Criteria	Require a 1 month trial of generic metformin IR tablets and generic metformin ER (i.e. generic Glucophage XR) tablets in the last 180 days
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GnRH Agonists

Products Affected

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

Details

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

Products Affected

- **ZIRGAN 0.15 % EYE GEL**

Details

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

Products Affected

- **INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION**
- **TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH**
- **ACTIVATED TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED (30 ACTUAT)**

Details

Criteria	Require a 1 month trial of Spiriva (Step 1 drug) in the last 90 days
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Lactulose

Products Affected

- **KRISTALOSE 10 GRAM ORAL PACKET**
 - **KRISTALOSE 20 GRAM ORAL PACKET**
- *lactulose 10 gram oral packet*

Details

Criteria	Require a 1 month trial of lactulose solution (Step 1 drug) in the last 90 days
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Mirabegron ER

Products Affected

- *mirabegron er 25 mg tablet, extended release 24 hr*
- *mirabegron er 50 mg tablet, extended release 24 hr*

Details

Criteria	Require a 1 month trial of Myrbetriq (Step 1 drug) in the last 90 days
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Mupirocin

Products Affected

- *mupirocin calcium 2 % topical cream*

Details

Criteria	Require a 1 month trial of generic mupirocin ointment (Step 1 drug) in the last 90 days
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Pegfilgrastim

Products Affected

- **FYLNETRA 6 MG/0.6 ML
SUBCUTANEOUS SYRINGE**
- **NYVEPRIA 6 MG/0.6 ML
SUBCUTANEOUS SYRINGE**
- **STIMUFEND 6 MG/0.6 ML
SUBCUTANEOUS SYRINGE**
- **UDENYCA 6 MG/0.6 ML
SUBCUTANEOUS SYRINGE**
- **UDENYCA AUTOINJECTOR 6 MG/0.6
ML SUBCUTANEOUS AUTO-
INJECTOR**

Details

Criteria	Require a trial of 2 of the following (Step 1 drug): Neulasta, Fulphila, or Ziextenzo in the last 180 days
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Pennsaid

Products Affected

- *diclofenac 20 mg/gram/actuation (2 %) topical soln metered-dose pump* **(2 %) TOPICAL SOLN IN METERED-DOSE PUMP**
- **PENNSAID 20 MG/GRAM/ACTUATION**

Details

Criteria	Require a 1 month trial of Diclofenac 1.5% (Step 1 drug) in the last 90 days
-----------------	--

Riomet

Products Affected

- *metformin 500 mg/5 ml oral solution*

Details

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

Products Affected

- **DHIVY 25 MG-100 MG TABLET**
- **RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE**

Details

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

Products Affected

- **BELSOMRA 10 MG TABLET**
- **BELSOMRA 15 MG TABLET**
- **BELSOMRA 20 MG TABLET**
- **BELSOMRA 5 MG TABLET**
- **DAYVIGO 10 MG TABLET**
- **DAYVIGO 5 MG TABLET**
- **QUVIVIQ 25 MG TABLET**
- **QUVIVIQ 50 MG TABLET**

Details

Criteria	Require a trial of 2 of the following (Step 1 drug): generic zolpidem tablet/zolpidem ER tablet, zaleplon or eszopiclone in the last 180 days
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Soanz

Products Affected

- SOAANZ 20 MG TABLET
- SOAANZ 40 MG TABLET
- SOAANZ 60 MG TABLET

Details

Criteria	Require a 1 month trial of generic furosemide tablets and generic torsemide tablets in the last 180 days
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Suboxone

Products Affected

- **SUBOXONE 12 MG-3 MG SUBLINGUAL FILM**
- **SUBOXONE 2 MG-0.5 MG SUBLINGUAL FILM**
- **SUBOXONE 4 MG-1 MG SUBLINGUAL FILM**
- **SUBOXONE 8 MG-2 MG SUBLINGUAL FILM**

Details

Criteria	Require a 1 month trial of Zubsolv (Step 1 drug) in the last 90 days
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Symbicort

Products Affected

- **SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER**
- **SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER**

Details

Criteria	Require a 1 month trial of budesonide-formoterol or Breyna (Step 1 drug) in the last 90 days
-----------------	--

Topical Antifungals

Products Affected

- **ERTACZO 2 % TOPICAL CREAM**
- **EXELDERM 1 % TOPICAL CREAM**
- **EXELDERM 1 % TOPICAL SOLUTION**
- **KETODAN 2 % TOPICAL FOAM**
- *naftifine 1 % topical cream*
- *naftifine 2 % topical cream*
- *naftifine 2 % topical gel*
- **NAFTIN 1 % TOPICAL GEL**
- **NAFTIN 2 % TOPICAL GEL**
- *oxiconazole 1 % topical cream*
- **OXISTAT 1 % LOTION**

Details

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

Products Affected

- *calcipotriene 0.005 % topical foam*
- *calcipotriene-betamethasone 0.005 %-0.064 % topical ointment*
- *calcipotriene-betamethasone 0.005 %-0.064 % topical suspension*
- *calcitriol 3 mcg/gram topical ointment*
- **ENSTILAR 0.005 %-0.064 % TOPICAL FOAM**
- **SORILUX 0.005 % TOPICAL FOAM**
- **TACLONEX 0.005 %-0.064 % TOPICAL OINTMENT**
- **TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION**
- **VECTICAL 3 MCG/GRAM TOPICAL OINTMENT**

Details

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

Products Affected

- **RELTONE 200 MG CAPSULE**
- **RELTONE 400 MG CAPSULE**
- **URSO 250 250 MG TABLET**
- **URSO FORTE 500 MG TABLET**
- *ursodiol 200 mg capsule*
- *ursodiol 400 mg capsule*

Details

Criteria	Require a 1 month trial of generic ursodiol 250mg tablet, 300mg capsule or 500mg tablet (step 1 drug) in the last 90 days
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ADDERALL XR 5 MG	APTENSIO XR 30 MG
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ADZENYS XR-ODT 12.5 MG	SPRINKLE1
EXTENDED RELEASE	APTENSIO XR 40 MG
DISINTEGRATING TABLET1	CAPSULE,EXTENDED RELEASE
ADZENYS XR-ODT 15.7 MG	SPRINKLE1
EXTENDED RELEASE	APTENSIO XR 50 MG
DISINTEGRATING TABLET1	CAPSULE,EXTENDED RELEASE
ADZENYS XR-ODT 18.8 MG	SPRINKLE1
EXTENDED RELEASE	APTENSIO XR 60 MG
DISINTEGRATING TABLET1	CAPSULE,EXTENDED RELEASE
ADZENYS XR-ODT 3.1 MG	SPRINKLE1
EXTENDED RELEASE	ARANESP 10 MCG/0.4 ML (IN
DISINTEGRATING TABLET1	POLYSORBATE) INJECTION
ADZENYS XR-ODT 6.3 MG	SYRINGE15
EXTENDED RELEASE	ARANESP 100 MCG/0.5 ML (IN
DISINTEGRATING TABLET1	POLYSORBATE) INJECTION
ADZENYS XR-ODT 9.4 MG	SYRINGE15
EXTENDED RELEASE	ARANESP 100 MCG/ML (IN
DISINTEGRATING TABLET1	POLYSORBATE) INJECTION15
AIRSUPRA 90 MCG-80	ARANESP 150 MCG/0.3 ML (IN
MCG/ACTUATION HFA AEROSOL	POLYSORBATE) INJECTION
INHALER4	SYRINGE15
<i>albuterol sulfate hfa 90 mcg/actuation</i>	ARANESP 200 MCG/0.4 ML (IN
<i>aerosol inhaler (nda020983)</i>4	POLYSORBATE) INJECTION
<i>alogliptin 12.5 mg tablet</i>11	SYRINGE15
<i>alogliptin 12.5 mg-metformin 1,000 mg</i>	ARANESP 200 MCG/ML (IN
<i>tablet</i>11	POLYSORBATE) INJECTION15
<i>alogliptin 12.5 mg-metformin 500 mg</i>	ARANESP 25 MCG/0.42 ML (IN
<i>tablet</i>11	POLYSORBATE) INJECTION
<i>alogliptin 12.5 mg-pioglitazone 30 mg</i>	SYRINGE15
<i>tablet</i>11	ARANESP 25 MCG/ML (IN
<i>alogliptin 25 mg tablet</i>11	POLYSORBATE) INJECTION15

ARANESP 300 MCG/0.6 ML (IN POLYSORBATE) INJECTION SYRINGE	15	CONCERTA 27 MG TABLET,EXTENDED RELEASE	1
ARANESP 40 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE	15	CONCERTA 36 MG TABLET,EXTENDED RELEASE	1
ARANESP 40 MCG/ML (IN POLYSORBATE) INJECTION	15	CONCERTA 54 MG TABLET,EXTENDED RELEASE	1
ARANESP 500 MCG/ML (IN POLYSORBATE) INJECTION SYRINGE	15	COTEMPLA XR-ODT 17.3 MG EXTENDED RELEASE DISINTEGRATING TABLET	1
ARANESP 60 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE	15	COTEMPLA XR-ODT 25.9 MG EXTENDED RELEASE DISINTEGRATING TABLET	1
ARANESP 60 MCG/ML (IN POLYSORBATE) INJECTION	15	COTEMPLA XR-ODT 8.6 MG EXTENDED RELEASE DISINTEGRATING TABLET	1
AZSTARYS 26.1 MG-5.2 MG CAPSULE	1	<i>dapagliflozin propaned 10 mg-metformin er 1,000 mg tablet,ext rel 24hr</i>	29
AZSTARYS 39.2 MG-7.8 MG CAPSULE	1	<i>dapagliflozin propaned 5 mg-metformin er 1,000 mg tablet, ext rel 24hr</i>	29
AZSTARYS 52.3 MG-10.4 MG CAPSULE	1	<i>dapagliflozin propanediol 10 mg tablet</i>	29
BELSOMRA 10 MG TABLET	30	<i>dapagliflozin propanediol 5 mg tablet</i>	29
BELSOMRA 15 MG TABLET	30	DAYVIGO 10 MG TABLET	30
BELSOMRA 20 MG TABLET	30	DAYVIGO 5 MG TABLET	30
BELSOMRA 5 MG TABLET	30	DEXEDRINE SPANSULE 10 MG CAPSULE,EXTENDED RELEASE	1
<i>calcipotriene 0.005 % topical foam</i>	35	<i>dextroamphetamine-amphetamine er 12.5 mg capsule, 3 bead, ext rel 24hr</i>	1
<i>calcipotriene-betamethasone 0.005 %-0.064 % topical ointment</i>	35	<i>dextroamphetamine-amphetamine er 25 mg capsule,3 bead,ext release 24hr</i>	1
<i>calcipotriene-betamethasone 0.005 %-0.064 % topical suspension</i>	35	<i>dextroamphetamine-amphetamine er 37.5 mg capsule, 3 bead, ext rel 24hr</i>	1
<i>calcitriol 3 mcg/gram topical ointment</i>	35	<i>dextroamphetamine-amphetamine er 50 mg capsule,3 bead,ext release 24hr</i>	1
CELEBREX 100 MG CAPSULE	8	DHIVY 25 MG-100 MG TABLET	28
CELEBREX 200 MG CAPSULE	8	<i>diclofenac 20 mg/gram/actuation (2 %) topical soln metered-dose pump</i>	26
CELEBREX 400 MG CAPSULE	8	DYANAVEL XR 10 MG TABLET, EXTENDED RELEASE	1
CELEBREX 50 MG CAPSULE	8	DYANAVEL XR 15 MG TABLET, EXTENDED RELEASE	1
<i>celecoxib 100 mg capsule</i>	8	DYANAVEL XR 2.5 MG/ML ORAL 24 HR EXTENDED RELEASE SUSPENSION	1
<i>celecoxib 200 mg capsule</i>	8	DYANAVEL XR 20 MG TABLET, EXTENDED RELEASE	1
<i>celecoxib 400 mg capsule</i>	8		
<i>celecoxib 50 mg capsule</i>	8		
CEQUA 0.09 % EYE DROPS IN A DROPPERETTE	13		
<i>clonidine hcl er 0.17 mg tablet,extended release 24 hr</i>	9		
CONCERTA 18 MG TABLET,EXTENDED RELEASE	1		

DYANAVEL XR 5 MG TABLET, EXTENDED RELEASE	1	GLUMETZA 1,000 MG TABLET,EXTENDED RELEASE	18
DYMISTA 137 MCG-50 MCG/SPRAY NASAL SPRAY	14	GLUMETZA 500 MG TABLET,EXTENDED RELEASE	18
ENSTILAR 0.005 %-0.064 % TOPICAL FOAM	35	GRANIX 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE	16
EPOGEN 2,000 UNIT/ML INJECTION SOLUTION	15	GRANIX 300 MCG/ML SUBCUTANEOUS SOLUTION	16
EPOGEN 20,000 UNIT/2 ML INJECTION SOLUTION	15	GRANIX 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE	16
EPOGEN 20,000 UNIT/ML INJECTION SOLUTION	15	GRANIX 480 MCG/1.6 ML SUBCUTANEOUS SOLUTION	16
EPOGEN 3,000 UNIT/ML INJECTION SOLUTION	15	INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION	21
EPOGEN 4,000 UNIT/ML INJECTION SOLUTION	15	INPEFA 200 MG TABLET	29
ERTACZO 2 % TOPICAL CREAM	34	INPEFA 400 MG TABLET	29
EXELDERM 1 % TOPICAL CREAM	34	IYUZEH (PF) 0.005 % EYE DROPS IN A DROPPERETTE	5
EXELDERM 1 % TOPICAL SOLUTION	34	JORNAY PM 100 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE	1
<i>fluticasone furoate 100 mcg-vilanterol 25 mcg/dose inhalation powder</i>	7	JORNAY PM 20 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE	1
<i>fluticasone furoate 200 mcg-vilanterol 25 mcg/dose inhalation powder</i>	7	JORNAY PM 40 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE	1
FOCALIN 10 MG TABLET	1	JORNAY PM 60 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE	1
FOCALIN 2.5 MG TABLET	1	JORNAY PM 80 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE	1
FOCALIN 5 MG TABLET	1	KAZANO 12.5 MG-1,000 MG TABLET .	11
FOCALIN XR 10 MG CAPSULE,EXTENDED RELEASE	1	KAZANO 12.5 MG-500 MG TABLET	11
FOCALIN XR 15 MG CAPSULE,EXTENDED RELEASE	1	KETODAN 2 % TOPICAL FOAM	34
FOCALIN XR 20 MG CAPSULE,EXTENDED RELEASE	1	KRISTALOSE 10 GRAM ORAL PACKET	22
FOCALIN XR 25 MG CAPSULE,EXTENDED RELEASE	1	KRISTALOSE 20 GRAM ORAL PACKET	22
FOCALIN XR 30 MG CAPSULE,EXTENDED RELEASE	1		
FOCALIN XR 35 MG CAPSULE,EXTENDED RELEASE	1		
FOCALIN XR 40 MG CAPSULE,EXTENDED RELEASE	1		
FOCALIN XR 5 MG CAPSULE,EXTENDED RELEASE	1		
FYLNETHRA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE	25		

<i>lactulose 10 gram oral packet</i>	22	<i>metformin er 1,000 mg tablet,extended release 24hr (osmotic)</i>	17
<i>leuprolide 22.5 mg (3 month) intramuscular suspension</i>	19	<i>metformin er 500 mg 24 hr tablet,extended release (gastric retention)</i>	18
<i>levamlodipine 2.5 mg tablet</i>	10	<i>metformin er 500 mg tablet,extended release 24hr (osmotic)</i>	17
<i>levamlodipine 5 mg tablet</i>	10	METHYLIN 10 MG/5 ML ORAL SOLUTION	1
<i>lisdexamfetamine 10 mg capsule</i>	1	METHYLIN 5 MG/5 ML ORAL SOLUTION	1
<i>lisdexamfetamine 10 mg chewable tablet</i>	1	<i>methylphenidate er 45 mg tablet,extended release 24 hr</i>	1
<i>lisdexamfetamine 20 mg capsule</i>	1	<i>methylphenidate er 63 mg tablet,extended release 24 hr</i>	1
<i>lisdexamfetamine 20 mg chewable tablet</i>	1	<i>methylphenidate er 72 mg tablet,extended release 24 hr</i>	1
<i>lisdexamfetamine 30 mg capsule</i>	1	MIEBO (PF) 100 % EYE DROPS	13
<i>lisdexamfetamine 30 mg chewable tablet</i>	1	<i>mirabegron er 25 mg tablet,extended release 24 hr</i>	23
<i>lisdexamfetamine 40 mg capsule</i>	1	<i>mirabegron er 50 mg tablet,extended release 24 hr</i>	23
<i>lisdexamfetamine 40 mg chewable tablet</i>	1	<i>mupirocin calcium 2 % topical cream</i>	24
<i>lisdexamfetamine 50 mg capsule</i>	1	MYDAYIS 12.5 MG CAPSULE EXTENDED RELEASE 24 HR	1
<i>lisdexamfetamine 50 mg chewable tablet</i>	1	MYDAYIS 25 MG CAPSULE EXTENDED RELEASE 24 HR	1
<i>lisdexamfetamine 60 mg capsule</i>	1	MYDAYIS 37.5 MG CAPSULE EXTENDED RELEASE 24 HR	1
<i>lisdexamfetamine 60 mg chewable tablet</i>	1	MYDAYIS 50 MG CAPSULE EXTENDED RELEASE 24 HR	1
<i>lisdexamfetamine 70 mg capsule</i>	1	<i>naftifine 1 % topical cream</i>	34
LUPRON DEPOT 11.25 MG (3 MONTH) INTRAMUSCULAR SYRINGE KIT	19	<i>naftifine 2 % topical cream</i>	34
LUPRON DEPOT 22.5 MG (3 MONTH) INTRAMUSCULAR SYRINGE KIT	19	<i>naftifine 2 % topical gel</i>	34
LUPRON DEPOT 3.75 MG INTRAMUSCULAR SYRINGE KIT	19	NAFTIN 1 % TOPICAL GEL	34
LUPRON DEPOT 30 MG (4 MONTH) INTRAMUSCULAR SYRINGE KIT	19	NAFTIN 2 % TOPICAL GEL	34
LUPRON DEPOT 45 MG (6 MONTH) INTRAMUSCULAR SYRINGE KIT	19	NESINA 12.5 MG TABLET	11
LUPRON DEPOT 7.5 MG INTRAMUSCULAR SYRINGE KIT	19	NESINA 25 MG TABLET	11
METADATE CD 10 MG CAPSULE,EXTENDED RELEASE	1	NESINA 6.25 MG TABLET	11
METADATE CD 20 MG CAPSULE,EXTENDED RELEASE	1	NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE	16
METADATE CD 30 MG CAPSULE,EXTENDED RELEASE	1	NEUPOGEN 300 MCG/ML INJECTION SOLUTION	16
METADATE CD 40 MG CAPSULE,EXTENDED RELEASE	1	NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE	16
METADATE CD 50 MG CAPSULE,EXTENDED RELEASE	1	NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION	16
METADATE CD 60 MG CAPSULE,EXTENDED RELEASE	1		
<i>metformin 500 mg/5 ml oral solution</i>	27		
<i>metformin er 1,000 mg 24 hr tablet,extended release (gastric reten.)</i>	18		

NEXICLON XR 0.17 MG		RELEXXII 63 MG	
TABLET,EXTENDED RELEASE	9	TABLET,EXTENDED RELEASE	1
NYVEPRIA 6 MG/0.6 ML		RELTONE 200 MG CAPSULE	36
SUBCUTANEOUS SYRINGE	25	RELTONE 400 MG CAPSULE	36
OSENI 12.5 MG-30 MG TABLET	11	RHOPRESSA 0.02 % EYE DROPS	5
OSENI 25 MG-15 MG TABLET	11	RITALIN 10 MG TABLET	1
OSENI 25 MG-30 MG TABLET	11	RITALIN 20 MG TABLET	1
OSENI 25 MG-45 MG TABLET	11	RITALIN 5 MG TABLET	1
<i>oxiconazole 1 % topical cream</i>	34	RITALIN LA 10 MG	
OXISTAT 1 % LOTION	34	CAPSULE,EXTENDED RELEASE	1
PENNSAID 20		RITALIN LA 20 MG	
MG/GRAM/ACTUATION (2 %)		CAPSULE,EXTENDED RELEASE	1
TOPICAL SOLN IN METERED-DOSE		RITALIN LA 30 MG	
PUMP	26	CAPSULE,EXTENDED RELEASE	1
PROAIR RESPICLICK 90		RITALIN LA 40 MG	
MCG/ACTUATION BREATH		CAPSULE,EXTENDED RELEASE	1
ACTIVATED	4	ROCKLATAN 0.02 %-0.005 % EYE	
QTERN 10 MG-5 MG TABLET	12	DROPS	5
QTERN 5 MG-5 MG TABLET	12	RYALTRIS 665 MCG-25 MCG/SPRAY	
QUILLICHEW ER 20 MG		NASAL SPRAY	14
CHEWABLE TABLET, EXTENDED		RYTARY 23.75 MG-95 MG	
RELEASE	1	CAPSULE,EXTENDED RELEASE	28
QUILLICHEW ER 30 MG		RYTARY 36.25 MG-145 MG	
CHEWABLE TABLET, EXTENDED		CAPSULE,EXTENDED RELEASE	28
RELEASE	1	RYTARY 48.75 MG-195 MG	
QUILLICHEW ER 40 MG		CAPSULE,EXTENDED RELEASE	28
CHEWABLE, EXTENDED RELEASE		RYTARY 61.25 MG-245 MG	
TABLET	1	CAPSULE,EXTENDED RELEASE	28
QUILLIVANT XR 5 MG/ML (25 MG/5		<i>saxagliptin 2.5 mg tablet</i>	11
ML) ORAL SUSPENSION,EXTEND		<i>saxagliptin 2.5 mg-metformin er 1,000 mg</i>	
RELEASE 24HR	1	<i>tablet,extend release 24hr mp</i>	11
QUVIVIQ 25 MG TABLET	30	<i>saxagliptin 5 mg tablet</i>	11
QUVIVIQ 50 MG TABLET	30	<i>saxagliptin 5 mg-metformin er 1,000 mg</i>	
RELEUKO 300 MCG/0.5 ML		<i>tablet,extend release 24hr mp</i>	11
SUBCUTANEOUS SYRINGE	16	<i>saxagliptin 5 mg-metformin er 500 mg</i>	
RELEUKO 480 MCG/0.8 ML		<i>tablet,extend release 24hr mp</i>	11
SUBCUTANEOUS SYRINGE	16	SEGLUROMET 2.5 MG-1,000 MG	
RELEXXII 18 MG		TABLET	29
TABLET,EXTENDED RELEASE	1	SEGLUROMET 2.5 MG-500 MG	
RELEXXII 27 MG		TABLET	29
TABLET,EXTENDED RELEASE	1	SEGLUROMET 7.5 MG-1,000 MG	
RELEXXII 36 MG		TABLET	29
TABLET,EXTENDED RELEASE	1	SEGLUROMET 7.5 MG-500 MG	
RELEXXII 45 MG		TABLET	29
TABLET,EXTENDED RELEASE	1	<i>sitagliptin 100 mg tablet</i>	11
		<i>sitagliptin 25 mg tablet</i>	11

<i>sitagliptin 50 mg tablet</i>	11	TUDORZA PRESSAIR 400	
<i>sitagliptin 50 mg-metformin 1,000 mg</i>		MCG/ACTUATION BREATH	
<i>tablet</i>	11	ACTIVATED (30 ACTUAT)	21
<i>sitagliptin 50 mg-metformin 500 mg tablet</i> ..	11	TYRVAYA 0.03 MG/SPRAY NASAL	
SOAANZ 20 MG TABLET	31	SPRAY	13
SOAANZ 40 MG TABLET	31	UDENYCA 6 MG/0.6 ML	
SOAANZ 60 MG TABLET	31	SUBCUTANEOUS SYRINGE	25
SORILUX 0.005 % TOPICAL FOAM	35	UDENYCA AUTOINJECTOR 6	
STEGLATRO 15 MG TABLET	29	MG/0.6 ML SUBCUTANEOUS AUTO-	
STEGLATRO 5 MG TABLET	29	INJECTOR	25
STEGLUJAN 15 MG-100 MG TABLET	12	URSO 250 250 MG TABLET	36
STEGLUJAN 5 MG-100 MG TABLET ...12		URSO FORTE 500 MG TABLET	36
STIMUFEND 6 MG/0.6 ML		<i>ursodiol 200 mg capsule</i>	36
SUBCUTANEOUS SYRINGE	25	<i>ursodiol 400 mg capsule</i>	36
STRATTERA 10 MG CAPSULE	1	VECTICAL 3 MCG/GRAM TOPICAL	
STRATTERA 100 MG CAPSULE	1	OINTMENT	35
STRATTERA 18 MG CAPSULE	1	VEVYE 0.1 % EYE DROPS	13
STRATTERA 25 MG CAPSULE	1	VYVANSE 10 MG CAPSULE	1
STRATTERA 40 MG CAPSULE	1	VYVANSE 10 MG CHEWABLE	
STRATTERA 60 MG CAPSULE	1	TABLET	1
STRATTERA 80 MG CAPSULE	1	VYVANSE 20 MG CAPSULE	1
SUBOXONE 12 MG-3 MG		VYVANSE 20 MG CHEWABLE	
SUBLINGUAL FILM	32	TABLET	1
SUBOXONE 2 MG-0.5 MG		VYVANSE 30 MG CAPSULE	1
SUBLINGUAL FILM	32	VYVANSE 30 MG CHEWABLE	
SUBOXONE 4 MG-1 MG		TABLET	1
SUBLINGUAL FILM	32	VYVANSE 40 MG CAPSULE	1
SUBOXONE 8 MG-2 MG		VYVANSE 40 MG CHEWABLE	
SUBLINGUAL FILM	32	TABLET	1
SYMBICORT 160 MCG-4.5		VYVANSE 50 MG CAPSULE	1
MCG/ACTUATION HFA AEROSOL		VYVANSE 50 MG CHEWABLE	
INHALER	33	TABLET	1
SYMBICORT 80 MCG-4.5		VYVANSE 60 MG CAPSULE	1
MCG/ACTUATION HFA AEROSOL		VYVANSE 60 MG CHEWABLE	
INHALER	33	TABLET	1
TACLONEX 0.005 %-0.064 %		VYVANSE 70 MG CAPSULE	1
TOPICAL OINTMENT	35	VYZULTA 0.024 % EYE DROPS	5
TACLONEX 0.005 %-0.064 %		XELSTRYM 13.5 MG/9 HOUR	
TOPICAL SUSPENSION	35	TRANSDERMAL 24 HOUR PATCH	1
TRELSTAR 11.25 MG IM		XELSTRYM 18 MG/9 HOUR	
SUSPENSION	19	TRANSDERMAL 24 HOUR PATCH	1
TRELSTAR 22.5 MG IM SUSPENSION	19	XELSTRYM 4.5 MG/9 HOUR	
TRELSTAR 3.75 MG IM SUSPENSION	19	TRANSDERMAL 24 HOUR PATCH	1
TUDORZA PRESSAIR 400		XELSTRYM 9 MG/9 HOUR	
MCG/ACTUATION BREATH		TRANSDERMAL 24 HOUR PATCH	1
ACTIVATED	21		

XOPENEX HFA 45	
MCG/ACTUATION AEROSOL	
INHALER.....	6
ZIRGAN 0.15 % EYE GEL.....	20
ZITUVIO 100 MG TABLET.....	11
ZITUVIO 25 MG TABLET.....	11
ZITUVIO 50 MG TABLET.....	11