Medicare Part D: 5 Tier Closed Formulary

Please click here.

For Medicare Part D: Prior Authorization Criteria

Please click here.

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List of Abbreviations

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.

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.

Below is a list of drug name formatting patterns that may appear in the following pages.

List of Patterns

lowercase italics: Generic drugs

UPPERCASE BOLD: Brand name drugs

Drug Name	Drug Tier	Requirements/Limits
Anti - Infectives		
abacavir oral tablet	T2	
ABACAVIR-LAMIVUDINE	T5	
abacavir-lamivudine-zidovudine	T2	
ABELCET	T5	PA-BvD
acyclovir oral capsule	T2	
acyclovir oral suspension 200 mg/5 ml	T2	
acyclovir oral tablet	T2	
acyclovir sodium intravenous solution	T2	PA-BvD
adefovir	T2	
ALBENZA	T4	
ALINIA	T4	
amantadine hcl	T2	
AMBISOME	T4	PA-BvD
amikacin injection solution 500 mg/2 ml	T2	
amoxicillin oral capsule	T1	
amoxicillin oral suspension for reconstitution	T1	
amoxicillin oral tablet	T1	
amoxicillin oral tablet,chewable 125 mg, 250 mg	T1	
amoxicillin-pot clavulanate	T2	
amphotericin b	T2	PA-BvD
ampicillin oral capsule	T2	
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg	T2	
ampicillin-sulbactam injection	T2	
APTIVUS	T5	
atovaquone	T5	
atovaquone-proguanil	T2	
ATRIPLA	T5	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	T4	
AVELOX IN NACL (ISO-OSMOTIC)	T3	
AVYCAZ	T5	
AZACTAM IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2 GRAM/50 ML	T3	
azithromycin	T2	
aztreonam injection recon soln 1 gram	T2	
baciim	T2	

Drug Name	Drug Tier	Requirements/Limits
bacitracin intramuscular	T2	
BARACLUDE ORAL SOLUTION	T3	
BARACLUDE ORAL TABLET	T5	
BETHKIS	T4	PA
BICILLIN C-R	T3	
BICILLIN L-A	T3	
BILTRICIDE	T3	
CANCIDAS	T4	
CAPASTAT	T4	
CASPOFUNGIN	T4	
CAYSTON	T5	
cefaclor oral capsule	T2	
cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml	T2	
cefaclor oral tablet extended release 12 hr	T2	
cefadroxil oral capsule	T2	
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	T2	
cefadroxil oral tablet	T2	
cefazolin injection recon soln 1 gram, 10 gram, 500 mg	T2	
cefdinir	T2	
cefepime	T2	
cefixime	T2	
cefotaxime injection recon soln 1 gram, 2 gram, 500 mg	T2	
cefotetan injection	T2	
cefoxitin	T2	
cefpodoxime	T2	
cefprozil	T2	
ceftazidime	T2	
CEFTIN ORAL SUSPENSION FOR RECONSTITUTION	T4	
ceftriaxone injection recon soln 10 gram, 250 mg, 500 mg	T2	
ceftriaxone intravenous	T2	
cefuroxime axetil oral tablet	T2	
cefuroxime sodium injection recon soln 750 mg	T2	
cefuroxime sodium intravenous	T2	
cephalexin	T2	

Drug Name	Drug Tier	Requirements/Limits
chloramphenicol sod succinate	T2	
chloroquine phosphate	T2	
cidofovir	T2	
ciprofloxacin	T2	
ciprofloxacin (mixture)	T2	
ciprofloxacin hcl oral	T1	
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	T2	
ciprofloxacin lactate intravenous solution 400 mg/40 ml	T1	
clarithromycin	T2	
CLEOCIN HCL ORAL CAPSULE 75 MG	T3	
clindamycin hcl	T2	
clindamycin in 5 % dextrose	T2	
clindamycin pediatric	T2	
clindamycin phosphate injection	T2	
clindamycin phosphate intravenous solution 600 mg/4 ml	T2	
clotrimazole mucous membrane	T2	
COARTEM	T4	
colistin (colistimethate na)	T2	
COMBIVIR	T5	
COMPLERA	T5	
COPEGUS	T4	
CRESEMBA	T5	
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	T3	
CUBICIN	T5	
CYTOVENE	T4	PA-BvD
DAKLINZA	T5	PA; QL (28 EA per 28 days)
DALVANCE	T5	
DAPSONE ORAL	T3	
DAPTOMYCIN	T5	
DARAPRIM	T3	
demeclocycline	T2	
DESCOVY	T5	QL (31 EA per 31 days)
dicloxacillin	T2	
didanosine	T2	
DIFICID	T5	QL (20 EA per 10 days)

Drug Name	Drug Tier	Requirements/Limits
DORIBAX INTRAVENOUS RECON SOLN 500 MG	T4	
doxy-100	T2	
doxycycline hyclate oral capsule	T2	
doxycycline hyclate oral tablet 100 mg	T2	
doxycycline hyclate oral tablet 20 mg	T1	
doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg, 200 mg, 50 mg	T2	
doxycycline hyclate oral tablet,delayed release (dr/ec) 150 mg, 75 mg	T1	
doxycycline monohydrate oral capsule	T2	
doxycycline monohydrate oral suspension for reconstitution	T2	
doxycycline monohydrate oral tablet	T2	
e.e.s. 400 oral tablet	T2	
E.E.S. GRANULES	T4	
EDURANT	T4	
EMTRIVA	T3	
EMVERM	T4	
entecavir	T5	
EPCLUSA	T5	PA; QL (28 EA per 28 days)
EPIVIR HBV ORAL SOLUTION	T3	
EPIVIR HBV ORAL TABLET	T4	
EPIVIR ORAL SOLUTION	T3	
EPIVIR ORAL TABLET	T4	
EPZICOM	T5	
ERAXIS(WATER DILUENT)	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 (as stearate) oral tablet 250 mg	T2	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	T3	
erythromycin ethylsuccinate oral suspension for reconstitution	T2	
erythromycin ethylsuccinate oral tablet	T2	
erythromycin oral capsule,delayed release(dr/ec)	T2	

Drug Name	Drug Tier	Requirements/Limits
erythromycin oral tablet	T2	
ethambutol	T2	
EVOTAZ	T3	
famciclovir	T2	
fluconazole	T2	
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml	T2	
flucytosine	T2	
FUZEON SUBCUTANEOUS RECON SOLN	T5	
ganciclovir sodium	T2	PA-BvD
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml	T2	
gentamicin injection solution 40 mg/ml	T1	
GENVOYA	T5	
griseofulvin microsize	T2	
griseofulvin ultramicrosize	T2	
HARVONI	T5	PA; QL (28 EA per 28 days)
HEPSERA	T5	
hydroxychloroquine	T2	
imipenem-cilastatin	T2	
INTELENCE ORAL TABLET 100 MG, 200 MG	T5	
INTELENCE ORAL TABLET 25 MG	T4	
INVANZ INJECTION	T4	
INVIRASE ORAL CAPSULE	T4	
INVIRASE ORAL TABLET	T5	
ISENTRESS HD	T5	
ISENTRESS ORAL POWDER IN PACKET	T4	
ISENTRESS ORAL TABLET	T5	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	T5	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	T3	
isoniazid injection	T1	
isoniazid oral solution	T2	
isoniazid oral tablet	T1	
itraconazole	T2	
ivermectin	T2	
KALETRA ORAL TABLET 100-25 MG	T3	

Drug Name	Drug Tier	Requirements/Limits
KALETRA ORAL TABLET 200-50 MG	T5	
ketoconazole oral	T2	
LAMISIL ORAL TABLET	T4	QL (90 EA per 180 days)
lamivudine	T2	
lamivudine-zidovudine	T2	
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	T2	
levofloxacin intravenous	T2	
levofloxacin oral	T2	
LEXIVA ORAL SUSPENSION	T3	
LEXIVA ORAL TABLET	T5	
LINCOCIN	T4	
lincomycin	T2	
linezolid intravenous	T4	
linezolid oral	T5	
LOPINAVIR-RITONAVIR	T5	
MAVYRET	T5	PA; QL (84 EA per 28 days)
mefloquine	T2	
MEPRON	T5	
meropenem	T2	
methenamine hippurate	T2	
metronidazole in nacl (iso-os)	T2	
metronidazole oral	T1	
minocycline	T2	
moderiba	T2	
moderiba dose pack oral tablets,dose pack 400 mg (7)- 400 mg (7), 600 mg (7)- 600 mg (7)	T2	
MONUROL	T4	
morgidox oral capsule 50 mg	T3	
moxifloxacin oral	T3	
MOXIFLOXACIN-SOD.ACE,SUL-WATER	T4	
MYCAMINE	T4	
nafcillin injection recon soln 1 gram, 10 gram	T2	
NEBUPENT	T4	PA-BvD
neomycin	T2	
nevirapine	T2	
nitrofurantoin	T2	PA; QL (1800 ML per 365 days)
nitrofurantoin macrocrystal oral capsule 100 mg	T2	PA; QL (90 EA per 365 days)
nitrofurantoin macrocrystal oral capsule 25 mg	T2	PA; QL (360 EA per 365 days)

Drug Name	Drug Tier	Requirements/Limits
nitrofurantoin macrocrystal oral capsule 50 mg	T2	PA; QL (180 EA per 365 days)
nitrofurantoin monohyd/m-cryst	T2	PA; QL (90 EA per 365 days)
NORVIR	T3	
NOXAFIL ORAL SUSPENSION	T5	
nystatin oral suspension	T2	
nystatin oral tablet	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
ofloxacin oral tablet 300 mg, 400 mg	T2	
OLYSIO	T5	PA; QL (28 EA per 28 days)
ORAVIG	T4	
ORBACTIV	T5	
oseltamivir	T2	
oxacillin in dextrose(iso-osm)	T2	
oxacillin injection recon soln 10 gram	T2	
paromomycin	T2	
PASER	T4	
PCE	T4	
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML	T4	
penicillin g potassium injection recon soln 5 million unit	T2	
penicillin g procaine intramuscular syringe 1.2 million unit/2 ml	T2	
penicillin g sodium	T2	
penicillin v potassium	T1	
PENTAM	T4	
piperacillin-tazobactam intravenous recon soln 3.375 gram, 4.5 gram, 40.5 gram	T2	
polymyxin b sulfate	T2	
PREZCOBIX	T3	
PREZISTA ORAL SUSPENSION	T3	
PREZISTA ORAL TABLET 150 MG, 75 MG	T3	
PREZISTA ORAL TABLET 600 MG, 800 MG	T5	
PRIFTIN	T4	
PRIMAQUINE	T3	
PRIMSOL	T4	
pyrazinamide	T2	
quinine sulfate	T2	

Drug Name	Drug Tier	Requirements/Limits
REBETOL ORAL SOLUTION	T4	
RELENZA DISKHALER	T3	
RESCRIPTOR	T3	
RETROVIR INTRAVENOUS	T3	
RETROVIR ORAL CAPSULE	T4	
RETROVIR ORAL SYRUP	T4	
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	T3	
REYATAZ ORAL POWDER IN PACKET	T4	
ribasphere oral capsule	T2	
ribasphere oral tablet 200 mg, 400 mg	T2	
ribasphere oral tablet 600 mg	T5	
ribasphere ribapak oral tablets,dose pack 200 mg (7)- 400 mg (7)	T2	
ribasphere ribapak oral tablets,dose pack 400-400 mg (28)-mg (28), 600-400 mg (28)-mg (28), 600-600 mg (28)-mg (28)	T5	
ribavirin oral capsule	T2	
ribavirin oral tablet 200 mg	T2	
rifabutin	T2	
rifampin	T2	
RIFATER	T4	
rimantadine	T2	
SELZENTRY ORAL TABLET	T5	
SIRTURO	T5	
SIVEXTRO INTRAVENOUS	T5	
SIVEXTRO ORAL	T5	QL (6 EA per 31 days)
SOVALDI	T5	PA; QL (28 EA per 28 days)
SPORANOX ORAL SOLUTION	T3	
stavudine oral capsule	T2	
STREPTOMYCIN	T3	
STRIBILD	T5	
sulfadiazine	T2	
sulfamethoxazole-trimethoprim	T1	
SUPRAX ORAL CAPSULE	T3	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION	T3	
SUSTIVA	T3	
SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML	T5	

Drug Name	Drug Tier	Requirements/Limits
SYNERCID	T4	
TAMIFLU	T3	
TAZICEF INJECTION	T4	
TECHNIVIE	T5	PA; QL (56 EA per 28 days)
TEFLARO	T4	
terbinafine hcl oral	T1	QL (90 EA per 180 days)
tetracycline	T2	
TIGECYCLINE	T5	
tinidazole	T2	
TIVICAY ORAL TABLET 10 MG	T4	
TIVICAY ORAL TABLET 25 MG, 50 MG	T5	
TOBI	T4	PA
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	T3	PA
tobramycin in 0.225 % nacl	T5	PA
tobramycin sulfate injection solution	T1	
TRECATOR	T4	
trimethoprim	T2	
TRIUMEQ	T5	
TRIZIVIR	T4	
TRUVADA	T5	
TYBOST	T3	
TYGACIL	T5	
valacyclovir	T2	
VALCYTE ORAL RECON SOLN	T4	
VALCYTE ORAL TABLET	T5	
VALGANCICLOVIR ORAL RECON SOLN	T4	
valganciclovir oral tablet	T5	
VANCOCIN	T5	
vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg	T2	
vancomycin oral capsule 125 mg	T4	
vancomycin oral capsule 250 mg	T5	
VEMLIDY	T5	QL (31 EA per 31 days)
VFEND	T5	
VIDEX 2 GRAM PEDIATRIC	T3	
VIDEX EC	T4	
VIEKIRA PAK	T5	PA; QL (112 EA per 28 days)
VIEKIRA XR	T5	PA; QL (84 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
VIRACEPT ORAL TABLET	T5	
VIRAMUNE ORAL SUSPENSION	T4	
VIRAMUNE XR	T4	
VIREAD	T3	
voriconazole intravenous	T2	
voriconazole oral suspension for reconstitution	T2	
voriconazole oral tablet 200 mg	T5	
voriconazole oral tablet 50 mg	T2	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	T4	QL (9 EA per 3 days)
XIFAXAN ORAL TABLET 550 MG	T5	PA; QL (62 EA per 31 days)
ZEPATIER	T5	PA; QL (28 EA per 28 days)
ZERBAXA	T4	
ZERIT	T4	
ZIAGEN ORAL SOLUTION	T3	
ZIAGEN ORAL TABLET	T4	
zidovudine	T2	
ZMAX	T4	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML, 3.375 GRAM/50 ML	T3	
ZYVOX INTRAVENOUS PARENTERAL SOLUTION 600 MG/300 ML	T5	
ZYVOX ORAL	T5	
Antineoplastic / Immunosuppressant Drugs		
ABRAXANE	T4	
ADRIAMYCIN INTRAVENOUS SOLUTION 20 MG/10 ML	T4	PA-BvD
adrucil intravenous solution 500 mg/10 ml	T2	PA-BvD
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)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALIMTA INTRAVENOUS RECON SOLN 500 MG	T3	
ALUNBRIG	T5	PA-NS; QL (186 EA per 31 days)
anastrozole	T2	

Drug Name	Drug Tier	Requirements/Limits
ARIMIDEX	T4	
AROMASIN	T4	
ARRANON	T4	
ASTAGRAF XL	T3	PA-BvD
AVASTIN	T5	
azacitidine	T5	
AZASAN	T4	PA-BvD
azathioprine	T2	PA-BvD
azathioprine sodium	T3	PA-BvD
BAVENCIO	T5	PA-NS
BELEODAQ	T5	PA-NS
bexarotene	T5	
bicalutamide	T2	
BICNU	T4	
bleomycin injection recon soln 30 unit	T2	PA-BvD
BOSULIF	T5	PA-NS
busulfan	T4	
BUSULFEX	T4	
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CAPRELSA	T5	PA-NS
carboplatin intravenous solution	T2	
CASODEX	T4	
CELLCEPT INTRAVENOUS	T4	PA-BvD
CELLCEPT ORAL CAPSULE	T4	PA-BvD
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION	T4	PA-BvD
CELLCEPT ORAL TABLET	T5	PA-BvD
cisplatin	T2	
cladribine	T2	PA-BvD
CLOFARABINE	T4	
COMETRIQ	T5	PA-NS
COTELLIC	T5	PA-NS
CYCLOPHOSPHAMIDE ORAL CAPSULE	T4	PA-BvD
cyclosporine intravenous	T2	PA-BvD
cyclosporine modified	T2	PA-BvD
cyclosporine oral capsule	T2	PA-BvD
CYRAMZA	T5	
cytarabine	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)	T2	PA-BvD
dacarbazine intravenous recon soln 200 mg	T2	
DACOGEN	T5	
DARZALEX	T5	PA-NS
daunorubicin intravenous solution	T2	
decitabine	T5	
dexrazoxane hcl intravenous recon soln 250 mg	T2	
docetaxel intravenous solution 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)	T2	
doxorubicin intravenous solution 50 mg/25 ml	T2	PA-BvD
doxorubicin, peg-liposomal	T2	PA-BvD
DROXIA	T4	
ELIGARD	T4	
ELIGARD (3 MONTH)	T4	
ELIGARD (4 MONTH)	T4	
ELIGARD (6 MONTH)	T4	
ELITEK	T5	
ELLENCE INTRAVENOUS SOLUTION 200 MG/100 ML	T4	
EMCYT	T3	
EMPLICITI	T5	PA-BvD
ENVARSUS XR	T4	PA-BvD
EPIRUBICIN INTRAVENOUS SOLUTION 200 MG/100 ML	T4	
ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML	T3	
ERIVEDGE	T5	PA-NS
ERWINAZE	T5	
ETOPOPHOS	T4	
etoposide intravenous	T2	
exemestane	T2	
FARESTON	T3	
FARYDAK	T5	PA-NS
FASLODEX	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	

Drug Name	Drug Tier	Requirements/Limits
fludarabine intravenous recon soln	T2	
fluorouracil intravenous solution 2.5 gram/50 ml	T2	PA-BvD
flutamide	T2	
FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)	T5	
FUSILEV	T4	
gemcitabine intravenous recon soln 1 gram	T2	
gengraf	T2	PA-BvD
GILOTRIF	T5	PA-NS
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	T4	
HALAVEN	T5	
HERCEPTIN INTRAVENOUS RECON SOLN 440 MG	T5	
HEXALEN	T3	
hydroxyurea	T2	
IBRANCE	T5	PA-NS; QL (21 EA per 28 days)
ICLUSIG	T5	PA-NS
idarubicin	T2	
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)
ifosfamide intravenous recon soln 1 gram	T2	
imatinib oral tablet 100 mg	T5	PA-NS; QL (93 EA per 31 days)
imatinib oral tablet 400 mg	T5	PA-NS; QL (62 EA per 31 days)
IMBRUVICA	T5	PA-NS; QL (124 EA per 31 days)
IMFINZI	T5	PA-NS
IMURAN	T4	PA-BvD
INLYTA	T5	PA-NS
IRESSA	T5	PA-NS
irinotecan intravenous solution 100 mg/5 ml	T2	
ISTODAX	T5	
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
JEVTANA	T5	
KADCYLA INTRAVENOUS RECON SOLN 100 MG	T5	
KEPIVANCE	T5	
KEYTRUDA	T5	PA-NS

Drug Name	Drug Tier	Requirements/Limits
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)
KYPROLIS	T5	
LARTRUVO	T5	
LENVIMA	T5	PA-NS
letrozole	T2	
leucovorin calcium injection recon soln 100 mg, 350 mg	T2	
leucovorin calcium oral	T2	
LEUKERAN	T3	
leuprolide subcutaneous kit	T2	
levoleucovorin intravenous recon soln 50 mg	T4	
levoleucovorin intravenous solution	T4	
LONSURF	T5	PA-NS
LUPRON DEPOT (3 MONTH)	T5	
LUPRON DEPOT (4 MONTH)	T5	
LUPRON DEPOT (6 MONTH)	T5	
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	T3	
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG	T5	
LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG	T5	
LYNPARZA ORAL CAPSULE	T5	PA-NS
LYNPARZA ORAL TABLET	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T3	
MATULANE	T5	
MEGACE ES	T4	
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml	T2	
megestrol oral tablet	T2	

Drug Name	Drug Tier	Requirements/Limits
MEKINIST	T5	PA-NS
melphalan hcl	T5	
mercaptopurine	T2	
mesna	T2	
MESNEX ORAL	T3	
methotrexate sodium (pf)	T2	PA-BvD
methotrexate sodium injection	T2	PA-BvD
methotrexate sodium oral	T1	PA-BvD
mitomycin	T2	
mitoxantrone	T2	
MUSTARGEN	T4	
mycophenolate mofetil	T2	PA-BvD
mycophenolate mofetil hcl	T2	PA-BvD
mycophenolate sodium	T2	PA-BvD
MYFORTIC	T4	PA-BvD
NEORAL	T3	PA-BvD
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
NEXAVAR	T5	PA-NS
NILANDRON	T5	
nilutamide	T5	
NINLARO	T5	PA-NS
NIPENT	T4	
NULOJIX	T5	PA-BvD
octreotide acetate injection solution 1,000 mcg/ml, 200 mcg/ml	T3	
octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml	T2	
octreotide acetate injection solution 500 mcg/ml	T5	
ODOMZO	T5	PA-NS
OPDIVO INTRAVENOUS SOLUTION 40 MG/4 ML	T5	PA-NS
oxaliplatin intravenous solution 100 mg/20 ml	T4	
paclitaxel	T2	
PERJETA	T5	
POMALYST	T5	PA-NS; QL (21 EA per 28 days)
PROGRAF INTRAVENOUS	T3	PA-BvD
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG	T4	PA-BvD
PROGRAF ORAL CAPSULE 5 MG	T5	PA-BvD
PURIXAN	T4	

Drug Name	Drug Tier	Requirements/Limits
RAPAMUNE ORAL SOLUTION	T3	PA-BvD
RAPAMUNE ORAL TABLET 0.5 MG	T4	PA-BvD
RAPAMUNE ORAL TABLET 1 MG, 2 MG	T5	PA-BvD
REVLIMID	T5	PA-NS; QL (21 EA per 28 days)
RITUXAN	T5	
RUBRACA ORAL TABLET 200 MG, 300 MG	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE	T3	PA-BvD
SANDOSTATIN INJECTION SOLUTION 1,000 MCG/ML, 100 MCG/ML, 200 MCG/ML	T5	
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON	T5	
SIGNIFOR	T5	PA
SIGNIFOR LAR	T5	
SIMULECT INTRAVENOUS RECON SOLN 20 MG	T4	PA-BvD
sirolimus	T2	PA-BvD
SOLTAMOX	T4	
SOMATULINE DEPOT	T5	
SPRYCEL	T5	PA-NS; QL (31 EA per 31 days)
STIVARGA	T5	PA-NS
SUTENT	T5	PA-NS
SYLVANT INTRAVENOUS RECON SOLN 100 MG	T5	PA-NS
SYNRIBO	T5	
TABLOID	T3	
tacrolimus oral capsule 0.5 mg, 1 mg	T2	PA-BvD
tacrolimus oral capsule 5 mg	T5	PA-BvD
TAFINLAR	T5	PA-NS
TAGRISSO	T5	PA-NS; QL (31 EA per 31 days)
tamoxifen	T1	
TARCEVA	T5	PA-NS; QL (31 EA per 31 days)
TARGRETIN	T5	
TASIGNA	T5	PA-NS
TECENTRIQ	T5	
THALOMID	T5	PA-NS
thiotepa	T5	
toposar	T2	

Drug Name	Drug Tier	Requirements/Limits
topotecan intravenous recon soln	T2	
TORISEL	T5	
TREANDA INTRAVENOUS RECON SOLN 100 MG	T4	
TRELSTAR INTRAMUSCULAR SYRINGE	T3	
tretinoin (chemotherapy)	T2	
TREXALL	T3	PA-BvD
TRISENOX	T4	
TYKERB	T5	PA-NS
VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)	T4	
VELCADE	T5	
VENCLEXTA ORAL TABLET 10 MG, 50 MG	T4	PA-NS
VENCLEXTA ORAL TABLET 100 MG	T5	PA-NS
VENCLEXTA STARTING PACK	T5	PA-NS
VIDAZA	T5	
vinblastine intravenous solution	T2	PA-BvD
vincasar pfs intravenous solution 1 mg/ml	T2	PA-BvD
vincristine intravenous solution 1 mg/ml	T2	PA-BvD
vinorelbine intravenous solution 50 mg/5 ml	T2	
VOTRIENT	T5	PA-NS
VYXEOS	T5	PA-NS
XALKORI	T5	PA-NS; QL (62 EA per 31 days)
XERMELO	T5	PA; QL (93 EA per 31 days)
XGEVA	T5	
XTANDI	T5	PA-NS; QL (124 EA per 31 days)
YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)	T5	
YONDELIS	T5	
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)	T5	
ZANOSAR	T4	
ZEJULA	T5	PA-NS; QL (93 EA per 31 days)
ZELBORAF	T5	PA-NS
ZINECARD (AS HCL) INTRAVENOUS RECON SOLN 250 MG	T4	
ZOLINZA	T5	PA-NS
ZORTRESS ORAL TABLET 0.25 MG	T4	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
ZORTRESS ORAL TABLET 0.5 MG, 0.75 MG	T5	PA-BvD
ZYDELIG	T5	PA-NS
ZYKADIA	T5	PA-NS
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 MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG	T5	
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING	T5	
ABILIFY ORAL TABLET 10 MG, 20 MG, 30 MG	T5	PA-NS
ABILIFY ORAL TABLET 15 MG, 2 MG, 5 MG	T4	PA-NS
ABSTRAL SUBLINGUAL TABLET 100 MCG	T4	PA; QL (124 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 200 MCG, 300 MCG	T5	PA; QL (124 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 400 MCG	T5	PA; QL (119 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 600 MCG	T5	PA; QL (79 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 800 MCG	T5	PA; QL (60 EA per 31 days)
acetaminophen-codeine oral solution 120-12 mg/5 ml	T1	PA; QL (5167 ML per 31 days)
acetaminophen-codeine oral tablet	T2	PA; QL (403 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 1,200 MCG	T5	PA; QL (40 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 1,600 MCG	T5	PA; QL (30 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 200 MCG	T5	PA; QL (124 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 400 MCG	T5	PA; QL (119 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 600 MCG	T5	PA; QL (79 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 800 MCG	T5	PA; QL (59 EA per 31 days)
ALLZITAL	T4	QL (372 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
almotriptan malate oral tablet 12.5 mg	T2	QL (8 EA per 31 days)
almotriptan malate oral tablet 6.25 mg	T2	QL (16 EA per 31 days)
alprazolam intensol	T2	PA
alprazolam oral tablet 0.25 mg, 0.5 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet 1 mg, 2 mg	T2	PA; QL (155 EA per 31 days)
alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg	T2	PA; QL (31 EA per 31 days)
alprazolam oral tablet extended release 24 hr 2 mg	T2	PA; QL (155 EA per 31 days)
alprazolam oral tablet extended release 24 hr 3 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet,disintegrating 1 mg, 2 mg	T2	PA; QL (155 EA per 31 days)
AMERGE ORAL TABLET 1 MG	T4	QL (20 EA per 31 days)
AMERGE ORAL TABLET 2.5 MG	T4	QL (8 EA per 31 days)
amitriptyline	T2	PA-NS
amitriptyline-chlordiazepoxide	T2	PA-NS
amoxapine	T1	
AMPYRA	T5	PA; QL (62 EA per 31 days)
APLENZIN	T4	
APOKYN	T5	
APTENSIO XR	T4	
APTIOM	T4	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 5 mg	T3	PA-NS
aripiprazole oral tablet 20 mg, 30 mg	T5	PA-NS
aripiprazole oral tablet,disintegrating	T3	PA-NS
ARISTADA	T4	
armodafinil	T4	PA; QL (31 EA per 31 days)
ascomp with codeine	T2	PA; QL (372 EA per 31 days)
ATOMOXETINE	T4	PA
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)
AXERT ORAL TABLET 12.5 MG	T4	QL (8 EA per 31 days)
AXERT ORAL TABLET 6.25 MG	T4	QL (16 EA per 31 days)
AZILECT	T3	
baclofen oral tablet 10 mg	T1	
baclofen oral tablet 20 mg	T2	

Drug Name	Drug Tier	Requirements/Limits
BANZEL ORAL SUSPENSION	T4	
BANZEL ORAL TABLET 200 MG	T4	
BANZEL ORAL TABLET 400 MG	T5	
BELBUCA	T4	PA; QL (62 EA per 31 days)
benztropine	T2	
BRISDELLE	T4	
BRIVIACT	T4	
bromocriptine	T2	
BUNAVAIL BUCCAL FILM 2.1-0.3 MG	T4	QL (31 EA per 31 days)
BUNAVAIL BUCCAL FILM 4.2-0.7 MG, 6.3-1 MG	T4	QL (62 EA per 31 days)
BUPRENEX	T4	QL (267 ML per 30 days)
BUPRENORPHINE	T4	PA; QL (4 EA per 28 days)
buprenorphine hcl injection	T1	QL (267 ML per 30 days)
buprenorphine hcl sublingual tablet 2 mg	T2	QL (93 EA per 31 days)
buprenorphine hcl sublingual tablet 8 mg	T2	QL (62 EA per 31 days)
buprenorphine-naloxone	T2	QL (93 EA per 31 days)
bupropion hcl oral tablet	T1	
bupropion hcl oral tablet extended release 12 hr	T3	QL (62 EA per 31 days)
bupropion hcl oral tablet extended release 24 hr 150 mg	T2	QL (93 EA per 31 days)
bupropion hcl oral tablet extended release 24 hr 300 mg	T2	QL (31 EA per 31 days)
buspirone oral tablet 10 mg, 15 mg, 5 mg	T1	
buspirone oral tablet 30 mg, 7.5 mg	T2	
butalbital compound w/codeine	T2	QL (372 EA per 31 days)
butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg	T2	PA; QL (403 EA per 31 days)
butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg	T2	PA; QL (372 EA per 31 days)
butalbital-acetaminophen oral tablet 50-300 mg	T2	QL (403 EA per 31 days)
butalbital-acetaminophen oral tablet 50-325 mg	T2	QL (372 EA per 31 days)
butalbital-acetaminophen-caff oral capsule 50-300-40 mg	T2	QL (403 EA per 31 days)
butalbital-acetaminophen-caff oral capsule 50-325-40 mg	T2	QL (372 EA per 31 days)
butalbital-acetaminophen-caff oral tablet 50-325-40 mg	T2	QL (372 EA per 31 days)
butalbital-aspirin-caffeine oral capsule	T2	
BUTISOL ORAL TABLET 30 MG	T4	

Drug Name	Drug Tier	Requirements/Limits
butorphanol tartrate injection solution 1 mg/ml	T2	QL (720 ML per 30 days)
butorphanol tartrate injection solution 2 mg/ml	T2	QL (360 ML per 30 days)
butorphanol tartrate nasal	T2	QL (5 ML per 28 days)
BUTRANS	T4	PA; QL (4 EA per 28 days)
CAMBIA	T4	
carbamazepine oral capsule, er multiphase 12 hr	T2	
carbamazepine oral suspension 100 mg/5 ml	T1	
carbamazepine oral tablet	T1	
carbamazepine oral tablet extended release 12 hr	T2	
carbamazepine oral tablet,chewable	T1	
CARBATROL	T4	
carbidopa	T2	
carbidopa-levodopa	T2	
carbidopa-levodopa-entacapone	T2	
carisoprodol-asa-codeine	T2	PA; QL (2582 EA per 31 days)
celecoxib	T2	
CELONTIN ORAL CAPSULE 300 MG	T3	
CEREBYX INJECTION SOLUTION 500 MG PE/10 ML	T4	
chlordiazepoxide hcl	T2	
chlorpromazine	T2	
citalopram	T1	
clomipramine	T2	PA-NS
clonazepam	T2	
clonidine hcl oral tablet extended release 12 hr	T2	PA
clorazepate dipotassium	T2	
clozapine oral tablet 100 mg, 200 mg	T2	
clozapine oral tablet 25 mg, 50 mg	T1	
clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 25 mg	T2	
CLOZAPINE ORAL TABLET,DISINTEGRATING 150 MG, 200 MG	T4	
CLOZARIL	T4	
codeine sulfate oral tablet	T2	PA; QL (186 EA per 31 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	T5	QL (31 ML per 31 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	T5	QL (12 ML per 28 days)
cyclobenzaprine oral tablet	T2	PA

Drug Name	Drug Tier	Requirements/Limits
dantrolene	T2	
DAYTRANA	T4	
DEPACON	T4	
DEPAKENE	T4	
DEPAKOTE	T4	
DEPAKOTE ER	T4	
DEPAKOTE SPRINKLES	T4	
desipramine	T2	
DESVENLAFAXINE ORAL TABLET EXTENDED RELEASE 24 HR	T4	
desvenlafaxine succinate	T4	
dexmethylphenidate	T2	
dextroamphetamine oral capsule, extended release	T2	
dextroamphetamine oral tablet	T2	
dextroamphetamine-amphetamine oral capsule,extended release 24hr	T2	QL (31 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 10 mg, 30 mg	T2	QL (62 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 12.5 mg, 15 mg, 5 mg, 7.5 mg	T1	QL (62 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 20 mg	T2	QL (93 EA per 31 days)
DIASTAT	T4	
DIASTAT ACUDIAL	T4	
diazepam intensol	T2	
diazepam oral solution 5 mg/5 ml (1 mg/ml)	T2	QL (1500 ML per 31 days)
diazepam oral tablet	T2	QL (124 EA per 31 days)
diazepam rectal kit 2.5 mg, 5-7.5-10 mg	T4	
diclofenac potassium	T1	
diclofenac sodium oral	T1	
diclofenac sodium topical drops	T2	
diclofenac sodium topical gel 1 %	T3	
diclofenac-misoprostol	T2	
diflunisal	T2	
dihydroergotamine injection	T2	
dihydroergotamine nasal	T2	QL (8 ML per 31 days)
DILANTIN	T4	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	

Drug Name	Drug Tier	Requirements/Limits
DILANTIN-125	T4	
divalproex oral capsule, delayed rel sprinkle	T2	
divalproex oral tablet extended release 24 hr	T3	
divalproex oral tablet,delayed release (dr/ec)	T2	
DOLOPHINE ORAL TABLET 10 MG	T4	PA; QL (206 EA per 31 days)
DOLOPHINE ORAL TABLET 5 MG	T4	PA; QL (248 EA per 31 days)
donepezil	T2	
doxepin oral	T2	PA-NS
DUEXIS	T4	PA; QL (93 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 60 mg	T3	QL (62 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 30 mg, 40 mg	T3	QL (31 EA per 31 days)
DUOPA	T4	PA-BvD
DURAGESIC TRANSDERMAL PATCH 72 HOUR 100 MCG/HR	T4	PA; QL (10 EA per 30 days)
DURAGESIC TRANSDERMAL PATCH 72 HOUR 12 MCG/HR, 25 MCG/HR	T4	PA; QL (20 EA per 30 days)
DURAGESIC TRANSDERMAL PATCH 72 HOUR 50 MCG/HR	T4	PA; QL (17 EA per 30 days)
DURAGESIC TRANSDERMAL PATCH 72 HOUR 75 MCG/HR	T4	PA; QL (12 EA per 30 days)
duramorph (pf) injection solution 0.5 mg/ml	T2	PA-BvD; QL (4000 ML per 30 days)
duramorph (pf) injection solution 1 mg/ml	T2	PA-BvD; QL (2000 ML per 30 days)
eletriptan hbr oral tablet 20 mg	T2	QL (12 EA per 31 days)
eletriptan hbr oral tablet 40 mg	T2	QL (6 EA per 31 days)
EMBEDA ORAL CAPSULE,ORAL ONLY,EXT.REL PELL	T4	PA; QL (62 EA per 31 days)
EMSAM	T5	
endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
entacapone	T2	
epitol	T1	
EQUETRO	T4	
ergoloid	T2	
ergotamine-caffeine	T2	
escitalopram oxalate	T4	
estazolam	T2	
eszopiclone	T2	

Drug Name	Drug Tier	Requirements/Limits
ethosuximide	T2	
etodolac	T2	
EVZIO INJECTION AUTO-INJECTOR 0.4 MG/0.4 ML	T4	
EVZIO INJECTION AUTO-INJECTOR 2 MG/0.4 ML	T5	
EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 16 MG, 8 MG	T4	PA; QL (62 EA per 31 days)
EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 32 MG	T4	PA; QL (48 EA per 31 days)
EXELON TRANSDERMAL	T3	
EXONDYS 51	T5	PA
FANAPT	T4	
FAZACLO ORAL TABLET,DISINTEGRATING 100 MG, 12.5 MG, 25 MG	T4	
FAZACLO ORAL TABLET,DISINTEGRATING 150 MG, 200 MG	T5	
felbamate	T2	
FELBATOL	T4	
FENOPROFEN ORAL CAPSULE 400 MG	T4	
fenoprofen oral tablet	T2	
fentanyl citrate buccal lozenge on a handle 1,200 mcg	T5	PA; QL (40 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 1,600 mcg	T5	PA; QL (30 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 200 mcg	T2	PA; QL (124 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 400 mcg	T5	PA; QL (119 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 600 mcg	T5	PA; QL (79 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 800 mcg	T5	PA; QL (59 EA per 31 days)
fentanyl transdermal patch 72 hour 100 mcg/hr	T3	PA; QL (10 EA per 30 days)
fentanyl transdermal patch 72 hour 12 mcg/hr	T3	PA; QL (20 EA per 30 days)
fentanyl transdermal patch 72 hour 25 mcg/hr	T2	PA; QL (20 EA per 30 days)
FENTANYL TRANSDERMAL PATCH 72 HOUR 37.5 MCG/HOUR	T4	PA; QL (20 EA per 30 days)
fentanyl transdermal patch 72 hour 50 mcg/hr	T2	PA; QL (17 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
FENTANYL TRANSDERMAL PATCH 72 HOUR 62.5 MCG/HOUR	T4	PA; QL (15 EA per 30 days)
fentanyl transdermal patch 72 hour 75 mcg/hr	T3	PA; QL (12 EA per 30 days)
FENTANYL TRANSDERMAL PATCH 72 HOUR 87.5 MCG/HOUR	T4	PA; QL (11 EA per 30 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG	T5	PA; QL (124 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 400 MCG	T5	PA; QL (119 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 600 MCG	T5	PA; QL (79 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 800 MCG	T5	PA; QL (59 EA per 31 days)
FETZIMA	T4	PA-NS
FLECTOR	T4	PA; QL (62 EA per 31 days)
fluoxetine oral capsule	T1	
fluoxetine oral capsule,delayed release(dr/ec)	T2	
fluoxetine oral solution	T1	
fluoxetine oral tablet 10 mg, 20 mg	T1	
FLUOXETINE ORAL TABLET 60 MG	T4	
fluphenazine decanoate	T2	
fluphenazine hcl	T1	
flurazepam	T2	
flurbiprofen	T2	
fluvoxamine	T2	
FOCALIN XR ORAL CAPSULE,ER BIPHASIC 50-50 20 MG, 25 MG, 35 MG	T4	
fosphenytoin injection solution 100 mg pe/2 ml	T2	
FROVA	T4	QL (12 EA per 31 days)
frovatriptan	T3	QL (12 EA per 31 days)
FYCOMPA ORAL SUSPENSION	T4	
FYCOMPA ORAL TABLET	T4	
gabapentin oral capsule	T2	
gabapentin oral solution 250 mg/5 ml	T2	
gabapentin oral tablet 600 mg, 800 mg	T2	
GABITRIL ORAL TABLET 12 MG, 16 MG	T3	
GABITRIL ORAL TABLET 2 MG, 4 MG	T4	
GABLOFEN INTRATHECAL SOLUTION 10,000 MCG/20ML (500 MCG/ML), 40,000 MCG/20ML (2,000 MCG/ML)	T4	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
GABLOFEN INTRATHECAL SYRINGE 50 MCG/ML (1 ML)	T4	PA-BvD
galantamine	T2	
GEODON INTRAMUSCULAR	T3	
GILENYA	T5	PA; QL (31 EA per 31 days)
glatopa	T5	QL (31 ML per 31 days)
GRALISE	T3	PA-NS
GRALISE 30-DAY STARTER PACK	T3	PA-NS
guanfacine oral tablet extended release 24 hr	T2	PA
guanidine	T2	
HALCION ORAL TABLET 0.25 MG	T4	PA
haloperidol decanoate	T2	
haloperidol lactate injection	T2	
haloperidol lactate oral	T1	
haloperidol oral tablet 0.5 mg, 1 mg, 2 mg, 20 mg, 5 mg	T1	
haloperidol oral tablet 10 mg	T2	
HETLIOZ	T5	PA
HORIZANT	T4	PA-NS
HYCET	T4	PA; QL (5723 ML per 31 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	T2	PA; QL (5723 ML per 31 days)
hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	T2	PA; QL (403 EA per 31 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	T2	PA; QL (155 EA per 31 days)
hydromorphone (pf)	T2	PA; QL (124 ML per 31 days)
hydromorphone injection syringe 2 mg/ml	T2	PA; QL (155 ML per 31 days)
hydromorphone oral liquid	T2	PA; QL (1550 ML per 31 days)
hydromorphone oral tablet	T2	PA; QL (186 EA per 31 days)
hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 8 mg	T2	PA; QL (62 EA per 31 days)
hydromorphone oral tablet extended release 24 hr 32 mg	T2	PA; QL (48 EA per 31 days)
HYSINGLA ER	T4	PA; QL (31 EA per 31 days)
ibuprofen oral suspension	T1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	T1	
ibuprofen-oxycodone	T2	PA; QL (30 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
imipramine hcl	T2	PA-NS
imipramine pamoate	T2	
IMITREX NASAL SPRAY,NON-AEROSOL 20 MG/ACTUATION	T4	QL (8 EA per 31 days)
IMITREX NASAL SPRAY,NON-AEROSOL 5 MG/ACTUATION	T4	QL (32 EA per 31 days)
IMITREX ORAL TABLET 100 MG	T4	QL (9 EA per 31 days)
IMITREX ORAL TABLET 25 MG	T4	QL (36 EA per 31 days)
IMITREX ORAL TABLET 50 MG	T4	QL (18 EA per 31 days)
IMITREX STATDOSE KIT REFILL SUBCUTANEOUS CARTRIDGE 4 MG/0.5 ML	T4	QL (6 ML per 31 days)
IMITREX STATDOSE KIT REFILL SUBCUTANEOUS CARTRIDGE 6 MG/0.5 ML	T4	QL (4 ML per 31 days)
IMITREX SUBCUTANEOUS	T4	QL (4 ML per 31 days)
INDOCIN ORAL	T4	
indomethacin oral	T1	
INGREZZA ORAL CAPSULE 40 MG	T5	PA; QL (62 EA per 31 days)
INTUNIV ER	T4	PA
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 1.5 MG, 3 MG	T4	
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG, 9 MG	T5	
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 78 MG/0.5 ML	T5	
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T4	
INVEGA TRINZA	T5	
KADIAN ORAL CAPSULE,EXTEND.RELEASE PELLETS 10 MG, 100 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 80 MG	T4	PA; QL (62 EA per 31 days)
KADIAN ORAL CAPSULE,EXTEND.RELEASE PELLETS 200 MG	T4	PA; QL (31 EA per 31 days)
KAPVAY	T4	PA
KEPPRA ORAL SOLUTION	T5	
KEPPRA ORAL TABLET 1,000 MG	T5	
KEPPRA ORAL TABLET 250 MG, 500 MG, 750 MG	T4	

Drug Name	Drug Tier	Requirements/Limits
KEPPRA XR	T4	
ketoprofen oral capsule	T2	
ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg	T2	
ketorolac injection cartridge 30 mg/ml	T2	
ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)	T2	
ketorolac oral	T2	
KEVEYIS	T4	PA; QL (124 EA per 31 days)
KHEDEZLA	T4	
LAMICTAL ODT	T3	
LAMICTAL ORAL TABLET	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, 200 MG, 25 MG, 250 MG, 50 MG	T4	
LAMICTAL XR STARTER (BLUE)	T4	
LAMICTAL XR STARTER (GREEN)	T4	
LAMICTAL XR STARTER (ORANGE)	T4	
lamotrigine oral tablet	T2	
lamotrigine oral tablet extended release 24hr	T2	
lamotrigine oral tablet, chewable dispersible	T2	
lamotrigine oral tablet,disintegrating	T2	
LATUDA ORAL TABLET 120 MG, 80 MG	T5	
LATUDA ORAL TABLET 20 MG, 40 MG, 60 MG	T4	
LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY	T5	PA; QL (31 EA per 31 days)
LAZANDA NASAL SPRAY,NON-AEROSOL 300 MCG/SPRAY	T5	PA; QL (16 EA per 31 days)
LAZANDA NASAL SPRAY,NON-AEROSOL 400 MCG/SPRAY	T5	PA; QL (12 EA per 31 days)
LEVETIRACETAM IN NACL (ISO-OS)	T4	
levetiracetam intravenous	T2	
levetiracetam oral solution 100 mg/ml	T2	
levetiracetam oral tablet	T2	

Drug Name	Drug Tier	Requirements/Limits
levetiracetam oral tablet extended release 24 hr	T2	
levorphanol tartrate	T1	PA; QL (186 EA per 31 days)
LIORESAL INTRATHECAL SOLUTION 2,000 MCG/ML, 500 MCG/ML	T4	PA-BvD
lithium carbonate	T1	
lithium citrate oral solution 8 meq/5 ml	T1	
lorazepam intensol	T2	
lorazepam oral tablet	T2	
lorcet (hydrocodone)	T2	PA; QL (372 EA per 31 days)
lorcet hd	T2	PA; QL (372 EA per 31 days)
lorcet plus oral tablet 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
loxapine succinate	T2	
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)
maprotiline	T2	
MARPLAN	T3	
MAXALT ORAL TABLET 10 MG	T4	QL (12 EA per 31 days)
MAXALT ORAL TABLET 5 MG	T4	QL (24 EA per 31 days)
MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG	T4	QL (12 EA per 31 days)
MAXALT-MLT ORAL TABLET,DISINTEGRATING 5 MG	T4	QL (24 EA per 31 days)
meclofenamate	T2	
mefenamic acid	T2	
meloxicam oral tablet	T1	
memantine oral solution	T3	
memantine oral tablet	T3	
MEMANTINE ORAL TABLETS,DOSE PACK	T4	
meperidine (pf) injection solution 100 mg/ml	T2	PA-BvD; QL (200 ML per 31 days)
meperidine (pf) injection solution 25 mg/ml	T2	PA-BvD; QL (800 ML per 31 days)
meperidine (pf) injection solution 50 mg/ml	T2	PA-BvD; QL (400 ML per 31 days)
MESTINON ORAL SYRUP	T3	
MESTINON TIMESPAN	T3	
metadate er	T2	QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
metaxall	T2	
metaxalone	T2	
methadone injection solution	T2	PA-BvD; QL (160 ML per 30 days)
methadone oral solution 10 mg/5 ml	T2	PA; QL (1033 ML per 31 days)
methadone oral solution 5 mg/5 ml	T2	PA; QL (2066 ML per 31 days)
methadone oral tablet 10 mg	T2	PA; QL (206 EA per 31 days)
methadone oral tablet 5 mg	T2	PA; QL (248 EA per 31 days)
methamphetamine	T5	PA
methylphenidate hcl oral capsule, er biphasic 30-70 10 mg, 30 mg, 50 mg, 60 mg	T2	
methylphenidate hcl oral capsule, er biphasic 30-70 20 mg	T2	QL (93 EA per 31 days)
methylphenidate hcl oral capsule, er biphasic 30-70 40 mg	T2	QL (62 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 20 mg	T2	QL (93 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 40 mg	T2	QL (62 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 60 mg	T2	QL (31 EA per 31 days)
methylphenidate hcl oral solution	T2	
methylphenidate hcl oral tablet	T2	QL (93 EA per 31 days)
methylphenidate hcl oral tablet extended release 10 mg	T2	QL (31 EA per 31 days)
methylphenidate hcl oral tablet extended release 20 mg	T2	QL (93 EA per 31 days)
methylphenidate hcl oral tablet extended release 24hr	T2	QL (31 EA per 31 days)
methylphenidate hcl oral tablet,chewable 10 mg	T2	QL (186 EA per 31 days)
methylphenidate hcl oral tablet,chewable 2.5 mg, 5 mg	T2	QL (93 EA per 31 days)
migergot	T2	
MIGRANAL	T4	QL (8 ML per 31 days)
MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HR 0.375 MG, 2.25 MG, 3 MG, 3.75 MG, 4.5 MG	T4	
mirtazapine	T2	
modafinil	T2	PA; QL (31 EA per 31 days)
morphine concentrate oral solution	T2	PA; QL (310 ML per 31 days)
MORPHINE INTRAVENOUS SYRINGE 10 MG/ML	T4	PA; QL (200 ML per 30 days)

Drug Name	Drug Tier	Requirements/Limits
morphine intravenous syringe 2 mg/ml	T2	PA; QL (1000 ML per 30 days)
morphine intravenous syringe 4 mg/ml	T2	PA; QL (500 ML per 30 days)
MORPHINE INTRAVENOUS SYRINGE 8 MG/ML	T4	PA; QL (250 ML per 30 days)
morphine oral capsule, er multiphase 24 hr 120 mg	T2	PA; QL (51 EA per 31 days)
morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	T2	PA; QL (62 EA per 31 days)
morphine oral capsule,extend.release pellets	T2	PA; QL (62 EA per 31 days)
morphine oral solution 10 mg/5 ml	T2	PA; QL (2800 ML per 31 days)
morphine oral solution 20 mg/5 ml (4 mg/ml)	T2	PA; QL (1400 ML per 31 days)
morphine oral tablet	T2	PA; QL (186 EA per 31 days)
morphine oral tablet extended release 100 mg	T2	PA; QL (62 EA per 31 days)
morphine oral tablet extended release 15 mg, 30 mg, 60 mg	T2	PA; QL (100 EA per 31 days)
morphine oral tablet extended release 200 mg	T2	PA; QL (31 EA per 31 days)
MYSOLINE	T4	
nabumetone	T1	
nalbuphine injection solution 10 mg/ml	T2	QL (200 ML per 30 days)
nalbuphine injection solution 20 mg/ml	T2	QL (100 ML per 30 days)
naloxone injection solution	T2	
naloxone injection syringe 1 mg/ml	T2	
naltrexone	T2	
NAMENDA ORAL TABLET	T4	PA
NAMENDA TITRATION PAK	T4	PA
NAMENDA XR	T4	PA
NAMZARIC	T4	PA
NAPRELAN CR	T4	
naproxen oral suspension	T1	
naproxen oral tablet	T1	
naproxen oral tablet,delayed release (dr/ec)	T2	
naproxen sodium oral tablet 275 mg, 550 mg	T1	
naproxen sodium oral tablet, er multiphase 24 hr	T2	
naratriptan oral tablet 1 mg	T2	QL (20 EA per 31 days)
naratriptan oral tablet 2.5 mg	T2	QL (8 EA per 31 days)
NARCAN NASAL SPRAY,NON-AEROSOL 4 MG/ACTUATION	T4	
nefazodone	T2	
NEUPRO	T4	

Drug Name	Drug Tier	Requirements/Limits
NEURONTIN	T4	
NORCO	T4	PA; QL (372 EA per 31 days)
nortriptyline	T2	
NUCYNTA ER	T4	QL (62 EA per 31 days)
NUCYNTA ORAL TABLET 100 MG	T4	QL (155 EA per 31 days)
NUCYNTA ORAL TABLET 50 MG, 75 MG	T4	QL (186 EA per 31 days)
NUEDEXTA	T3	
NUPLAZID	T5	PA-NS
olanzapine intramuscular	T2	
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 7.5 mg	T2	
olanzapine oral tablet 5 mg	T3	
olanzapine oral tablet,disintegrating	T2	
olanzapine-fluoxetine	T2	
ONFI ORAL SUSPENSION	T4	
ONFI ORAL TABLET 10 MG	T4	
ONFI ORAL TABLET 20 MG	T5	
ONZETRA XSAIL	T4	QL (16 EA per 31 days)
OPANA ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 5 MG, 7.5 MG	T4	PA; QL (100 EA per 31 days)
OPANA ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 30 MG	T4	PA; QL (69 EA per 31 days)
OPANA ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 40 MG	T4	PA; QL (51 EA per 31 days)
OPANA ORAL	T4	PA; QL (186 EA per 31 days)
ORAP ORAL TABLET 1 MG	T3	
oxaprozin	T2	
oxazepam	T2	
oxcarbazepine	T2	
OXTELLAR XR	T4	
oxycodone oral capsule	T2	PA; QL (186 EA per 31 days)
oxycodone oral concentrate	T2	PA; QL (180 ML per 31 days)
oxycodone oral solution	T2	PA; QL (4133 ML per 31 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg	T2	PA; QL (186 EA per 31 days)
oxycodone oral tablet 30 mg	T3	PA; QL (138 EA per 31 days)
OXYCODONE 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)

Drug Name	Drug Tier	Requirements/Limits
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG	T4	PA; QL (69 EA per 31 days)
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	T4	PA; QL (62 EA per 31 days)
oxycodone-acetaminophen oral solution	T2	PA; QL (1860 ML per 31 days)
oxycodone-acetaminophen oral tablet 10-325 mg	T3	PA; QL (372 EA per 31 days)
oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
oxycodone-aspirin	T2	PA; QL (360 EA per 30 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	T4	PA; QL (69 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	T4	PA; QL (62 EA per 31 days)
oxymorphone oral tablet	T2	PA; QL (186 EA per 31 days)
oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg	T2	PA; QL (100 EA per 31 days)
oxymorphone oral tablet extended release 12 hr 30 mg	T2	PA; QL (69 EA per 31 days)
oxymorphone oral tablet extended release 12 hr 40 mg	T2	PA; QL (51 EA per 31 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg	T3	
paliperidone oral tablet extended release 24hr 6 mg, 9 mg	T4	
paroxetine hcl oral tablet	T1	
paroxetine hcl oral tablet extended release 24 hr 12.5 mg	T1	
paroxetine hcl oral tablet extended release 24 hr 25 mg, 37.5 mg	T2	
PAXIL ORAL SUSPENSION	T4	
PEGANONE	T3	
pentazocine-naloxone	T2	QL (335 EA per 31 days)
PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	T4	PA; QL (372 EA per 31 days)
perphenazine	T2	
perphenazine-amitriptyline	T2	PA-NS
phenelzine	T2	
phenobarbital	T2	
PHENYTEK	T4	

Drug Name	Drug Tier	Requirements/Limits
phenytoin oral suspension 125 mg/5 ml	T2	
phenytoin oral tablet,chewable	T2	
phenytoin sodium extended	T2	
phenytoin sodium intravenous solution	T2	
pimozide	T2	
piroxicam oral capsule 10 mg	T1	
piroxicam oral capsule 20 mg	T2	
pramipexole	T2	
primidone	T2	
PRIMLEV	T4	PA; QL (403 EA per 31 days)
PRISTIQ	T4	
procentra	T2	
protriptyline	T2	
PROVIGIL ORAL TABLET 100 MG	T4	PA; QL (31 EA per 31 days)
PROVIGIL ORAL TABLET 200 MG	T5	PA; QL (31 EA per 31 days)
pyridostigmine bromide	T2	
quetiapine oral tablet 100 mg, 200 mg, 300 mg, 400 mg, 50 mg	T2	
quetiapine oral tablet 25 mg	T1	
QUILLIVANT XR	T4	
RADICAVA	T5	PA
rasagiline	T3	
RELPAX ORAL TABLET 20 MG	T4	QL (12 EA per 31 days)
RELPAX ORAL TABLET 40 MG	T4	QL (6 EA per 31 days)
REXULTI	T5	PA-NS; QL (31 EA per 31 days)
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML	T4	
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 50 MG/2 ML	T5	
RISPERDAL M-TAB	T4	
RISPERDAL ORAL SOLUTION	T5	
RISPERDAL ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 4 MG	T4	
RISPERDAL ORAL TABLET 3 MG	T5	
risperidone oral solution	T1	
risperidone oral tablet	T1	
risperidone oral tablet,disintegrating 0.25 mg	T2	
risperidone oral tablet,disintegrating 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	T1	

Drug Name	Drug Tier	Requirements/Limits
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG	T4	QL (186 EA per 31 days)
rivastigmine	T2	
rivastigmine tartrate	T2	
rizatriptan oral tablet 10 mg	T2	QL (12 EA per 31 days)
rizatriptan oral tablet 5 mg	T2	QL (24 EA per 31 days)
rizatriptan oral tablet,disintegrating 10 mg	T2	QL (12 EA per 31 days)
rizatriptan oral tablet,disintegrating 5 mg	T2	QL (24 EA per 31 days)
ropinirole	T2	
roweepra	T2	
ROXICODONE ORAL TABLET 15 MG, 5 MG	T4	PA; QL (186 EA per 31 days)
ROXICODONE ORAL TABLET 30 MG	T4	PA; QL (138 EA per 31 days)
ROZEREM	T4	
SABRIL	T5	
SAPHRIS (BLACK CHERRY)	T4	
selegiline hcl	T2	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR	T3	
sertraline	T1	
SILENOR	T4	PA-NS
SPRITAM	T4	
SUBOXONE SUBLINGUAL FILM 12-3 MG	T3	QL (62 EA per 31 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG, 8-2 MG	T3	QL (93 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY	T5	PA; QL (124 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 400 MCG/SPRAY	T5	PA; QL (86 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 600 MCG/SPRAY	T5	PA; QL (57 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 800 MCG/SPRAY	T5	PA; QL (43 EA per 31 days)
sulindac	T2	
sumatriptan nasal spray,non-aerosol 20 mg/actuation	T2	QL (8 EA per 31 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	T2	QL (32 EA per 31 days)
sumatriptan succinate oral tablet 100 mg	T2	QL (9 EA per 31 days)
sumatriptan succinate oral tablet 25 mg	T2	QL (36 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
sumatriptan succinate oral tablet 50 mg	T2	QL (18 EA per 31 days)
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml	T2	QL (6 ML per 31 days)
sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml	T2	QL (4 ML per 31 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml	T2	QL (6 ML per 31 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	T2	QL (4 ML per 31 days)
sumatriptan succinate subcutaneous solution	T2	QL (4 ML per 31 days)
sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml	T2	QL (4 ML per 31 days)
SUMAVEL DOSEPRO SUBCUTANEOUS NEEDLE-FREE INJECTOR 4 MG/0.5 ML	T4	QL (6 ML per 31 days)
SUMAVEL DOSEPRO SUBCUTANEOUS NEEDLE-FREE INJECTOR 6 MG/0.5 ML	T4	QL (4 ML per 31 days)
SURMONTIL	T4	PA-NS
SYNALGOS-DC	T4	PA; QL (300 EA per 30 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 ORAL TABLET EXTENDED RELEASE 12 HR 100 MG	T3	
TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 200 MG, 400 MG	T4	
temazepam	T2	
tencon oral tablet 50-325 mg	T2	QL (372 EA per 31 days)
tetrabenazine	T5	PA
thioridazine	T2	
thiothixene	T1	
tiagabine	T2	
tizanidine	T2	
tolcapone	T5	
tolmetin oral capsule	T2	
tolmetin oral tablet 600 mg	T2	
TOPAMAX	T4	

Drug Name	Drug Tier	Requirements/Limits
topiramate oral capsule, sprinkle	T2	
TOPIRAMATE ORAL CAPSULE,SPRINKLE,ER 24HR	T4	
topiramate oral tablet	T2	
TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 17-83	T4	QL (30 EA per 30 days)
TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 25-75 100 MG, 200 MG	T4	QL (30 EA per 30 days)
tramadol oral tablet	T1	QL (240 EA per 30 days)
tramadol oral tablet extended release 24 hr 100 mg, 200 mg	T2	QL (30 EA per 30 days)
tramadol oral tablet, er multiphase 24 hr 300 mg	T2	QL (30 EA per 30 days)
tramadol-acetaminophen	T2	QL (372 EA per 31 days)
tranylcypromine	T2	
trazodone oral tablet 100 mg, 150 mg, 50 mg	T1	
trazodone oral tablet 300 mg	T2	
TREXIMET ORAL TABLET 10-60 MG	T4	QL (9 EA per 31 days)
TREXIMET ORAL TABLET 85-500 MG	T4	QL (10 EA per 31 days)
triazolam	T2	PA
trifluoperazine	T2	
trihexyphenidyl	T2	
TRILEPTAL	T4	
trimipramine	T3	PA-NS
TRINTELLIX	T4	PA-NS
TROKENDI XR	T4	
TYLENOL-CODEINE #3	T4	PA; QL (403 EA per 31 days)
TYLENOL-CODEINE #4	T4	PA; QL (403 EA per 31 days)
TYSABRI	T5	QL (15 ML per 28 days)
valproate sodium	T2	
valproic acid	T2	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	T2	
venlafaxine oral capsule,extended release 24hr	T2	QL (31 EA per 31 days)
venlafaxine oral tablet	T2	
venlafaxine oral tablet extended release 24hr 150 mg, 37.5 mg, 75 mg	T2	QL (31 EA per 31 days)
VENLAFAXINE ORAL TABLET EXTENDED RELEASE 24HR 225 MG	T4	QL (31 EA per 31 days)
VERSACLOZ	T3	
vicodin	T2	PA; QL (403 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
vicodin es	T2	PA; QL (403 EA per 31 days)
vicodin hp	T2	PA; QL (403 EA per 31 days)
vigabatrin	T5	
VIIBRYD ORAL TABLET	T4	PA-NS
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)	T4	PA-NS
VIMOVO	T4	PA; QL (62 EA per 31 days)
VIMPAT INTRAVENOUS	T4	
VIMPAT ORAL SOLUTION	T4	
VIMPAT ORAL TABLET	T4	
VIVITROL	T4	
VOLTAREN TOPICAL	T4	PA
VRAYLAR ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
VRAYLAR ORAL CAPSULE,DOSE PACK	T4	PA-NS; QL (14 EA per 365 days)
VYVANSE ORAL CAPSULE	T4	QL (31 EA per 31 days)
WELLBUTRIN SR	T4	QL (62 EA per 31 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG	T4	QL (93 EA per 31 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T4	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)
XENAZINE	T5	PA
XODOL 10/300	T4	PA; QL (403 EA per 31 days)
XODOL 5/300	T4	PA; QL (403 EA per 31 days)
XODOL 7.5/300	T4	PA; QL (403 EA per 31 days)
XTAMPZA ER	T4	PA; QL (62 EA per 31 days)
XYREM	T5	PA
zaleplon	T2	
zamicet	T2	PA; QL (5723 ML per 31 days)
ZARONTIN	T4	
zebutal oral capsule 50-325-40 mg	T2	QL (372 EA per 31 days)
ZELAPAR	T5	
ZEMBRACE SYMTOUCH	T4	QL (8 ML per 31 days)

Drug Name	Drug Tier	Requirements/Limits
zenzedi oral tablet 10 mg, 5 mg	T2	
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	T4	
ZINBRYTA	T5	PA; QL (1 ML per 28 days)
ziprasidone hcl	T2	
ZOHYDRO ER ORAL CAPSULE, ORAL ONLY, ER 12HR	T4	PA; QL (100 EA per 31 days)
zolmitriptan oral tablet 2.5 mg	T2	QL (16 EA per 31 days)
zolmitriptan oral tablet 5 mg	T2	QL (8 EA per 31 days)
zolmitriptan oral tablet,disintegrating 2.5 mg	T2	QL (16 EA per 31 days)
zolmitriptan oral tablet,disintegrating 5 mg	T2	QL (8 EA per 31 days)
zolpidem oral	T2	
zolpidem sublingual	T3	
ZOMIG NASAL SPRAY,NON-AEROSOL 2.5 MG	T4	QL (16 EA per 31 days)
ZOMIG NASAL SPRAY,NON-AEROSOL 5 MG	T4	QL (8 EA per 31 days)
ZOMIG ORAL TABLET 2.5 MG	T4	QL (16 EA per 31 days)
ZOMIG ORAL TABLET 5 MG	T4	QL (8 EA per 31 days)
ZOMIG ZMT ORAL TABLET,DISINTEGRATING 2.5 MG	T4	QL (16 EA per 31 days)
ZOMIG ZMT ORAL TABLET,DISINTEGRATING 5 MG	T4	QL (8 EA per 31 days)
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG	T4	
zonisamide	T2	
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG, 2.9-0.71 MG	T4	QL (93 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 8.6-2.1 MG	T4	QL (62 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 5.7-1.4 MG	T4	QL (31 EA per 31 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	T4	
Cardiovascular, Hypertension / Lipids		
acebutolol	T1	
afeditab cr	T1	
AGGRENOX	T3	
ALTOPREV	T4	
amiloride	T1	

Drug Name	Drug Tier	Requirements/Limits
amiloride-hydrochlorothiazide	T1	
amiodarone intravenous solution	T2	
amiodarone oral	T2	
amlodipine	T1	
amlodipine-atorvastatin	T2	
amlodipine-benazepril	T1	
AMLODIPINE-OLMESARTAN	T3	QL (31 EA per 31 days)
amlodipine-valsartan	T2	
amlodipine-valsartan-hcthiazid	T2	
ANTARA ORAL CAPSULE 30 MG, 90 MG	T4	
ARIXTRA SUBCUTANEOUS SYRINGE 10 MG/0.8 ML, 5 MG/0.4 ML, 7.5 MG/0.6 ML	T5	
aspirin-dipyridamole	T2	
atenolol	T1	
atenolol-chlorthalidone	T1	
atorvastatin	T1	
benazepril	T1	
benazepril-hydrochlorothiazide	T1	
betaxolol oral tablet 10 mg	T2	
betaxolol oral tablet 20 mg	T1	
BIDIL	T4	
bisoprolol fumarate	T1	
bisoprolol-hydrochlorothiazide	T1	
BRILINTA	T3	
bumetanide	T1	
BYSTOLIC	T4	
candesartan	T1	
candesartan-hydrochlorothiazid	T1	
captopril	T1	
captopril-hydrochlorothiazide	T1	
CARDENE IV IN SODIUM CHLORIDE INTRAVENOUS PIGGYBACK 40 MG/200 ML	T4	
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HR 120 MG	T4	
cartia xt	T1	
carvedilol	T1	
chlorothiazide	T1	
chlorothiazide sodium	T1	

Drug Name	Drug Tier	Requirements/Limits
chlorthalidone oral tablet 25 mg, 50 mg	T1	
cholestyramine light	T2	
cilostazol	T2	
clonidine	T2	
clonidine hcl oral tablet	T1	
clopidogrel	T2	
clorpres oral tablet 0.1-15 mg, 0.2-15 mg	T2	
CLORPRES ORAL TABLET 0.3-15 MG	T3	
colestipol oral granules	T2	
colestipol oral tablet	T2	
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)
COUMADIN ORAL	T4	
DEMSER	T3	
DIBENZYLINE	T5	
digitek oral tablet 125 mcg	T1	PA
digitek oral tablet 250 mcg	T2	PA
digoxin injection solution	T2	PA
digoxin oral solution 50 mcg/ml	T2	PA
digoxin oral tablet 125 mcg	T1	PA
digoxin oral tablet 250 mcg	T2	PA
diltiazem hcl intravenous	T1	
diltiazem hcl oral capsule,extended release 12 hr	T1	
diltiazem hcl oral capsule,extended release 24 hr 180 mg, 360 mg, 420 mg	T1	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 240 mg, 300 mg	T1	
diltiazem hcl oral tablet	T1	
dilt-xr	T1	
DIURIL	T3	
dofetilide	T3	
doxazosin	T1	
DYRENIUM	T4	
EDARBYCLOR	T4	
EDECRIN	T3	
EFFIENT	T3	
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 31 days)
enalapril maleate	T1	

Drug Name	Drug Tier	Requirements/Limits
enalapril-hydrochlorothiazide	T1	
enoxaparin subcutaneous solution	T2	
enoxaparin subcutaneous syringe 100 mg/ml	T4	
enoxaparin subcutaneous syringe 120 mg/0.8 ml, 150 mg/ml	T5	
enoxaparin subcutaneous syringe 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml	T2	
ENTRESTO	T3	PA; QL (62 EA per 31 days)
eplerenone	T2	
eprosartan	T1	
ethacrynate sodium	T2	
ethacrynic acid	T2	
ezetimibe	T3	
ezetimibe-simvastatin	T3	
felodipine	T2	
fenofibrate micronized	T2	
fenofibrate nanocrystallized oral tablet 145 mg	T3	
fenofibrate nanocrystallized oral tablet 48 mg	T2	
FENOFIBRATE ORAL TABLET 120 MG, 40 MG	T4	
fenofibrate oral tablet 160 mg, 54 mg	T2	
fenofibric acid (choline)	T3	
fenofibric acid oral tablet 105 mg	T3	
fenofibric acid oral tablet 35 mg	T2	
FENOGLIDE	T4	
flecainide	T2	
fluvastatin oral capsule	T1	
fluvastatin oral tablet extended release 24 hr	T3	
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	T5	
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	T2	
fosinopril	T1	
fosinopril-hydrochlorothiazide	T1	
FRAGMIN SUBCUTANEOUS SOLUTION	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 18,000 ANTI-XA UNIT/0.72 ML, 7,500 ANTI-XA UNIT/0.3 ML	T5	

Drug Name	Drug Tier	Requirements/Limits
FRAGMIN SUBCUTANEOUS SYRINGE 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML	T3	
furosemide injection	T2	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	T2	
furosemide oral tablet	T1	
gemfibrozil	T2	
GONITRO	T4	
heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml), 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)	T2	
heparin (porcine) injection solution	T2	
hydralazine	T1	
hydrochlorothiazide	T1	
indapamide	T1	
INNOPRAN XL	T4	
irbesartan	T1	QL (31 EA per 31 days)
irbesartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
ISORDIL	T4	
isosorbide dinitrate oral	T2	
isosorbide mononitrate	T1	
isradipine	T2	
jantoven	T2	
JUXTAPID	T5	PA
KYNAMRO	T5	PA
labetalol intravenous solution	T1	
labetalol oral	T1	
LANOXIN	T4	PA
LESCOL XL	T4	
LIPOFEN	T4	
lisinopril	T1	
lisinopril-hydrochlorothiazide	T1	
LIVALO	T4	
losartan oral tablet 100 mg	T1	QL (31 EA per 31 days)
losartan oral tablet 25 mg	T1	QL (93 EA per 31 days)
losartan oral tablet 50 mg	T1	QL (62 EA per 31 days)
losartan-hydrochlorothiazide	T1	

Drug Name	Drug Tier	Requirements/Limits
lovastatin	T1	
LOVENOX SUBCUTANEOUS SYRINGE 150 MG/ML, 60 MG/0.6 ML	T4	
matzim la	T2	
methyclothiazide	T2	
methyldopa-hydrochlorothiazide	T1	
metolazone	T2	
metoprolol succinate	T1	
metoprolol ta-hydrochlorothiaz	T1	
metoprolol tartrate intravenous	T1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	T1	
mexiletine	T2	
minoxidil oral	T2	
moexipril	T1	
moexipril-hydrochlorothiazide	T1	
MULTAQ	T4	
nadolol	T1	
nadolol-bendroflumethiazide	T1	
niacin oral tablet extended release 24 hr 1,000 mg, 750 mg	T3	
niacin oral tablet extended release 24 hr 500 mg	T3	QL (31 EA per 31 days)
NIACOR	T4	
nicardipine intravenous solution	T2	
nicardipine oral	T2	
nifedipine oral tablet extended release	T2	
nifedipine oral tablet extended release 24hr	T2	
nimodipine	T2	
nisoldipine	T2	
nitro-bid	T2	
NITRO-DUR	T4	
nitroglycerin intravenous	T2	
nitroglycerin sublingual	T2	
nitroglycerin transdermal patch 24 hour	T2	
nitroglycerin translingual spray,non-aerosol	T2	
NITROSTAT	T4	
olmesartan oral tablet 20 mg, 40 mg	T3	QL (31 EA per 31 days)
olmesartan oral tablet 5 mg	T3	QL (93 EA per 31 days)
OLMESARTAN-AMLODIPIN-HCTHIAZID	T3	

Drug Name	Drug Tier	Requirements/Limits
olmesartan-hydrochlorothiazide	T3	QL (31 EA per 31 days)
omega-3 acid ethyl esters	T3	
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	T4	PA; QL (93 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG	T5	PA; QL (186 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG	T5	PA; QL (521 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG	T5	PA; QL (261 EA per 31 days)
pacerone oral tablet 100 mg, 200 mg, 400 mg	T2	
pentoxifylline	T2	
perindopril erbumine	T1	
phenoxybenzamine	T5	
pindolol	T1	
PRADAXA	T3	QL (62 EA per 31 days)
PRALUENT PEN	T5	PA; QL (2 ML per 28 days)
prasugrel	T3	
pravastatin	T1	
prazosin	T1	
prevalite oral powder	T2	
procainamide injection	T2	
PROMACTA	T5	PA
propafenone	T2	
propranolol intravenous	T1	
propranolol oral capsule,extended release 24 hr	T2	
propranolol oral solution	T1	
propranolol oral tablet	T1	
propranolol-hydrochlorothiazid	T1	
QBRELIS	T4	
quinapril	T1	
quinapril-hydrochlorothiazide	T1	
quinidine gluconate	T2	
quinidine sulfate oral tablet	T2	
ramipril	T1	
RANEXA	T3	
REMODULIN	T5	PA-BvD
REPATHA PUSHTRONEX	T5	PA; QL (3.5 ML per 28 days)
REPATHA SURECLICK	T5	PA; QL (2 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
REPATHA SYRINGE	T5	PA; QL (2 ML per 28 days)
rosuvastatin	T3	
SAVAYSA	T4	QL (31 EA per 31 days)
simvastatin	T1	
sorine	T1	
sotalol af oral tablet 120 mg	T1	
sotalol oral tablet 160 mg, 240 mg, 80 mg	T1	
SOTYLIZE	T4	
spironolactone	T1	
spironolacton-hydrochlorothiaz	T1	
taztia xt	T2	
TEKTURNA	T4	
TEKTURNA HCT	T4	
telmisartan	T1	
telmisartan-amlodipine	T1	
telmisartan-hydrochlorothiazid	T1	
terazosin	T1	
TIKOSYN	T3	
timolol maleate oral	T1	
torsemide oral	T2	
trandolapril	T1	
trandolapril-verapamil	T2	
tranexamic acid intravenous	T2	
triamterene-hydrochlorothiazid	T1	
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	T5	PA; QL (62 EA per 31 days)
UPTRAVI ORAL TABLET 200 MCG	T5	PA; QL (144 EA per 28 days)
UPTRAVI ORAL TABLETS,DOSE PACK	T5	PA; QL (200 EA per 28 days)
valsartan oral tablet 160 mg, 40 mg, 80 mg	T2	QL (62 EA per 31 days)
valsartan oral tablet 320 mg	T2	QL (31 EA per 31 days)
valsartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
VASCEPA	T4	
VECAMYL	T4	
verapamil intravenous solution	T2	
verapamil oral	T2	
warfarin	T1	
WELCHOL	T3	
XARELTO ORAL TABLET 10 MG, 20 MG	T3	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
XARELTO ORAL TABLET 15 MG	T3	QL (52 EA per 31 days)
XARELTO ORAL TABLETS,DOSE PACK	T3	QL (51 EA per 30 days)
YOSPRALA	T4	PA; QL (31 EA per 31 days)
ZETIA	T3	
ZONTIVITY	T4	
Dermatologicals/Topical Therapy		
ACANYA TOPICAL GEL WITH PUMP	T4	
acitretin oral capsule 10 mg, 25 mg	T5	
acitretin oral capsule 17.5 mg	T4	
acyclovir topical	T1	
ACZONE TOPICAL GEL	T4	
adapalene topical cream	T2	
adapalene topical gel	T2	
adapalene-benzoyl peroxide	T4	
ala-cort topical cream 1 %	T1	
ala-cort topical cream 2.5 %	T2	
alclometasone	T1	
amcinonide	T2	
ammonium lactate	T2	
amnesteem	T2	
apexicon e	T2	
ATRALIN	T4	
avita topical cream	T2	
AVITA TOPICAL GEL	T4	
AZELEX	T4	
betamethasone dipropionate	T1	
betamethasone valerate	T1	
betamethasone, augmented topical cream	T2	
betamethasone, augmented topical gel	T1	
betamethasone, augmented topical lotion	T2	
betamethasone, augmented topical ointment	T2	
calcipotriene	T2	
calcipotriene-betamethasone	T2	
calcitriol topical	T2	
CAPEX	T4	
CARAC	T5	
ciclopirox	T2	
claravis	T2	

Drug Name	Drug Tier	Requirements/Limits
CLINDACIN P	T4	
clindamycin phosphate topical	T2	
clindamycin-benzoyl peroxide topical gel	T2	
clindamycin-tretinoin	T2	
clobetasol scalp	T2	
clobetasol topical foam	T2	
clobetasol topical gel	T2	
clobetasol topical lotion	T2	
clobetasol topical ointment	T3	
clobetasol topical shampoo	T2	
clobetasol topical spray,non-aerosol	T2	
clobetasol-emollient topical cream	T3	
clodan	T2	
CLODERM	T4	
clotrimazole topical	T2	
clotrimazole-betamethasone	T2	
CONDYLOX TOPICAL GEL	T3	
CORDRAN TAPE LARGE ROLL	T3	
cormax scalp	T2	
CORTISPORIN TOPICAL	T3	
COSENTYX	T5	PA; QL (2 ML per 28 days)
COSENTYX PEN	T5	PA; QL (2 ML per 28 days)
CUTIVATE TOPICAL LOTION	T4	
DENAVIR	T3	
DESONATE	T4	
desonide	T2	
desoximetasone	T2	
diclofenac sodium topical gel 3 %	T4	
DIFFERIN TOPICAL LOTION	T4	
diflorasone	T2	
doxepin topical	T2	
DUPIXENT	T5	PA; QL (4 ML per 28 days)
econazole	T2	
ELIDEL	T4	
EPIDUO FORTE	T4	
EPIDUO TOPICAL GEL WITH PUMP	T4	
ery pads	T2	
erygel	T2	

Drug Name	Drug Tier	Requirements/Limits
erythromycin with ethanol topical gel	T2	
erythromycin with ethanol topical solution	T2	
erythromycin-benzoyl peroxide	T2	
EURAX TOPICAL CREAM	T3	
EURAX TOPICAL LOTION	T4	
EXELDERM	T4	
FINACEA	T4	
fluocinolone	T2	
fluocinonide topical cream 0.05 %	T2	
fluocinonide topical cream 0.1 %	T4	
fluocinonide topical gel	T2	
fluocinonide topical ointment	T2	
fluocinonide topical solution	T2	
fluocinonide-e	T2	
FLUOROURACIL TOPICAL CREAM 0.5 %	T5	
fluorouracil topical cream 5 %	T2	
fluorouracil topical solution	T2	
flurandrenolide	T3	
fluticasone topical	T2	
gentamicin topical	T1	
halobetasol propionate	T2	
HALOG	T4	
hydrocortisone butyrate topical ointment	T2	
hydrocortisone butyrate topical solution	T2	
hydrocortisone butyr-emollient	T2	
hydrocortisone topical cream 1 %, 2.5 %	T1	
hydrocortisone topical lotion 2.5 %	T1	
hydrocortisone topical ointment 1 %, 2.5 %	T1	
hydrocortisone valerate	T2	
imiquimod	T2	
KENALOG TOPICAL	T3	
ketoconazole topical	T2	
lidocaine (pf) injection solution 10 mg/ml (1 %), 5 mg/ml (0.5 %)	T2	
lidocaine hcl injection solution 20 mg/ml (2 %)	T2	
lidocaine hcl mucous membrane jelly	T2	
lidocaine hcl mucous membrane jelly in applicator	T2	

Drug Name	Drug Tier	Requirements/Limits
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	T2	
lidocaine hcl urethral	T2	
lidocaine topical adhesive patch,medicated	T2	PA; QL (124 EA per 31 days)
lidocaine topical ointment	T2	
lidocaine viscous	T2	
lidocaine-prilocaine topical cream	T2	
LIDODERM	T4	PA; QL (124 EA per 31 days)
lindane topical shampoo	T2	
malathion	T2	
MENTAX	T4	
methoxsalen	T2	
metronidazole topical cream	T2	
metronidazole topical gel 0.75 %	T2	
metronidazole topical gel 1 %	T1	
metronidazole topical lotion	T2	
mometasone topical	T2	
mupirocin	T2	
mupirocin calcium	T2	
myorisan	T2	
NAFTIFINE TOPICAL CREAM 1 %	T4	
naftifine topical cream 2 %	T3	
NAFTIN TOPICAL CREAM 2 %	T4	
NAFTIN TOPICAL GEL	T4	
NEO-SYNALAR	T4	
neuac	T2	
nolix	T3	
NORITATE	T4	
nyamyc	T2	
nyata	T2	
nystatin topical	T2	
nystatin-triamcinolone	T3	
nystop	T2	
oxiconazole	T2	
OXISTAT	T4	
PANDEL	T4	
PANRETIN	T5	
permethrin topical cream	T2	

Drug Name	Drug Tier	Requirements/Limits
PICATO	T3	
podofilox	T2	
prednicarbate	T2	
prudoxin	T2	
REGRANEX	T5	
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.08 %	T4	
SANTYL	T3	
selenium sulfide topical lotion	T1	
SILIQ	T5	PA; QL (3 ML per 28 days)
silver sulfadiazine	T1	
SORIATANE ORAL CAPSULE 10 MG, 17.5 MG	T5	
SORIATANE ORAL CAPSULE 25 MG	T4	
ssd	T2	
STELARA INTRAVENOUS	T5	PA; QL (104 ML per 180 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 28 days)
sulfacetamide sodium (acne)	T1	
SULFAMYLON TOPICAL CREAM	T3	
TACLONEX TOPICAL SUSPENSION	T5	
tacrolimus topical	T2	
TALTZ AUTOINJECTOR (3 PACK)	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE	T5	PA; QL (1 ML per 28 days)
TAZAROTENE	T4	
TAZORAC TOPICAL CREAM 0.05 %	T4	
TAZORAC TOPICAL GEL	T4	
TOLAK	T4	
tretinoin	T2	
tretinoin microspheres topical gel with pump	T2	
triamcinolone acetonide topical aerosol	T2	
triamcinolone acetonide topical cream	T1	
triamcinolone acetonide topical lotion	T1	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	T1	
trianex	T2	
triderm topical cream 0.1 %	T1	

Drug Name	Drug Tier	Requirements/Limits
VALCHLOR	T4	PA-NS
VEREGEN	T4	
zenatane oral capsule 30 mg	T2	
ZOVIRAX TOPICAL CREAM	T3	
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP 2.5 %	T4	
ZYCLARA TOPICAL CREAM IN PACKET	T5	
Diagnostics / Miscellaneous Agents		
acamprosate	T2	
ADAGEN	T5	
alendronate oral tablet 40 mg	T1	
anagrelide	T2	
ARALAST NP INTRAVENOUS RECON SOLN 500 MG	T5	PA
AURYXIA	T4	
BUPHENYL	T5	
bupropion hcl (smoking deter)	T3	QL (62 EA per 31 days)
CARBAGLU	T5	PA
CARNITOR	T4	PA-BvD
cevimeline	T2	
CHANTIX	T4	
CHANTIX CONTINUING MONTH BOX	T4	
CHANTIX STARTING MONTH BOX	T4	
CHEMET	T3	
CLINIMIX 4.25%/D5W SULFIT FREE	T3	PA-BvD
CLINIMIX E 2.75%/D10W SUL FREE	T4	PA-BvD
CLINIMIX E 2.75%/D5W SULF FREE	T4	PA-BvD
d10 %-0.45 % sodium chloride	T2	
d2.5 %-0.45 % sodium chloride	T2	
d5 % and 0.9 % sodium chloride	T2	
d5 %-0.45 % sodium chloride	T2	
dextrose 10 % and 0.2 % nacl	T2	
dextrose 10 % in water (d10w)	T2	
dextrose 5 % in water (d5w) intravenous parenteral solution	T2	
dextrose 5 %-lactated ringers	T2	
dextrose 5%-0.2 % sod chloride	T2	
dextrose 5%-0.3 % sod.chloride	T2	
dextrose with sodium chloride	T2	

Drug Name	Drug Tier	Requirements/Limits
disulfiram	T2	
etidronate disodium	T2	
EXJADE	T5	
FERRIPROX	T5	
FOSRENOL ORAL POWDER IN PACKET	T4	
FOSRENOL ORAL TABLET,CHEWABLE 1,000 MG, 750 MG	T4	
FOSRENOL ORAL TABLET,CHEWABLE 500 MG	T5	
GLASSIA	T5	PA
INCRELEX	T5	PA
kionex	T2	
lactated ringers irrigation	T2	
levocarnitine (with sugar)	T2	PA-BvD
levocarnitine oral tablet	T2	PA-BvD
LITHOSTAT	T4	
midodrine	T2	
neomycin-polymyxin b gu	T1	
NICOTROL	T4	
NICOTROL NS	T3	
NORTHERA	T5	PA
NUTRESTORE	T4	
ORFADIN	T5	
pilocarpine hcl oral	T2	
PROLASTIN-C	T5	PA
RAVICTI	T5	PA
RENAGEL	T3	
RENVELA ORAL TABLET	T3	
RILUTEK	T5	
riluzole	T5	
ringer's irrigation	T2	
risedronate oral tablet 30 mg	T2	
sevelamer carbonate	T3	
sodium chloride 0.9 % intravenous parenteral solution	T2	
sodium chloride irrigation	T2	
sodium phenylbutyrate oral powder	T5	
sodium polystyrene (sorb free)	T2	
sps (with sorbitol) oral	T2	

Drug Name	Drug Tier	Requirements/Limits
SYPRINE	T3	
THIOLA	T4	
VELPHORO	T5	
VELTASSA	T4	PA; QL (30 EA per 30 days)
water for irrigation, sterile	T2	
ZEMAIRA	T5	PA
zoledronic acid-mannitol-water	T2	
Ear, Nose / Throat Medications		
acetic acid otic (ear)	T2	
azelastine nasal	T2	
BACTROBAN NASAL	T3	
chlorhexidine gluconate mucous membrane	T1	
CIPRO HC	T4	
CIPRODEX	T3	
COLY-MYCIN S	T4	
floxin otic (ear) drops	T2	
fluocinolone acetonide oil	T2	
hydrocortisone-acetic acid	T2	
ipratropium bromide nasal	T1	
neomycin-polymyxin-hc otic (ear)	T2	
ofloxacin otic (ear)	T2	
olopatadine nasal	T2	
OTOVEL	T4	
periogard	T2	
triamcinolone acetonide dental	T2	
Endocrine/Diabetes		
acarbose	T1	
ACTHAR H.P.	T5	PA
ACTOPLUS MET XR	T4	
AFREZZA	T4	
alcohol pads	T2	
ALDURAZYME	T5	
ALOGLIPTIN	T4	
ALOGLIPTIN-METFORMIN	T4	
ALOGLIPTIN-PIOGLITAZONE	T4	
ANADROL-50	T4	PA
ANDRODERM	T3	PA

Drug Name	Drug Tier	Requirements/Limits
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	T3	PA
ANDROGEL TRANSDERMAL GEL IN PACKET	T3	PA
APIDRA	T4	
APIDRA SOLOSTAR	T4	
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	
AVANDIA ORAL TABLET 2 MG, 4 MG	T3	
AVEED	T4	PA
AXIRON	T4	PA
BASAGLAR KWIKPEN	T3	
BYDUREON	T3	QL (4 EA per 28 days)
cabergoline	T2	
calcitonin (salmon)	T2	
calcitriol intravenous solution 1 mcg/ml	T2	PA-BvD
calcitriol oral	T2	PA-BvD
CERDELGA	T5	PA
CEREZYME INTRAVENOUS RECON SOLN 400 UNIT	T5	
chorionic gonadotropin, human	T2	PA-BvD
cortisone	T2	
CYCLOSET	T4	
danazol	T2	
DDAVP NASAL SOLUTION	T4	
DEPO-MEDROL	T4	
DEPO-TESTOSTERONE	T4	PA
desmopressin injection	T2	
desmopressin nasal solution	T2	
desmopressin nasal spray,non-aerosol	T2	
desmopressin oral	T2	
dexamethasone intensol	T2	
dexamethasone oral elixir	T1	
dexamethasone oral tablet	T1	
dexamethasone sodium phosphate injection solution	T2	
DEXPAK 13 DAY	T4	
doxercalciferol intravenous	T2	PA-BvD
doxercalciferol oral capsule 0.5 mcg, 2.5 mcg	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
doxercalciferol oral capsule 1 mcg	T5	PA-BvD
ELAPRASE	T5	
ELELYSO	T5	
EMFLAZA	T5	PA
FABRAZYME INTRAVENOUS RECON SOLN 35 MG	T5	
FARXIGA	T3	
fludrocortisone	T2	
FORTESTA	T4	PA
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T3	
glimepiride	T1	
glipizide	T1	
glipizide-metformin	T1	
GLUCAGEN HYPOKIT	T3	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 500 MG	T4	PA
glyburide	T2	PA
glyburide micronized	T2	PA
glyburide-metformin	T2	PA
GLYSET	T3	
HECTOROL INTRAVENOUS SOLUTION 4 MCG/2 ML	T4	PA-BvD
HECTOROL ORAL CAPSULE 0.5 MCG	T4	PA-BvD
HECTOROL ORAL CAPSULE 1 MCG, 2.5 MCG	T5	PA-BvD
HUMALOG	T3	
HUMALOG KWIKPEN	T3	
HUMALOG MIX 50-50	T3	
HUMALOG MIX 50-50 KWIKPEN	T3	
HUMALOG MIX 75-25	T3	
HUMALOG MIX 75-25 KWIKPEN	T3	
HUMULIN 70/30	T3	
HUMULIN 70/30 KWIKPEN	T3	
HUMULIN N	T3	
HUMULIN N KWIKPEN	T3	
HUMULIN R U-100	T3	
HUMULIN R U-500 (CONC) KWIKPEN	T3	
HUMULIN R U-500 (CONCENTRATED)	T3	

Drug Name	Drug Tier	Requirements/Limits
hydrocortisone oral	T1	
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE	T3	
INVOKAMET	T3	
INVOKAMET XR	T3	
INVOKANA	T3	
JANUMET	T3	
JANUMET XR	T3	
JANUVIA	T3	
JARDIANCE	T3	
JENTADUETO	T3	
JENTADUETO XR	T3	
KANUMA	T5	PA
KOMBIGLYZE XR	T4	
KORLYM	T5	PA
KUVAN ORAL TABLET,SOLUBLE	T5	
LANTUS	T3	
LANTUS SOLOSTAR	T3	
LEVEMIR	T3	
LEVEMIR FLEXTOUCH	T3	
levothyroxine oral	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	T2	
liothyronine	T2	
LUMIZYME	T5	
MEDROL ORAL TABLET 2 MG	T4	
metformin oral tablet	T1	
metformin oral tablet extended release 24 hr	T1	
metformin oral tablet extended release 24hr	T1	
methimazole oral tablet 10 mg, 5 mg	T2	
METHITEST	T4	PA
methylprednisolone	T2	
methylprednisolone acetate	T2	
methylprednisolone sodium succ injection recon soln 40 mg	T2	
methylprednisolone sodium succ intravenous	T2	
methyltestosterone oral capsule	T5	PA

Drug Name	Drug Tier	Requirements/Limits
MIACALCIN INJECTION	T4	PA-BvD
miglitol	T2	
MILLIPRED ORAL SOLUTION	T4	
millipred oral tablet	T2	
MYALEPT	T5	PA
NAGLAZYME	T5	
nateglinide	T1	
NATESTO	T4	PA
NATPARA	T5	PA
NESINA	T4	
novarel intramuscular recon soln 10,000 unit	T2	PA-BvD
NOVOLIN 70/30	T3	
NOVOLIN N	T3	
NOVOLIN R	T3	
NOVOLOG	T3	
NOVOLOG FLEXPEN	T3	
NOVOLOG MIX 70-30	T3	
NOVOLOG MIX 70-30 FLEXPEN	T3	
NOVOLOG PENFILL	T3	
ONGLYZA	T4	
OSENI	T4	
oxandrolone oral tablet 10 mg	T5	PA
oxandrolone oral tablet 2.5 mg	T2	PA
pamidronate intravenous solution	T2	PA-BvD
PARICALCITOL INTRAVENOUS	T4	PA-BvD
paricalcitol oral capsule 1 mcg	T2	PA-BvD
paricalcitol oral capsule 2 mcg, 4 mcg	T1	PA-BvD
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"	T4	
pioglitazone	T1	
pioglitazone-glimepiride	T1	
pioglitazone-metformin	T1	
prednisolone sodium phosphate oral solution 10 mg/5 ml, 15 mg/5 ml (3 mg/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)	T2	
prednisolone sodium phosphate oral tablet,disintegrating	T2	
prednisone intensol	T2	

Drug Name	Drug Tier	Requirements/Limits
prednisone oral solution	T1	
prednisone oral tablet	T1	
prednisone oral tablets,dose pack	T2	
PREGNYL	T4	PA-BvD
PROGLYCEM	T3	
propylthiouracil	T2	
repaglinide oral tablet 0.5 mg	T1	
repaglinide oral tablet 1 mg, 2 mg	T2	
repaglinide-metformin	T2	
RIOMET	T4	PA; QL (791 ML per 31 days)
ROCALTROL	T4	PA-BvD
SAMSCA	T5	
SENSIPAR ORAL TABLET 30 MG	T3	
SENSIPAR ORAL TABLET 60 MG, 90 MG	T5	
SOLU-CORTEF (PF) INJECTION RECON SOLN 100 MG/2 ML, 250 MG/2 ML	T4	
SOLU-MEDROL (PF) INJECTION	T4	
SOLU-MEDROL (PF) INTRAVENOUS RECON SOLN 500 MG/4 ML	T4	
SOLU-MEDROL INTRAVENOUS RECON SOLN 2 GRAM	T4	
SOMAVERT	T5	
STIMATE	T3	
STRENSIQ	T5	PA
STRIANT	T4	PA
SYMLINPEN 120	T3	
SYMLINPEN 60	T3	
SYNAREL	T5	
SYNTHROID	T4	
TESTIM	T4	PA
testosterone cypionate	T2	PA
testosterone enanthate	T2	PA
TESTOSTERONE TRANSDERMAL GEL IN METERED-DOSE PUMP	T3	PA
testosterone transdermal gel in packet 1 % (25 mg/2.5gram)	T3	PA
TESTOSTERONE TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)	T3	PA
TESTOSTERONE TRANSDERMAL SOLUTION IN METERED PUMP W/APP	T4	PA

Drug Name	Drug Tier	Requirements/Limits
THYROLAR-1	T4	
THYROLAR-1/2	T4	
THYROLAR-1/4	T4	
THYROLAR-2	T4	
THYROLAR-3	T4	
TIROSINT	T4	
tolazamide	T1	
tolbutamide	T1	
TOUJEO SOLOSTAR	T3	
TRADJENTA	T3	
TRESIBA FLEXTOUCH U-100	T3	
TRESIBA FLEXTOUCH U-200	T3	
TRULICITY	T3	QL (2 ML per 28 days)
unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	T1	
veripred 20	T2	
VICTOZA 3-PAK	T3	QL (9 ML per 30 days)
VOGELXO TRANSDERMAL GEL	T4	PA
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	T4	PA
VPRIV	T5	
XIGDUO XR	T3	
ZAVESCA	T5	
ZEMPLAR INTRAVENOUS	T4	PA-BvD
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	T4	PA-BvD
zoledronic acid intravenous solution	T2	
ZOMETA	T5	
Gastroenterology		
AKYNZEO	T4	PA-BvD
alosetron oral tablet 0.5 mg	T2	
alosetron oral tablet 1 mg	T5	
ALOXI	T4	
AMITIZA	T3	QL (62 EA per 31 days)
amoxicil-clarithromy-lansopraz	T2	
ANZEMET ORAL	T4	PA-BvD
APREPITANT	T4	PA-BvD
APRISO	T3	

Drug Name	Drug Tier	Requirements/Limits
ASACOL HD	T3	
atropine injection syringe 0.05 mg/ml	T2	
balsalazide	T2	
budesonide oral	T4	
CANASA	T3	
carafate oral suspension	T3	
CESAMET	T4	PA-BvD
CHENODAL	T5	PA
CHOLBAM	T5	PA
cimetidine	T2	
cimetidine hcl oral	T2	
CIMZIA	T5	PA; QL (2 EA per 28 days)
CIMZIA POWDER FOR RECONST	T5	PA; QL (6 EA per 28 days)
colocort	T2	
compro	T2	
constulose	T2	
CREON	T3	
cromolyn oral	T2	
CUVPOSA	T4	
CYSTADANE	T3	
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)	T3	
dicyclomine intramuscular	T2	
dicyclomine oral capsule	T2	
dicyclomine oral solution	T2	
dicyclomine oral tablet	T2	
DIPENTUM	T3	
diphenoxylate-atropine	T2	
dronabinol oral capsule 10 mg	T5	PA-BvD
dronabinol oral capsule 2.5 mg, 5 mg	T2	PA-BvD
EMEND INTRAVENOUS	T4	
EMEND ORAL	T4	PA-BvD
enulose	T2	
esomeprazole magnesium	T2	QL (31 EA per 31 days)
esomeprazole sodium	T2	
famotidine (pf)	T1	
famotidine (pf)-nacl (iso-os)	T2	
famotidine oral suspension	T1	

Drug Name	Drug Tier	Requirements/Limits
famotidine oral tablet 20 mg, 40 mg	T1	
GATTEX ONE-VIAL	T5	PA
gavilyte-c	T2	
gavilyte-g	T2	
gavilyte-n	T2	
generlac	T2	
glycopyrrolate injection	T2	
glycopyrrolate oral tablet 1 mg, 2 mg	T2	
GOLYTELY ORAL POWDER IN PACKET	T4	
granisetron (pf) intravenous solution 100 mcg/ml	T2	
granisetron hcl intravenous	T2	
granisetron hcl oral	T2	PA-BvD
hydrocortisone rectal	T1	
INFLECTRA	T5	PA; QL (8 EA per 28 days)
lactulose oral solution 10 gram/15 ml	T1	
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	T3	QL (31 EA per 31 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	T3	QL (62 EA per 31 days)
LIALDA	T3	
LINZESS	T3	QL (31 EA per 31 days)
loperamide oral capsule	T2	
LOTRONEX ORAL TABLET 0.5 MG	T3	
LOTRONEX ORAL TABLET 1 MG	T5	
MARINOL ORAL CAPSULE 10 MG, 5 MG	T4	PA-BvD
MARINOL ORAL CAPSULE 2.5 MG	T5	PA-BvD
meclizine oral tablet 12.5 mg, 25 mg	T2	
MESALAMINE ORAL TABLET,DELAYED RELEASE (DR/EC) 800 MG	T4	
mesalamine with cleansing wipe	T2	
methscopolamine	T2	
metoclopramide hcl injection solution	T2	
metoclopramide hcl oral	T2	
misoprostol	T2	
MOVANTIK	T3	QL (31 EA per 31 days)
MOVIPREP	T4	
MYTESI	T4	QL (62 EA per 31 days)
nizatidine	T2	
OCALIVA	T5	PA; QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
omeprazole oral capsule,delayed release(dr/ec)	T1	
omeprazole-sodium bicarbonate	T2	
ondansetron	T2	PA-BvD
ondansetron hcl (pf)	T2	
ondansetron hcl oral	T2	PA-BvD
OSMOPREP	T4	
PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,500-35,500- 61,500 UNIT, 16,800-56,800- 98,400 UNIT, 2,600-6,200- 10,850 UNIT, 21,000-54,700- 83,900 UNIT, 4,200-14,200- 24,600 UNIT	T3	
pantoprazole	T2	
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram	T2	
peg-electrolyte soln	T2	
PENTASA	T3	
PERTZYE	T3	
polyethylene glycol 3350 oral powder	T2	
PREPOPIK	T4	
prochlorperazine	T2	
prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)	T2	
prochlorperazine maleate	T2	
procto-pak	T2	
proctosol hc topical	T2	
proctozone-hc	T2	
propantheline	T2	
PYLERA	T4	
rabeprazole	T2	QL (62 EA per 31 days)
ranitidine hcl injection solution 50 mg/2 ml (25 mg/ml)	T4	
ranitidine hcl oral capsule	T2	
ranitidine hcl oral syrup	T1	
ranitidine hcl oral tablet 150 mg, 300 mg	T1	
RECTIV	T4	
RELISTOR ORAL	T5	PA; QL (93 EA per 31 days)
RELISTOR SUBCUTANEOUS SOLUTION	T4	QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	T4	QL (18.6 ML per 31 days)

Drug Name	Drug Tier	Requirements/Limits
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	T4	QL (12.4 ML per 31 days)
REMICADE	T5	PA; QL (8 EA per 28 days)
RENFLEXIS	T5	PA; QL (8 EA per 28 days)
SANCUSO	T4	
SUCRAID	T5	
sucralfate oral tablet	T2	
sulfasalazine	T2	
SUPREP BOWEL PREP KIT	T3	
SYNDROS	T5	PA
TRANSDERM-SCOP	T4	
trilyte with flavor packets	T2	
trimethobenzamide oral	T2	PA
ursodiol	T3	
VARUBI	T4	PA-BvD
VIBERZI	T5	PA; QL (62 EA per 31 days)
ZENPEP	T3	
ZOFRAN (AS HYDROCHLORIDE) ORAL	T5	PA-BvD
ZOFRAN ODT ORAL TABLET,DISINTEGRATING 4 MG	T4	PA-BvD
ZOFRAN ODT ORAL TABLET,DISINTEGRATING 8 MG	T5	PA-BvD
ZUPLENZ	T4	PA-BvD
Immunology, Vaccines / Biotechnology		
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA-NS
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION	T3	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	T3	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 200 MCG/ML, 300 MCG/ML	T5	PA-BvD
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, 60 MCG/0.3 ML	T3	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML	T5	PA-BvD
ARCALYST	T5	PA
ATGAM	T3	PA-BvD
AVONEX (WITH ALBUMIN)	T5	QL (1 EA per 28 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	QL (4 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	QL (4 EA per 28 days)
BCG VACCINE, LIVE (PF)	T4	
BETASERON SUBCUTANEOUS KIT	T5	QL (15 EA per 31 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T4	
BOTOX	T4	PA
CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM	T5	PA
DAPTACEL (DTAP PEDIATRIC) (PF)	T4	
DYSPORT	T4	PA
EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG	T5	PA-NS
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
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	T3	PA-BvD
EXTAVIA SUBCUTANEOUS KIT	T5	QL (15 EA per 31 days)
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	T5	PA
fomepizole	T1	
GAMASTAN S/D	T4	PA
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

Drug Name	Drug Tier	Requirements/Limits
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	
GRASTEK	T4	PA
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	T3	
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	T3	
HIBERIX (PF)	T4	
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT)	T5	PA
HUMATROPE INJECTION CARTRIDGE 6 MG (18 UNIT)	T4	PA
HUMATROPE INJECTION RECON SOLN	T5	PA
HYPERRAB S/D (PF)	T4	PA-BvD
ILARIS (PF) SUBCUTANEOUS RECON SOLN	T5	PA
IMOGAM RABIES-HT (PF)	T4	PA-BvD
IMOVAX RABIES VACCINE (PF)	T4	PA-BvD
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	T3	
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)	T3	PA-NS
INTRON A INJECTION RECON SOLN 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML)	T5	PA-NS
INTRON A INJECTION SOLUTION	T5	PA-NS
IPOL	T3	
IXIARO (PF)	T4	
KINRIX (PF)	T4	
LEUKINE INJECTION RECON SOLN	T5	

Drug Name	Drug Tier	Requirements/Limits
MENACTRA (PF) INTRAMUSCULAR SOLUTION	T3	
MENVEO A-C-Y-W-135-DIP (PF)	T4	
MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 200 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML	T4	PA-BvD
M-M-R II (PF)	T4	
MOZOBIL	T5	PA
NEULASTA SUBCUTANEOUS SYRINGE	T5	
NEUPOGEN INJECTION SOLUTION 300 MCG/ML	T4	
NEUPOGEN INJECTION SOLUTION 480 MCG/1.6 ML	T5	
NEUPOGEN INJECTION SYRINGE	T5	
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML)	T5	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
NUTROPIN AQ NUSPIN	T5	PA
OCTAGAM	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T4	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	T4	PA
PEDIARIX (PF)	T4	PA-BvD
PEDVAX HIB (PF)	T4	
PEGASYS	T5	PA
PEGASYS PROCLICK	T5	PA
PEGINTRON REDIPEN SUBCUTANEOUS PEN INJECTOR KIT 120 MCG/0.5 ML	T5	PA
PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5 ML	T5	PA
PLEGRIDY SUBCUTANEOUS PEN INJECTOR	T5	QL (1 ML per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	T5	QL (1 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 40,000 UNIT/ML	T5	PA-BvD
PROLEUKIN	T5	
PROQUAD (PF)	T3	
QUADRACEL (PF)	T4	
RABAVERT (PF)	T4	PA-BvD
RAGWITEK	T4	PA
REBIF (WITH ALBUMIN)	T5	QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	T5	QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	T5	QL (4.2 ML per 365 days)
REBIF TITRATION PACK	T5	QL (8.4 ML per 365 days)
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	T4	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	T4	PA-BvD
ROTARIX	T4	
ROTATEQ VACCINE	T3	
SAIZEN	T5	PA
SAIZEN CLICK.EASY	T5	PA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	T5	PA
SYLATRON	T5	PA-NS
TENIVAC (PF) INTRAMUSCULAR SYRINGE	T4	
TETANUS,DIPHTHERIA TOX PED(PF)	T4	
TETANUS-DIPHTHERIA TOXOIDS-TD	T3	
THYMOGLOBULIN	T4	
TRUMENBA	T3	
TWINRIX (PF) INTRAMUSCULAR SUSPENSION	T3	
TYPHIM VI INTRAMUSCULAR SOLUTION	T3	
TYPHIM VI INTRAMUSCULAR SYRINGE	T4	
VAQTA (PF) INTRAMUSCULAR SYRINGE	T3	

Drug Name	Drug Tier	Requirements/Limits
VARIVAX (PF)	T3	
VARIZIG INTRAMUSCULAR SOLUTION	T4	
XEOMIN INTRAMUSCULAR RECON SOLN 50 UNIT	T4	PA
YF-VAX (PF)	T3	
ZARXIO	T5	
ZINPLAVA	T5	PA
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG	T5	PA
ZOMACTON SUBCUTANEOUS RECON SOLN 5 MG	T4	PA
ZORBTIVE	T5	PA
ZOSTAVAX (PF)	T3	
Musculoskeletal / Rheumatology		
ACTEMRA INTRAVENOUS	T5	PA; QL (40 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
alendronate oral solution	T1	
alendronate oral tablet 10 mg	T2	
alendronate oral tablet 35 mg, 5 mg, 70 mg	T1	
allopurinol	T1	
ALLOPURINOL SODIUM	T5	
aloprim	T2	
ARAVA	T5	
BENLYSTA INTRAVENOUS RECON SOLN 120 MG	T4	
BENLYSTA INTRAVENOUS RECON SOLN 400 MG	T5	
BENLYSTA SUBCUTANEOUS	T5	
BONIVA INTRAVENOUS	T4	PA-BvD
COLCHICINE	T4	
COLCRYS	T3	
CUPRIMINE	T5	
DEPEN TITRATABS	T5	
ENBREL SUBCUTANEOUS RECON SOLN	T5	PA; QL (8 EA per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51)	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (0.98 ML)	T5	PA; QL (7.84 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (7.84 ML per 28 days)
FORTEO	T5	PA; QL (2.4 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
HUMIRA	T5	PA; QL (2 EA per 28 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	T5	PA; QL (3 EA per 28 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (6 PACK)	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA PEN CROHN'S-UC-HS START	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN PSORIASIS-UVEITIS	T5	PA; QL (4 EA per 28 days)
ibandronate intravenous solution	T2	PA-BvD
ibandronate oral	T2	
KEVZARA	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
leflunomide	T2	
MITIGARE	T4	QL (62 EA per 31 days)
ORENCIA (WITH MALTOSE)	T5	PA; QL (8 EA per 28 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	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) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.4 ML, 12.5 MG/0.4 ML, 15 MG/0.4 ML, 17.5 MG/0.4 ML, 20 MG/0.4 ML, 22.5 MG/0.4 ML, 25 MG/0.4 ML	T4	PA
probenecid	T2	
probenecid-colchicine	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)
raloxifene	T3	
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML	T4	PA
RIDAURA	T3	
risedronate	T2	

Drug Name	Drug Tier	Requirements/Limits
SAVELLA	T4	PA
SIMPONI ARIA	T5	PA; QL (16 ML 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 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
TYMLOS	T5	PA; QL (1.56 ML per 31 days)
ULORIC	T3	
XELJANZ	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
ZURAMPIC	T4	
Obstetrics / Gynecology		
alyacen 1/35 (28)	T2	
amabelz	T2	
amethia	T2	
amethia lo	T2	
ANGELIQ ORAL TABLET 0.5-1 MG	T4	
apri	T2	
aranelle (28)	T2	
ashlyna	T2	
AVC VAGINAL	T4	
aviane	T2	
balziva (28)	T2	
bekyree (28)	T2	
BEYAZ	T4	
blisovi 24 fe	T2	
blisovi fe 1.5/30 (28)	T2	
blisovi fe 1/20 (28)	T2	
briellyn	T2	
camila	T2	
camrese lo	T2	
caziant (28)	T2	
CLEOCIN VAGINAL SUPPOSITORY	T4	
CLIMARA PRO	T4	
clindamycin phosphate vaginal	T2	
CLINDESSE	T4	
CRINONE	T4	PA

Drug Name	Drug Tier	Requirements/Limits
cryselle (28)	T2	
cyclafem 1/35 (28)	T2	
cyclafem 7/7/7 (28)	T2	
DEPO-ESTRADIOL	T4	
DEPO-PROVERA INTRAMUSCULAR SOLUTION	T4	
DIVIGEL TRANSDERMAL GEL IN PACKET 0.5 MG/0.5 GRAM (0.1 %)	T4	
drospirenone-e.estradiol-lm.fa	T2	
drospirenone-ethinyl estradiol	T2	
emoquette	T2	
enpresse	T2	
errin	T2	
ESTRACE VAGINAL	T4	
estradiol oral	T1	
estradiol transdermal	T2	
estradiol vaginal	T4	
estradiol valerate intramuscular oil 20 mg/ml	T2	
estradiol-norethindrone acet	T2	
ESTRING	T4	
estropipate	T1	
ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg	T2	
EVAMIST	T4	
FEMRING	T4	
femynor	T2	
fyavolv	T2	
gildagia	T2	
GYNAZOLE-1	T4	
hydroxyprogesterone caproate	T5	
introvale	T2	
jinteli	T2	
jolivette	T2	
juleber	T2	
junel 1.5/30 (21)	T2	
junel 1/20 (21)	T2	
junel fe 1.5/30 (28)	T2	
junel fe 1/20 (28)	T2	
junel fe 24	T2	

Drug Name	Drug Tier	Requirements/Limits
kaitlib fe	T2	
kariva (28)	T2	
kelnor 1/35 (28)	T2	
kimidess (28)	T2	
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	T2	
larissia	T2	
layolis fe	T2	
lessina	T2	
levonest (28)	T2	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg	T2	
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month	T2	
levonorg-eth estrad triphasic	T2	
levora-28	T2	
LO LOESTRIN FE	T4	
loryna (28)	T2	
low-ogestrel (28)	T2	
LUPANETA PACK (1 MONTH)	T5	
LUPANETA PACK (3 MONTH)	T5	
lutera (28)	T2	
lyza	T2	
MAKENA INTRAMUSCULAR OIL 250 MG/ML (1 ML)	T5	
marlissa	T2	
medroxyprogesterone intramuscular suspension	T2	
medroxyprogesterone oral	T2	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	T4	
metronidazole vaginal	T2	
mibelas 24 fe	T2	
miconazole-3 vaginal suppository	T2	
microgestin 1.5/30 (21)	T2	
microgestin 1/20 (21)	T2	
microgestin fe 1.5/30 (28)	T2	
microgestin fe 1/20 (28)	T2	
mononessa (28)	T2	
necon 0.5/35 (28)	T2	

Drug Name	Drug Tier	Requirements/Limits
necon 7/7/7 (28)	T2	
noreth-ethinyl estradiol-iron	T2	
norethindrone (contraceptive)	T2	
norethindrone acetate	T2	
norethindrone ac-eth estradiol	T2	
norgestimate-ethinyl estradiol	T2	
nortrel 0.5/35 (28)	T2	
nortrel 1/35 (21)	T2	
nortrel 1/35 (28)	T2	
nortrel 7/7/7 (28)	T2	
NUVARING	T3	
NUVESSA	T4	
ogestrel (28)	T2	
orsythia	T2	
ORTHO TRI-CYCLEN LO (28)	T3	
pimtrea (28)	T2	
pirmella oral tablet 1-35 mg-mcg	T2	
portia	T2	
PREFEST	T4	
PREMARIN VAGINAL	T3	
previfem	T2	
progesterone micronized	T2	
quasense	T2	
reclipsen (28)	T2	
SAFYRAL	T4	
setlakin	T2	
sprintec (28)	T2	
sronyx	T2	
terconazole	T2	
tranexamic acid oral	T2	
tri-legest fe	T2	
tri-lo-estarylla	T2	
tri-lo-sprintec	T2	
trinessa (28)	T2	
tri-previfem (28)	T2	
tri-sprintec (28)	T2	
trivora (28)	T2	
VAGIFEM	T4	

Drug Name	Drug Tier	Requirements/Limits
vandazole	T2	
velivet triphasic regimen (28)	T2	
vestura (28)	T2	
vienva	T2	
vyfemla (28)	T2	
YUVAFEM	T4	
zarah	T2	
zenchent fe	T2	
zovia 1/35e (28)	T2	
zovia 1/50e (28)	T2	
Ophthalmology		
acetazolamide	T2	
acetazolamide sodium	T2	
ACUVAIL (PF)	T4	
ALOCRIL	T4	
ALOMIDE	T3	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
apraclonidine	T2	
atropine ophthalmic (eye) drops	T2	
AZASITE	T4	
azelastine ophthalmic (eye)	T2	
AZOPT	T3	
bacitracin ophthalmic (eye)	T2	
bacitracin-polymyxin b ophthalmic (eye)	T2	
BESIVANCE	T4	
betaxolol ophthalmic (eye)	T2	
BETIMOL	T4	
BETOPTIC S	T4	
bimatoprost ophthalmic (eye)	T2	
BLEPH-10	T4	
BLEPHAMIDE	T3	
BLEPHAMIDE S.O.P.	T3	
brimonidine	T2	
bromfenac	T2	
carteolol	T2	
CILOXAN OPHTHALMIC (EYE) OINTMENT	T3	
ciprofloxacin hcl ophthalmic (eye)	T1	

Drug Name	Drug Tier	Requirements/Limits
COMBIGAN	T3	
cromolyn ophthalmic (eye)	T2	
CYSTARAN	T5	
dexamethasone sodium phosphate ophthalmic (eye)	T2	
diclofenac sodium ophthalmic (eye)	T1	
dorzolamide	T2	
dorzolamide-timolol	T2	
DUREZOL	T3	
EMADINE	T4	
epinastine	T2	
erythromycin ophthalmic (eye)	T2	
fluorometholone	T2	
flurbiprofen sodium	T2	
gatifloxacin	T2	
gentak ophthalmic (eye) ointment	T2	
gentamicin ophthalmic (eye) drops	T1	
ILEVRO	T3	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	T3	
ISTALOL	T4	
ketorolac ophthalmic (eye)	T2	
LACRISERT	T4	
LASTACAFT	T4	
latanoprost	T1	
levobunolol ophthalmic (eye) drops 0.5 %	T1	
levofloxacin ophthalmic (eye)	T2	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
methazolamide	T2	
metipranolol	T2	
MOXEZA	T4	
moxifloxacin ophthalmic (eye)	T4	
NATACYN	T3	
neomycin-bacitracin-poly-hc	T2	
neomycin-bacitracin-polymyxin	T2	
neomycin-polymyxin b-dexameth	T2	
neomycin-polymyxin-gramicidin	T2	
neomycin-polymyxin-hc ophthalmic (eye)	T2	

Drug Name	Drug Tier	Requirements/Limits
NEVANAC	T4	
ofloxacin ophthalmic (eye)	T2	
olopatadine ophthalmic (eye)	T3	
PAZEO	T3	
PHOSPHOLINE IODIDE	T3	
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	T2	
polymyxin b sulf-trimethoprim	T2	
PRED-G	T4	
PRED-G S.O.P.	T4	
prednisolone acetate	T3	
prednisolone sodium phosphate ophthalmic (eye)	T2	
RESTASIS	T3	
SIMBRINZA	T3	
sulfacetamide sodium ophthalmic (eye) drops	T2	
sulfacetamide sodium ophthalmic (eye) ointment	T1	
sulfacetamide-prednisolone	T2	
timolol maleate ophthalmic (eye) drops	T1	
timolol maleate ophthalmic (eye) gel forming solution	T2	
TIMOPTIC OCUDOSE (PF)	T4	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
TOBRADEX ST	T3	
tobramycin	T1	
tobramycin-dexamethasone	T2	
TOBREX OPHTHALMIC (EYE) OINTMENT	T3	
TRAVATAN Z	T3	
trifluridine	T2	
VIGAMOX	T4	
XIIDRA	T4	
ZIOPTAN (PF)	T4	
ZIRGAN	T4	
ZYLET	T4	
Respiratory And Allergy		
acetylcysteine	T2	PA-BvD
ADCIRCA	T5	PA; QL (62 EA per 31 days)
ADEMPAS	T5	PA; QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
adrenalin injection solution 1 mg/ml (1 ml)	T2	
ADVAIR DISKUS	T4	QL (60 EA per 30 days)
ADVAIR HFA	T4	QL (12 GM per 30 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml	T2	PA-BvD
albuterol sulfate oral syrup	T1	
albuterol sulfate oral tablet	T1	
albuterol sulfate oral tablet extended release 12 hr	T2	
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
ASMANEX HFA	T3	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 220 MCG (120 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES)	T3	QL (1 EA per 30 days)
ATROVENT HFA	T3	QL (25.8 GM per 30 days)
BECONASE AQ	T4	
BERINERT INTRAVENOUS KIT	T5	PA
BEVESPI AEROSPHERE	T3	QL (10.7 GM per 30 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BROVANA	T4	PA-BvD
budesonide inhalation	T2	PA-BvD
budesonide nasal	T2	
cetirizine oral solution 1 mg/ml	T2	
CINRYZE	T5	PA
CLARINEX-D 12 HOUR	T4	
COMBIVENT RESPIMAT	T4	QL (4 GM per 30 days)
cromolyn inhalation	T2	PA-BvD
cyproheptadine	T2	
DALIRESP	T3	QL (31 EA per 31 days)
desloratadine	T2	
diphenhydramine hcl injection solution 50 mg/ml	T2	
DYMISTA	T4	
EPINEPHRINE INJECTION AUTO-INJECTOR	T3	
EPIPEN 2-PAK	T3	
EPIPEN JR 2-PAK	T3	
ESBRIET ORAL CAPSULE	T5	PA; QL (279 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
ESBRIET ORAL TABLET 267 MG	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 801 MG	T5	PA; QL (93 EA per 31 days)
FIRAZYR	T5	PA; QL (18 ML per 30 days)
flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)	T2	
fluticasone nasal	T2	
FLUTICASONE-SALMETEROL	T3	QL (1 EA per 30 days)
hydroxyzine hcl intramuscular	T2	
hydroxyzine hcl oral solution 10 mg/5 ml	T2	
hydroxyzine hcl oral tablet	T2	
ipratropium bromide inhalation	T1	PA-BvD
ipratropium-albuterol	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
KARBINAL ER	T4	
LETAIRIS	T5	PA; QL (31 EA per 31 days)
levalbuterol hcl	T2	PA-BvD
LEVALBUTEROL TARTRATE	T4	QL (30 GM per 30 days)
levocetirizine	T2	
metaproterenol	T2	
mometasone nasal	T3	
montelukast oral granules in packet	T2	QL (31 EA per 31 days)
montelukast oral tablet	T3	QL (31 EA per 31 days)
montelukast oral tablet,chewable	T2	QL (31 EA per 31 days)
NASONEX	T4	
NUCALA	T5	PA
OFEV	T5	PA; QL (62 EA per 31 days)
OMNARIS	T4	
OPSUMIT	T5	PA; QL (31 EA per 31 days)
ORKAMBI	T5	PA; QL (124 EA per 31 days)
PERFOROMIST	T4	PA-BvD
phenadoz rectal suppository 12.5 mg	T2	
phenergan rectal	T2	
PROAIR HFA	T3	QL (17 GM per 30 days)
PROAIR RESPICLICK	T3	QL (2 EA per 30 days)
promethazine injection solution	T2	
promethazine oral syrup	T2	PA
promethazine rectal	T2	

Drug Name	Drug Tier	Requirements/Limits
promethazine vc	T2	
promethegan rectal suppository 25 mg, 50 mg	T2	
PULMICORT	T4	PA-BvD
PULMOZYME	T5	PA
QVAR INHALATION AEROSOL 40 MCG/ACTUATION	T3	QL (8.7 GM per 30 days)
QVAR INHALATION AEROSOL 80 MCG/ACTUATION	T3	QL (17.4 GM per 30 days)
REVATIO INTRAVENOUS	T5	PA
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	T5	PA; QL (224 ML per 31 days)
REVATIO ORAL TABLET	T5	PA; QL (93 EA per 31 days)
RUCONEST	T5	PA
SEMPREX-D	T4	
SEREVENT DISKUS	T4	QL (60 EA per 30 days)
sildenafil (antihypertensive) intravenous	T5	PA
sildenafil (antihypertensive) oral	T3	PA; QL (93 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER	T3	QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T4	QL (4 GM per 30 days)
SYMBICORT	T3	QL (10.2 GM per 30 days)
terbutaline	T2	
THEO-24	T4	
theophylline oral solution	T2	
theophylline oral tablet extended release 12 hr	T2	
theophylline oral tablet extended release 24 hr	T2	
TRACLEER	T5	PA; QL (62 EA per 31 days)
triamcinolone acetonide nasal	T3	
VENTAVIS	T5	PA-BvD
VENTOLIN HFA	T3	QL (36 GM per 30 days)
XOLAIR	T5	
XOPENEX	T4	PA-BvD
XOPENEX CONCENTRATE	T4	PA-BvD
zafirlukast	T2	
ZILEUTON	T5	PA
ZYFLO	T4	PA
Urologicals		
alfuzosin	T2	

Drug Name	Drug Tier	Requirements/Limits
bethanechol chloride	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	
darifenacin	T3	
dutasteride	T3	
dutasteride-tamsulosin	T3	
ELMIRON	T3	
finasteride oral tablet 5 mg	T2	
flavoxate	T2	
GELNIQUE TRANSDERMAL GEL IN PACKET	T3	PA; QL (30 GM per 30 days)
MYRBETRIQ	T3	QL (31 EA per 31 days)
oxybutynin chloride oral syrup	T2	
oxybutynin chloride oral tablet	T2	
oxybutynin chloride oral tablet extended release 24hr	T3	
OXYTROL	T4	PA; QL (8 EA per 28 days)
potassium citrate oral tablet extended release 10 meq (1,080 mg)	T3	
potassium citrate oral tablet extended release 15 meq, 5 meq (540 mg)	T2	
PROCYSBI	T5	PA
RAPAFLO	T3	
tamsulosin	T1	
tolterodine	T3	
TOVIAZ	T3	QL (31 EA per 31 days)
trospium	T2	
VESICARE	T3	QL (31 EA per 31 days)
Vitamins, Hematinics / Electrolytes		
amino acids 15 %	T2	PA-BvD
AMINOSYN 7 % WITH ELECTROLYTES	T4	PA-BvD
AMINOSYN 8.5 %-ELECTROLYTES	T4	PA-BvD
AMINOSYN II 10 %	T4	PA-BvD
AMINOSYN II 15 %	T4	PA-BvD
AMINOSYN II 8.5 %	T4	PA-BvD
AMINOSYN II 8.5 %-ELECTROLYTES	T4	PA-BvD
AMINOSYN-HBC 7%	T3	PA-BvD
AMINOSYN-PF 10 %	T3	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
AMINOSYN-PF 7 % (SULFITE-FREE)	T3	PA-BvD
AMINOSYN-RF 5.2 %	T4	PA-BvD
calcium acetate oral capsule	T2	
calcium acetate oral tablet 667 mg	T2	
CLINIMIX 5%/D15W SULFITE FREE	T3	PA-BvD
CLINIMIX 5%/D25W SULFITE-FREE	T3	PA-BvD
CLINIMIX 2.75%/D5W SULFIT FREE	T3	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T3	PA-BvD
CLINIMIX 4.25%-D20W SULF-FREE	T3	PA-BvD
CLINIMIX 4.25%-D25W SULF-FREE	T4	PA-BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	T3	PA-BvD
CLINIMIX E 4.25%/D10W SUL FREE	T4	PA-BvD
CLINIMIX E 4.25%/D25W SUL FREE	T4	PA-BvD
CLINIMIX E 4.25%/D5W SULF FREE	T4	PA-BvD
CLINIMIX E 5%/D15W SULFIT FREE	T4	PA-BvD
CLINIMIX E 5%/D20W SULFIT FREE	T4	PA-BvD
CLINIMIX E 5%/D25W SULFIT FREE	T4	PA-BvD
CLINISOL SF 15 %	T4	PA-BvD
dextrose-kcl-nacl	T2	
eliphos	T2	
fluoride (sodium) oral tablet	T2	
FREAMINE HBC 6.9 %	T4	PA-BvD
HEPATAMINE 8%	T3	PA-BvD
intralipid intravenous emulsion 20 %	T2	PA-BvD
INTRALIPID INTRAVENOUS EMULSION 30 %	T4	PA-BvD
IONOSOL-B IN D5W	T4	PA-BvD
IONOSOL-MB IN D5W	T4	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T3	PA-BvD
ISOLYTE-S	T3	PA-BvD
klor-con 10	T2	
klor-con 8	T2	
klor-con m10	T2	
klor-con m15	T2	
klor-con m20	T2	
klor-con sprinkle	T2	
K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ, 20 MEQ	T4	
k-tab oral tablet extended release 8 meq	T1	

Drug Name	Drug Tier	Requirements/Limits
lactated ringers intravenous	T2	
magnesium sulfate injection	T2	
NEPHRAMINE 5.4 %	T3	PA-BvD
NORMOSOL-M IN 5 % DEXTROSE	T4	PA-BvD
NORMOSOL-R IN 5 % DEXTROSE	T4	PA-BvD
NORMOSOL-R PH 7.4	T4	PA-BvD
NUTRILIPID	T4	PA-BvD
PHOSLYRA	T4	
PLASMA-LYTE 148	T4	PA-BvD
PLASMA-LYTE A	T4	PA-BvD
potassium chlorid-d5-0.45%nacl	T2	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	T2	
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 40 meq/l	T2	
potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	T2	
potassium chloride intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml	T2	
potassium chloride intravenous solution	T2	
potassium chloride oral capsule, extended release	T1	
potassium chloride oral liquid	T2	
potassium chloride oral tablet extended release	T1	
potassium chloride oral tablet,er particles/crystals	T1	
potassium chloride-0.45 % nacl	T2	
potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l	T2	
potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l	T2	
potassium chloride-d5-0.9%nacl	T2	
premasol 10 %	T2	PA-BvD
PREMASOL 6 %	T3	PA-BvD
prenatal vitamin plus low iron	T2	
PROCALAMINE 3%	T4	PA-BvD
PROSOL 20 %	T4	PA-BvD
ringer's intravenous	T2	
sodium chloride 0.45 % intravenous parenteral solution	T2	
sodium chloride 3 %	T2	

Drug Name	Drug Tier	Requirements/Limits
sodium chloride 5 %	T2	
sodium chloride intravenous parenteral solution 2.5 meq/ml	T2	
sodium lactate	T2	
travasol 10 %	T2	PA-BvD
TROPHAMINE 10 %	T4	PA-BvD
TROPHAMINE 6%	T3	PA-BvD

Index of Drugs

actemra

Products Affected

- **ACTEMRA INTRAVENOUS**
- **ACTEMRA SUBCUTANEOUS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Kineret, Remicade, Humira, Orencia, Enbrel, Simponi, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis -OR- documentation of moderate to severe juvenile idiopathic rheumatoid arthritis (Actemra IV only)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Actemra SubQ, patients must have an adequate trial or intolerance to the preferred SubQ products, Enbrel and Humira, for rheumatoid arthritis. For Actemra IV, patients must have an adequate trial or intolerance to one of the preferred IV products, Remicade or Simponi Aria, for rheumatoid arthritis.

acthar h.p.

Products Affected

- **ACTHAR H.P.**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Covered for the following indications: 1. Infantile spasms (West syndrome) 2. Acute exacerbations of multiple sclerosis (MS) for patients receiving concurrent immunomodulator therapy (e.g., interferon beta, glatiramer acetate, dimethyl fumerate, fingolimod, teriflunomide) 3. Rheumatic disorders 4. Collagen diseases 5. Dermatologic diseases 6. Allergic states 7. Ophthalmic diseases 8. Respiratory diseases 9. Transfusion reaction due to serum protein reaction 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). 11. Diagnosis for adrenal insufficiency with trial/failure or contraindication to cosyntropin. 12. Gout and intolerance or contraindication to at least two first-line gout therapies (e.g, allopurinol, probenecid, colchicine). 13. Pediatric acquired epileptic aphasia. For covered indications 2 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.
Age Restrictions	
Prescriber Restrictions	neurologist for infantile spasm
Coverage Duration	1 month
Other Criteria	

actimmune

Products Affected

- **ACTIMMUNE**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

adempas

Products Affected

- **ADEMPAS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary hypertension, substantiated by results from right heart catheterization and/or direct measurement of pulmonary arterial pressure, defined as a mean pulmonary arterial pressure of greater than or equal to 25 mmHg, with a pulmonary capillary wedge pressure of less than or equal to 15 mmHg -OR- diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) (WHO group 4) after surgical treatment or inoperable CTEPH.
Age Restrictions	
Prescriber Restrictions	cardiologist, pulmonologist
Coverage Duration	12 months
Other Criteria	

ADHD Drugs

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	

afinitor

Products Affected

- **AFINITOR** **FOR SUSPENSION 2 MG, 3 MG, 5 MG**
- **AFINITOR DISPERZ ORAL TABLET**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of advanced renal cell carcinoma and trial/failure with sunitinib or sorafenib for clear cell histology -OR- documentation of patients with progressive neuroendocrine tumors of pancreatic origin (PNET) that is unresectable, locally advanced or metastatic -OR- documentation of renal angiomyolipoma and tuberous sclerosis complex (TSC) -OR- documentation of use in postmenopausal advanced hormone receptor-positive, HER2-negative breast cancer in combination with exemestane after failure of treatment with letrozole or anastrozole -OR- documentation of SEGA associated with tuberous sclerosis for those not a candidate for surgical resection-OR-documentation of progressive, well-differentiated, non-functional, neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin with unresectable, locally advanced or metastatic disease.
Age Restrictions	
Prescriber Restrictions	oncologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For renal cell carcinoma with clear cell histology additional trial/failure of cabozantinib or nivolumab per NCCN guidelines.

alecensa

Products Affected

- **ALECENSA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive AND previous trial and failure or intolerance to crizotinib (Xalkori)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

ALPHA1-PROTEINASE INHIBITORS

Products Affected

- **ARALAST NP INTRAVENOUS RECON SOLN 500 MG**
- **GLASSIA**
- **PROLASTIN-C**
- **ZEMAIRA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of panacinar emphysema AND documentation of a decline in forced expiratory volume in 1 second (fev1) despite optimal medical therapy (bronchodilators, corticosteroids, oxygen if indicated) 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.

alunbrig

Products Affected

- **ALUNBRIG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive AND previous trial and failure or intolerance to crizotinib (Xalkori)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

ampyra

Products Affected

- **AMPYRA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	Doses greater than 20 mg/day will not be approved. For reauthorization, documentation supporting improvement in walking impairment from baseline is required.

anabolic steroids

Products Affected

- **ANADROL-50**
- *methyltestosterone oral capsule*
- *oxandrolone*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis (methyltestosterone, oxymetholone, oxandrolone)-AND- either 1 or 2 when applicable to diagnosis. 1. For the diagnosis of anemia of chronic renal failure (oxymetholone) the trial/failure, intolerance or contraindication to an erythropoiesis stimulating agent is required. 2. For the diagnosis of osteoporosis (oxandrolone) the trial/failure, intolerance or contraindication to at least 2 federal legend drugs indicated for use in osteoporisis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

atypical antipsychotics

Products Affected

- **ABILIFY ORAL TABLET**
- *aripiprazole oral tablet*
- *aripiprazole oral tablet,disintegrating*
- **REXULTI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis. If medication is being used for major depressive disorder, documentation of adjunctive therapy and an adequate trial of 1 alternative antidepressant is required (e.g. SSRI, SNRI, NDRIs, TCA, MAOI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

aubagio

Products Affected

- **AUBAGIO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Aubagio and other disease modifying agents such as fingolimod, interferons, Copaxone , Tysabri
Required Medical Information	Documentation of relapsing-remitting or relapsing secondary progressive multiple sclerosis
Age Restrictions	
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	Doses greater than 14 mg per day will not be approved

austedo

Products Affected

- **AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-4) 1) chorea associated with Huntington's disease 2) trial, failure, intolerance, or contraindication to generic tetrabenazine 3) attestation of controlled depression in patients with a comorbid diagnosis of depression -AND- confirmation that patient will be concomitantly utilizing antidepressant therapy 4) attestation that patient is not actively suicidal
Age Restrictions	
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	

bavencio

Products Affected

- **BAVENCIO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of one of the following (1 or 2) 1) metastatic Merkel cell carcinoma -OR- 2) locally advanced or metastatic urothelial carcinoma in patients with progression on or after platinum-based chemotherapy -OR-in patients with progression within 12 months of neoadjuvant or adjuvant platinum-based chemotherapy
Age Restrictions	Deny if less than 12 years of age for metastatic Merkel cell carcinoma
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

belbuca

Products Affected

- **BELBUCA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of moderate to severe chronic pain -AND- trial and failure of at least two previous federal legend medications for pain, including NSAIDs, tramadol, or opioid analgesics
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Belbuca should not be used concomitantly with substance abuse therapies.

BELEODAQ

Products Affected

- **BELEODAQ**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory peripheral T-cell lymphoma (PTCL)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

berinert

Products Affected

- **BERINERT INTRAVENOUS KIT**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use for treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

bosulif

Products Affected

- **BOSULIF**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of chronic myelogenous leukemia (CML) of any phase and lack of response or intolerance to prior therapy (e.g. imatinib, dasatinib, nilotinib)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

botulinum toxin

Products Affected

- **BOTOX**
-
- **XEOMIN INTRAMUSCULAR RECON SOLN 50 UNIT**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Use for cosmetic purposes
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

brand metformin

Products Affected

- **GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 500 MG**
- **RIOMET**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Either 1, 2, or 3. 1) For oral immediate release (IR) tablets, trial/failure of generic metformin (IR). 2) For oral extended release (ER) tablets, trial/failure of generic metformin IR and metformin ER (i.e. generic Glucophage XR). 3) For Riomet oral solution, trial/failure of generic metformin IR OR documentation supporting the inability to swallow or difficulty swallowing tablets containing metformin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

brand NSAIDs

Products Affected

- **VOLTAREN TOPICAL**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND trial/failure of at least 2 generic formulary NSAIDs (e.g. diclofenac, ibuprofen, etc.) or contraindication to all oral NSAIDs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

butrans

Products Affected

- **BUPRENORPHINE**
- **BUTRANS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of moderate to severe chronic pain -AND- trial and failure of at least two previous federal legend medications for pain, including NSAIDs, tramadol, or opioid analgesics
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	buprenorphine patches should not be used concomitantly with substance abuse therapies.

cabometyx

Products Affected

- **CABOMETYX**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of advanced renal cell carcinoma (RCC) and failure of one prior anti-angiogenic therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

caprelsa

Products Affected

- **CAPRELSA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

carbaglu

Products Affected

- **CARBAGLU**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use as an adjunct therapy for acute hyperammonemia 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	

CERDELGA

Products Affected

- **CERDELGA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of type 1 Gaucher disease
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

CF drugs

Products Affected

- **BETHKIS**
- **PULMOZYME**
-
- **TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE**
- *tobramycin in 0.225 % nacl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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).

chenodal

Products Affected

- **CHENODAL**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of small (less than 15mm in diameter), floatable radiolucent gallstones AND an inadequate response 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

cholbam

Products Affected

- **CHOLBAM**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of bile acid synthesis disorders due to single enzyme defects (SEDs) -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	

cialis

Products Affected

- **CIALIS ORAL TABLET 2.5 MG, 5 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	

cimzia

Products Affected

- **CIMZIA**
- **CIMZIA POWDER FOR RECONST**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Orencia, Simponi, Actemra, Kineret
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis -OR- moderate to severe Crohn's disease -OR- psoriatic arthritis -OR- ankylosing spondylitis
Age Restrictions	
Prescriber Restrictions	Gastroenterologist/ Rheumatologist
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to one corticosteorid (e.g., prednisone or hydrocortisone) or Remicade-AND- the preferred biologic product, Humira, for a diagnosis of Crohn's disease. Patients must have an adequate trial or intolerance to both preferred products, Enbrel and Humira, for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis. For initial and indication therapy dosing, doses above plan quantity limit will be approved aligned with recommended initial and induction therapy dosing regimens per indication.

cinryze

Products Affected

- **CINRYZE**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Coverage for the following two indications: 1. Use as prophylaxis for hereditary angioedema (HAE) type I & II -AND- documentation that clinical laboratory performance C4 below lower limit of laboratory reference range -AND- C1 inhibitor level below lower limit of laboratory reference range -OR- normal C1 inhibitor level and a low C1INH functional level below laboratory reference range -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued. 2. Use as prophylaxis for hereditary angioedema (HAE) type III -AND- documentation that clinical laboratory performance C4, C1 inhibitor, and C1INH functional level are within normal limits of laboratory reference ranges -AND- documentation of family history of HAE -OR- FXII mutation -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

cometriq

Products Affected

- **COMETRIQ**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of progressive, metastatic medullary thyroid cancer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

corlanor

Products Affected

- **CORLANOR ORAL TABLET 5 MG, 7.5 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of stable, symptomatic heart failure and normal sinus rhythm AND left ventricular ejection fraction less than or equal to 35 percent AND resting heart rate greater than or equal to 70 beats per minute AND trial/failure of maximum tolerated dose of one beta-blocker used for treatment of heart failure (e.g., bisoprolol, carvedilol, metoprolol succinate) OR contraindication to beta-blocker use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

Cosentyx

Products Affected

- **COSENTYX**
- **COSENTYX PEN**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of moderate to severe psoriasis and failure of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy -OR- active psoriatic arthritis -OR- active ankylosing spondylitis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis and the preferred products, Enbrel and Humira, for psoriatic arthritis and ankylosing spondylitis. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.

cotellic

Products Affected

- **COTELLIC**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Disease progression on prior BRAF inhibitor therapy
Required Medical Information	Documentation of unresectable or metastatic melanoma in patients with a BRAF V600E or V600K mutation AND used in combination with vemurafenib
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

crinone

Products Affected

- **CRINONE**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Use to promote fertility
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

daklinza

Products Affected

- **DAKLINZA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
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	Criteria will be applied consistent with current AASLD-IDSA guidance.

darzalex

Products Affected

- **DARZALEX**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use in the treatment of multiple myeloma in one of the following (1, 2, or 3): 1) monotherapy in patients that have received at least 3 prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double-refractory to a PI and an immunomodulatory agent 2) combination therapy with lenalidomide and dexamethasone, or bortezomib and dexamethasone in patients that have received at least one prior therapy 3) combination therapy with pomalidomide and dexamethasone in patients that have received at least 2 prior therapies, including lenalidomide and a PI
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

duexis

Products Affected

- **DUEXIS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Both of the following. 1) Trial/failure of ibuprofen used in combination with famotidine. 2) Trial/failure of one additional generic formulary NSAID (other than ibuprofen) used in combination with one additional 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	

dupixent

Products Affected

- **DUPIXENT**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3): 1) moderate to severe atopic dermatitis 2) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- trial & failure, intolerance, or contraindication to at least one non-fluorinated topical corticosteroid for patients requesting treatment for atopic dermatitis of the face 3) trial & failure, intolerance, or contraindication to tacrolimus ointment, or pimecrolimus cream, or crisaborole ointment
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For induction dosing, doses above the plan quantity limit will be allowed upon prior authorization approval aligned with FDA approved induction therapy dosing regimen. For maintenance dosing, additional quantities above the plan limit will be reviewed via the quantity limit exception process. Reauthorization or continuation of therapy will be approved when attestation of improvement or response to therapy is provided.

egfr tyrosine kinase inhibitors

Products Affected

- **GILOTRIF**
- **TARCEVA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- both of the following. 1) Epidermal growth factor receptor (EGFR) mutations, if applicable to diagnosis. 2) Alternatives tried/failed and concomitant therapy, if applicable to diagnosis
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Coverage of pancreatic cancer diagnosis applies only to erlotinib (Tarceva). The use of Tarceva and Gilotrif for non-small cell lung cancer (NSCLC) will be approved as a first-line therapy. Applies to new starts only.

egrifta

Products Affected

- **EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	Applies to new starts only

emflaza

Products Affected

- **EMFLAZA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of Duchenne muscular dystrophy (DMD) with mutation of dystrophin gene -AND- onset of weekness or history of DMD starting before age 5 -AND- One of the following (1 or 2). 1) 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). 2) 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	Deny if less than 5 years of age
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	

enbrel

Products Affected

- **ENBREL SUBCUTANEOUS RECON SOLN**
- **ENBREL SUBCUTANEOUS SYRINGE**
- **25 MG/0.5ML (0.51), 50 MG/ML (0.98 ML)**
- **ENBREL SURECLICK**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Remicade, Cimzia, Humira, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe juvenile idiopathic rheumatoid arthritis and an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunamide) -OR- moderate to severe psoriasis after failure or intolerance of either systemic therapy (e.g., methotrexate or cyclosporine) or phototherapy or contraindication to systemic therapies or phototherapy.
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	rheumatologist, dermatologist
Coverage Duration	12 months
Other Criteria	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required.

entresto

Products Affected

- **ENTRESTO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of an ACE inhibitor or ARB
Required Medical Information	Documentation of chronic heart failure (NYHA Class II to IV) AND systolic dysfunction (LVEF less than or equal to 40 percent)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

epclusa

Products Affected

- **EPCLUSA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	G1,2,3,4,5,6: 12w, 24w criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than one tablet per day will not be approved.

erivedge

Products Affected

- **ERIVEDGE**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of advanced basal cell carcinoma (BCC), which includes metastatic and locally advanced basal cell carcinoma, for whom surgery is inappropriate
Age Restrictions	
Prescriber Restrictions	oncologist, dermatologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only, doses greater than 150mg/day will not be approved

exondys

Products Affected

- **EXONDYS 51**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-5): 1. diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 51 skipping. 2. Age less than 18 yo. 3. 3. Documented use of stable doses of oral corticosteroids for at least 6 months prior to initiating therapy. 4. Member is ambulatory (with or without assistance), not wheelchair dependent.
Age Restrictions	
Prescriber Restrictions	Neurologist or other physician who specializes in tratment of DMD
Coverage Duration	12 months
Other Criteria	

farydak

Products Affected

- **FARYDAK**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use in combination with bortezomib and dexamethasone for patients with multiple myeloma who have received at least 2 prior regimens, including bortezomib and an immunomodulatory agent (i.e. Thalomid, Revlimid, Pomolyst)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

firazyr

Products Affected

- **FIRAZYR**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Acute hereditary angioedema (HAE) type I & II: Documentation that clinical laboratory performance C4 below lower limit of laboratory reference range -AND- C1 inhibitor level below lower limit of laboratory reference range -OR- normal C1 inhibitor level and a low C1INH functional level below laboratory reference range -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued. Acute hereditary angioedema (HAE) type III: Documentation that clinical laboratory performance C4, C1 inhibitor level and C1INH functional level are within normal limits of the laboratory's reference range -AND- documentation of HAE family history -OR- FXL mutation -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

flector

Products Affected

- **FLECTOR**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to 2 oral generic NSAIDs one of which must be diclofenac
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	

forteo

Products Affected

- **FORTEO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Diagnosis of underlying hypercalcemic disorder such as hypercalcemia, hyperparathyroidism or hypoparathyroidism, or high risk for osteosarcoma (Paget's disease, prior radiation therapy, bone metastases, open epiphyses, etc.). Treatment duration greater than 24 months.
Required Medical Information	Documentation to support use for treatment of osteoporosis and the prevention of fractures in postmenopausal women and men having a T score of less than -2.5 and a trial and failure or contraindication to at least one bisphosphonate -OR- use to prevent fractures in men and postmenopausal women with a low bone mass (T score between -1.0 and -2.5) and history of previous osteoporotic fracture or those who are found to have a 10-year risk of major osteoporotic fracture greater than or equal to 20 percent or a risk of hip fracture greater than or equal to 3 percent and had a trial and failure or contraindication to at least one bisphosphonate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Tymlos or Forteo will be limited to a coverage duration of 24 months.

gattex

Products Affected

- **GATTEX ONE-VIAL**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of short bowel syndrome (SBS) AND dependence on parenteral nutrition or intravenous nutritional support for at least 12 months AND requiring parenteral nutrition at least 3 times per week
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

gilenya

Products Affected

- **GILENYA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Gilenya and other disease modifying agents such as interferons, Copaxone , Tysabri
Required Medical Information	Members must have a documented diagnosis of relapsing-remitting, relapsing secondary progressive or progressive relapsing multiple sclerosis -AND- new starts to therapy have the following baseline information documented within 6 months of initiating therapy: ophthalmologic evaluation, liver transaminase and bilirubin, complete blood count, and electrocardiogram if using an antiarrhythmic agent or have second degree or greater AV block -AND- new starts to therapy do not have any of the following comorbid conditions or concomitant therapies: bradycardia, congestive heart failure, sick sinus syndrome, prolonged QT interval, ischemic cardiac disease, irregular heartbeat, current neutropenia, current chronic or acute infections, use of antineoplastics, immunosuppressive or immune modulating therapies
Age Restrictions	
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	Doses greater than 0.5mg/day will not be approved

gleevec

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis and alternatives tried or concomitant therapy, if applicable for diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

gralise

Products Affected

- **GRALISE**
- **GRALISE 30-DAY STARTER PACK**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

GRASTEK

Products Affected

- **GRASTEK**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Asthma (severe, unstable or unconrolled), 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	allergy specialist, otolaryngologist, immunologist
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector

growth hormone

Products Affected

- **GENOTROPIN**
- **GENOTROPIN MINIQUICK**
- **HUMATROPE**
- **NORDITROPIN FLEXPRO**
- **NUTROPIN AQ NUSPIN**
- **SAIZEN**
- **SAIZEN CLICK.EASY**
- **SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG**
- **ZOMACTON**
- **ZORBTIVE**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis, growth chart, bone age, growth velocity, and response to stimulation test, when applicable
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

HARVONI

Products Affected

- **HARVONI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	G1:12w txn nocir, t/f PR.24w txex cir, t/fPI,SOF.G4,5,6:12w.DcpG1,4:12,24w t/fSOF.PosttxG1,4:12,24w
Other Criteria	Doses greater than one tablet per day will not be approved.

HETLIOZ

Products Affected

- **HETLIOZ**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Non-24 Sleep-Wake disorder -AND- patient is totally blind
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

high-risk meds

Products Affected

- *amitriptyline*
- *amitriptyline-chlordiazepoxide*
- *carisoprodol-asa-codeine*
- *clomipramine*
- *cyclobenzaprine oral tablet*
- *digitek*
- *digoxin injection solution*
- *digoxin oral solution 50 mcg/ml*
- *digoxin oral tablet*
- *doxepin oral*
- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*
- *imipramine hcl*
- **LANOXIN**
- *nitrofurantoin*
- *nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg*
- *nitrofurantoin monohyd/m-cryst*
- *perphenazine-amitriptyline*
- *promethazine oral syrup*
- **SILENOR**
- **SURMONTIL**
- *trimipramine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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. In addition to requirements 1 through 3 above, for digoxin doses exceeding 0.125 mg daily, provider confirmation that a lower dose of digoxin has or would be ineffective in managing the member's condition is required. For the target high-risk medications glyburide, TCAs and nitrofurantoin, 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. Non-high risk alternative medications for those target high-risk medications include the following: 1. Glyburide (non-high risk alternatives include glipizide and glimepiride) 2. TCAs (non-high risk alternatives include SSRIs and SNRIs) 3. Nitrofurantoin (non-high risk alternatives include Bactrim, Cipro, or cephalexin). If using one of the above 3 high-risk medications for a medically-accepted indication not shared by the safer alternatives listed, then no trial of alternatives is required for that target high-risk medication.
Age Restrictions	Automatic approval if less than 65 years of age

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected class drugs. Digoxin doses less than or equal to 0.125 mg per day and doxepin doses less than or equal to 6 mg per day will receive automatic approval.

homozygous fh

Products Affected

- **JUXTAPID**
- **KYNAMRO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic testing showing functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality -OR- untreated LDL-C concentrations greater than 500 mg/dL, treated LDL-C concentrations greater than or equal to 300 mg/dL, or a non-HDL-C concentration greater than or equal to 330mg/dL -AND- the presence of Xanthomas in the first decade of life -OR- documentation of elevated LDL-C greater than 190 mg/dL prior to lipid-lowering therapy consistent with HoFH in both parents -AND- will not be used concomitantly with a PCSK9 inhibitor [e.g. alirocumab (Praluent), evolocumab (Repatha)].
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Patients must have an adequate trial/failure or contraindication to the preferred product Repatha.

horizant

Products Affected

- **HORIZANT**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of moderate to severe active primary restless leg syndrome and trial and failure of two accepted medications for the treatment of this condition one of which must include pramipexole or ropinirole -OR- documentation of post herpetic neuralgia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

humira

Products Affected

- **HUMIRA**
- **HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 40 MG/0.8 ML (6 PACK)**
- **HUMIRA PEN**
- **HUMIRA PEN CROHN'S-UC-HS START**
- **HUMIRA PEN PSORIASIS-UVEITIS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Remicade, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of moderate to severe hidradenitis suppurativa -OR- moderate to severe rheumatoid arthritis -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe juvenile idiopathic rheumatoid arthritis and an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunamide) -OR- moderate to severe psoriasis after failure of either systemic therapy (e.g., methotrexate or cyclosporine) or phototherapy. -OR- moderate to severe Crohn's disease after failure of two immunosuppressants (e.g., corticosteroids, azathioprine) or monotherapy with infliximab -OR- moderate to severe ulcerative colitis after failure of two immunosuppressants (e.g. corticosteroids, azathioprine or 6-mercaptopurine)-OR-non-infectious uveitis (including intermediate, posterior, and panuveitis)
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	rheumatologist, dermatologist, gastroenterologist, ophthalmologist
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required. For Crohn's disease in adults (18 years or older), trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine) or monotherapy with infliximab is required. For Crohn's disease in pediatrics, trial of 1 immunosuppressant (e.g. corticosteroids, azathioprine) or monotherapy with infliximab is required. For Ulcerative Colitis, trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine or 6-mercaptopurine) is required. 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. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit.

Ibrance

Products Affected

- **IBRANCE**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of ER-positive, HER2-negative breast cancer in postmenopausal women and used as initial endocrine-based therapy for advanced disease in combination with an aromatase inhibitor-OR-documentation of use with fulvestrant (Faslodex) in women with HR-positive, HER2-negative metastatic breast cancer with disease progression following endocrine therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

iclusig

Products Affected

- **ICLUSIG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of T3151 chronic phase, accelerated phase or blast phase CML -OR- documentation of T3151 Ph+ ALL -OR- documentation of chronic phase, accelerated phase or blast phase CML in patients for whom no other tyrosine kinase inhibitor therapy is indicated -OR- documentation of Ph+ ALL in patients for whom no other tyrosine kinase inhibitor therapy is indicated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

idhifa

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

ig

Products Affected

- **BIVIGAM**
- **CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM**
- **FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %**
- **GAMASTAN S/D**
- **GAMMAGARD LIQUID**
- **GAMMAGARD S-D (IGA**
- **GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)**
- **GAMMAPLEX**
- **GAMMAPLEX (WITH SORBITOL)**
- **GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)**
- **OCTAGAM**
- **PRIVIGEN**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For select diagnoses the following apply- 1) For Myasthenia Gravis Syndrome, documentation that the patient is refractory to other standard therapies (e.g., cholinesterase inhibitors, corticosteroids, azathioprine) given in therapeutic doses over at least 3 months OR is intolerant of/has a 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 of/has a 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 of/has a contraindication to corticosteroids.
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

imbruvica

Products Affected

- **IMBRUVICA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of mantle cell lymphoma and treatment with at least one prior therapy -OR- documentation of chronic lymphocytic leukemia or small lymphocytic lymphoma -OR- documentation of chronic lymphocytic leukemia or small lymphocytic lymphoma with 17p deletion -OR- documentation of Waldenstrom macroglobulinemia -OR- documentation of marginal zone lymphoma in patients who require systemic therapy and have received at least one prior anti-CD20-based therapy -OR- documentation of chronic graft versus host disease in patients who have tried and failed one or more lines of systemic therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

imfinzi

Products Affected

- **IMFINZI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic urothelial carcinoma in patients with progression on or after platinum-based chemotherapy -OR-in patients with progression within 12 months of neoadjuvant or adjuvant platinum-based chemotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

increlex

Products Affected

- **INCRELEX**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis, growth chart, stimulation test results, growth velocity, IGF-1 level
Age Restrictions	Deny if greater than 18 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

inflectra

Products Affected

- **INFLECTRA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Humira, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe psoriasis after failure of systemic therapy or phototherapy -OR- moderate to severe Crohn's disease after failure of two immunosuppressants -OR- moderate to severe ulcerative colitis after failure of two immunosuppressants
Age Restrictions	For Crohn's disease, deny if less than 6 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required. For Crohn's disease and ulcerative colitis, trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine, 6-mercaptopurine) is required.

ingrezza

Products Affected

- **INGREZZA ORAL CAPSULE 40 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of tardive dyskinesia and trial, failure, or intolerance of generic tetrabenazine
Age Restrictions	
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	

inlyta

Products Affected

- **INLYTA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of advanced renal cell carcinoma (RCC) and failure one prior systemic therapy
Age Restrictions	
Prescriber Restrictions	oncologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

interferon alfa

Products Affected

- **INTRON A INJECTION**
- **PEGASYS**
- **PEGASYS PROCLICK**
- **PEGINTRON REDIPEN SUBCUTANEOUS PEN INJECTOR**
- **PEGINTRON SUBCUTANEOUS KIT 120 MCG/0.5 ML**
- **PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5 ML**
- **SYLATRON**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis only
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

interleukin-1b blockers

Products Affected

- **ARCALYST** **RECON SOLN**
- **ILARIS (PF) SUBCUTANEOUS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use with agents that inhibit IL-1 or TNF including Remicade, Humira, Enbrel, Orencia, or Kineret
Required Medical Information	documentation of diagnosis
Age Restrictions	Deny if less than 12 years of age (Arcalyst) or less than 2 years of age (Ilaris)
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

IPF AGENTS

Products Affected

- **ESBRIET ORAL CAPSULE MG**
- **ESBRIET ORAL TABLET 267 MG, 801 •**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of pirfenidone and nintedanib
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%.
Age Restrictions	
Prescriber Restrictions	pulmonologist
Coverage Duration	12 months
Other Criteria	

iressa

Products Affected

- **IRESSA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer (NSCLC) in patients whose tumors express EGFR exon 19 deletion mutations or exon 21 (L858R) mutations as detected by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

jakafi

Products Affected

- **JAKAFI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only. Platelet count to be provided.

kalydeco

Products Affected

- **KALYDECO ORAL GRANULES IN PACKET**
- **KALYDECO ORAL TABLET**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Homozygous for the F508del mutation in the CFTR gene
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	Deny if less than 6 years of age for oral tablets and less than 2 years of age for oral granules
Prescriber Restrictions	pulmonologist
Coverage Duration	12 months
Other Criteria	Doses greater than 300mg/day will not be approved

kanuma

Products Affected

- **KANUMA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of Lysosomal Acid Lipase (LAL) deficiency
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

keveyis

Products Affected

- **KEVEYIS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	12 months
Other Criteria	Doses exceeding 200 mg per day will not be approved.

kevzara

Products Affected

- **KEVZARA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of a biologic DMARD (e.g., Xeljanz, Enbrel, Humira, Kineret, Orencia, Remicade, Cimzia, or Simponi)
Required Medical Information	Documentation of all of the following (1 AND 2). 1)Diagnosis of rheumatoid arthritis (RA) -AND- 2) Trial, failure, or intolerance to at least one DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine, cyclosporine)
Age Restrictions	
Prescriber Restrictions	Deny if less than 18 years of age
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial, failure, or intolerance to at least two biologic products indicated for the treatment of RA (e.g. Humira, Enbrel, Actemra, Xeljanz, Xeljanz XR)

KEYTRUDA

Products Affected

- **KEYTRUDA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of unresectable or metastatic melanoma -OR- metastatic non-small cell lung cancer (NSCLC) with PD-L1-positive expressing tumor, as determined by an FDA-approved test, after failure of prior platinum-based chemotherapy-OR-recurrent or metastatic head and neck squamous cell carcinoma (HNSCC) with disease progression on or after platinum-containing chemotherapy-OR-classical Hodgkins lymphoma that is refractory, or has relapsed after three or more prior lines of therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

kineret

Products Affected

- **KINERET**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Actemra, Remicade, Humira, Orencia, Enbrel, Simponi, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and trial and failure of one DMARD -OR- neonatal-onset multisystem inflammatory disease (NOMID) or chronic infantile neurological, cutaneous and articular (CINCA) syndrome
Age Restrictions	
Prescriber Restrictions	rheumatologist, pediatrician
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for rheumatoid arthritis.

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
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of ER-positive, HER2-negative advanced or metastatic breast cancer in postmenopausal women AND used as initial endocrine-based therapy for advanced or metastatic disease in combination with letrozole (Femara) or another aromatase inhibitor
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

korlym

Products Affected

- **KORLYM**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of hyperglycemia secondary to hypercortisolism in patients with endogenous Cushing's syndrome who have Type 2 Diabetes Mellitus or glucose intolerance AND patient is not a candidate for surgery or radiotherapy or where surgery or radiotherapy has failed
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

lenvima

Products Affected

- **LENVIMA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of locally recurrent or metastatic, progressive, radioactive iodine refractory differentiated thyroid cancer-OR-advanced renal cell carcinoma when both of the following are met. 1) Lenvima will be used in combination with everolimus AND 2) trial of at least one prior anti-angiogenic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

leukotriene modifiers

Products Affected

- **ZILEUTON**
- **ZYFLO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of asthma -AND- trial/failure of generic montelukast
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

lidoderm

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
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) -OR- documentation of diabetic neuropathy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

lonsurf

Products Affected

- **LONSURF**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic colorectal cancer 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
Age Restrictions	
Prescriber Restrictions	oncologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

lynparza

Products Affected

- **LYNPARZA ORAL CAPSULE**
- **LYNPARZA ORAL TABLET**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use as monotherapy in patients with deleterious or suspected deleterious germline BRCA mutated advanced ovarian cancer after trial of three or more prior lines of chemotherapy (e.g. carboplatin, cisplatin, paclitaxel, gemcitabine) -OR- documentation of use as maintenance treatment in patients with recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, who are in a complete or partial response to platinum-based chemotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

lyrica

Products Affected

- **LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG**
- **LYRICA ORAL SOLUTION**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of DPN and trial/failure or intolerance to duloxetine-OR-PHN and trial/failure or intolerance to gabapentin -OR- 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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

mavyret

Products Affected

- **MAVYRET**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
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	Doses greater than three tablets per day will not be approved.

mekinist

Products Affected

- **MEKINIST**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Disease progression on prior BRAF inhibitor therapy
Required Medical Information	Documentation of unresectable or metastatic melanoma with BRAFV600E or BRAFV600K mutations -OR- documentation of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

methamphetamine

Products Affected

- *methamphetamine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

mozobil

Products Affected

- **MOZOBIL**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	used in combination with granulocyte-colony stimulating factor (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with multiple myeloma (MM) and non-Hodgkins lymphoma (NHL).
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

myalept

Products Affected

- **MYALEPT**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of congenital or acquired generalized lipodystrophy with absence or loss of subcutaneous body fat -AND- Leptin levels less than 8 ng/mL for males or less than 12 ng/mL for females -AND- the patient has been optimized on current diabetic medication and/or hypertriglyceridemia medication as needed -AND- the member has a diagnosis of diabetes or fasting insulin levels greater than 30uU/mL or fasting hypertriglyceridemia greater than 200mg/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

namenda

Products Affected

- **NAMENDA ORAL TABLET**
- **NAMENDA TITRATION PAK**
- **NAMENDA XR**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and trial/failure of generic memantine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

namzaric

Products Affected

- **NAMZARIC**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
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	

natpara

Products Affected

- **NATPARA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use as an adjunct to calcium and vitamin D to control hypocalcemia in patients with hypoparathyroidism
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

nerlynx

Products Affected

- **NERLYNX**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of early-stage HR-positive, HER2-positive breast cancer in patients who have received adjuvant trastuzumab-based therapy
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

nexavar

Products Affected

- **NEXAVAR**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of hepatocellular carcinoma -OR- advanced renal cell carcinoma after treatment of 1 other systemic therapy -OR- locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

ninlaro

Products Affected

- **NINLARO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

NORTHERA

Products Affected

- **NORTHERA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

nucala

Products Affected

- **NUCALA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of severe asthma evidenced by pretreatment forced expiratory volume in 1 second (FEV1) less than 80% predicted and FEV1 reversibility of at least 12% after albuterol administration -AND- Either 1 or 2. 1)History of 2 or more exacerbations in the previous year despite at least 12 months of high-dose inhaled corticosteroid (ICS) given in combination with at least 3 months of controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], or theophylline), unless intolerant of or contraindication to all of these agents. 2)Symptoms are inadequately controlled with use of 6 months of ICS with daily oral glucocorticoids given in combination with a minimum of 3 months of controller medication (e.g. LABA, LTRA, or theophylline), unless intolerant of or contraindication to all of these agents. -AND- 3 or 4. 3)Greater than or equal to 150 cells/uL screening within 6 weeks of dosing. 4)Greater than or equal to 300 cells/uL within 12 months of screening.
Age Restrictions	Deny if less than 12 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

nuplazid

Products Affected

- **NUPLAZID**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	Applies to new starts only

OAB drugs

Products Affected

- **GELNIQUE TRANSDERMAL GEL IN PACKET**
- **OXYTROL**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial/failure of at least 2 generic alternatives (e.g. oxybutynin, trospium, tolterodine)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

ocaliva

Products Affected

- **OCALIVA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

odomzo

Products Affected

- **ODOMZO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

olysio

Products Affected

- **OLYSIO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Previous failure of a Protease Inhibitor used in hepatitis C (boceprevir, telaprevir or simeprevir) -OR- decompensated cirrhosis
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 18 years old
Prescriber Restrictions	
Coverage Duration	12 wks or 24 wks depending on treatment regimen and presence or absence of cirrhosis
Other Criteria	Doses greater than or less than 150mg/day will not be approved

opdivo

Products Affected

- **OPDIVO INTRAVENOUS SOLUTION 40 MG/4 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of unresectable or metastatic melanoma in combination with ipilimumab (Yervoy) or, as monotherapy if BRAF V600 mutation positive or BRAF V600 wild-type -OR- documentation of metastatic squamous non-small cell lung cancer (NSCLC) with progression on or after platinum-based chemotherapy -OR- documentation of advanced renal cell carcinoma in patients who have received prior antiangiogenic therapy -OR- documentation of classical Hodgkin lymphoma that has relapsed or progressed after autologous hematopoietic stem cell transplantation (HSCT) and brentuximab vedotin or 3 or more lines of systemic therapy that includes autologous HSCT -OR- documentation of recurrent or metastatic squamous cell carcinoma of the head and neck with disease progression on or after a platinum-based therapy -OR- documentation of locally advanced or metastatic urothelial carcinoma that has progressed during or following platinum-based chemotherapy or that has progressed w/in 12 mos of neoadjuvant or adjuvant treatment with platinum-based chemotherapy -OR- documentation of microsatellite instability-high or mismatch repair deficient metastatic colorectal cancer that has progressed after treatment w/ a fluoropyrimidine, oxaliplatin, and irinotecan -OR- documentation of hepatocellular carcinoma in patients who have been previously treated with sorafenib
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

oralair

Products Affected

- **ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Asthma (severe, unstable or unconrolled), 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, 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 10 years of age or greater than 65 years of age
Prescriber Restrictions	allergy specialist, otolaryngologist, immunologist
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector

orencia

Products Affected

- **ORENCIA (WITH MALTOSE) SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML**
- **ORENCIA CLICKJECT**
- **ORENCIA SUBCUTANEOUS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Orencia, Simponi, Kineret, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis -OR- documentation of moderate to severe juvenile idiopathic rheumatoid arthritis -OR- documentation of psoriatic arthritis
Age Restrictions	
Prescriber Restrictions	rheumatologist
Coverage Duration	12 months
Other Criteria	For Orencia SubQ, patients must have an adequate trial or intolerance to the preferred SubQ products, Enbrel and Humira, for rheumatoid arthritis and psoriatic arthritis. For Orencia IV, patients must have an adequate trial or intolerance to one of the preferred IV products, Remicade or Simponi Aria, for rheumatoid arthritis or Remicade for psoriatic arthritis.

orkambi

Products Affected

- **ORKAMBI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis and homozygous F508del mutation
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 showing a FEV1 improvement from baseline must be provided.

OTEZLA

Products Affected

- **OTEZLA**
- **OTEZLA STARTER ORAL**

TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of active psoriatic arthritis -OR- documentation of moderate to severe psoriasis
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	rheumatologist, dermatologist
Coverage Duration	12 months
Other Criteria	Maintenance doses greater than 60 mg per day will not be approved. Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for psoriatic arthritis and psoriasis.

otrexup

Products Affected

- **OTREXUP (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.4 ML, 12.5 MG/0.4 ML, 15 MG/0.4 ML, 17.5 MG/0.4 ML, 20 MG/0.4 ML, 22.5 MG/0.4 ML, 25 MG/0.4 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to oral generic methotrexate tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

pomalyst

Products Affected

- **POMALYST**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of multiple myeloma, previous trial of at least 2 therapies including lenalidomide and bortezomib, and disease progression on or within 60 days of last therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

praluent

Products Affected

- **PRALUENT PEN**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of the following: 1. Heterozygous Familial Hypercholesterolemia (HeFH) as supported by the presence of causal mutation of familial hypercholesterolemia by genetic testing, physical signs of FD (e.g. xanthomas, xanthelasma), clinical diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register diagnostic criteria AND LDL-C greater than or equal to 190 mg/dL prior to lipid lowering therapy (greater than or equal to 160 mg/dL if age less than 20) or LDL-C greater than or equal to 160 mg/dL after treatment with antihyperlipidemic agents but prior to Praluent therapy AND Previous treatment with at least two trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has been ineffective in achieving LDL-C goal AND Praluent must be used concomitantly with a statin which is dosed at maximally tolerated dose OR documentation of statin intolerance is provided as defined by statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin. 2. Hypercholesterolemia ASCVD (e.g. acute coronary syndrome, history of myocardial infarction) AND Previous treatment with at least two trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has been ineffective in achieving LDL-C goal (LDL-C is still greater than or equal to 100 mg/dL) AND Praluent must be used concomitantly with a statin which is dosed at maximally tolerated dose OR documentation of statin intolerance is provided as defined by statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization

PA Criteria	Criteria Details
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Praluent therapy from baseline must be provided.

prescription drug combo

Products Affected

- *acetaminophen-codeine oral solution 120-12 mg/5 ml*
- *acetaminophen-codeine oral tablet*
- *alprazolam intensol*
- *alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg*
- *alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *ascomp with codeine*
- *butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg*
- *codeine sulfate oral tablet*
- **DOLOPHINE ORAL TABLET 10 MG, 5 MG**
- **DURAGESIC TRANSDERMAL PATCH 72 HOUR 100 MCG/HR, 12 MCG/HR, 25 MCG/HR, 50 MCG/HR, 75 MCG/HR**
- **EMBEDA ORAL CAPSULE,ORAL ONLY,EXT.REL PELL**
- *endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg*
- **EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 16 MG, 32 MG, 8 MG**
- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*
- **FENTANYL TRANSDERMAL PATCH 72 HOUR 37.5 MCG/HOUR, 62.5 MCG/HOUR, 87.5 MCG/HOUR**
- **HALCION ORAL TABLET 0.25 MG**
- **HYCET**
- *hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml*
- *hydrocodone-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*
- *hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg*
- *hydromorphone (pf)*
- *hydromorphone injection syringe 2 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**
- *ibuprofen-oxycodone*
- **KADIAN ORAL CAPSULE,EXTEND.RELEASE PELLETS 10 MG, 100 MG, 20 MG, 200 MG, 30 MG, 40 MG, 50 MG, 60 MG, 80 MG**
- *levorphanol tartrate*
- *lorcet (hydrocodone)*
- *lorcet hd*
- *lorcet plus oral tablet 7.5-325 mg*
- *methadone oral solution 10 mg/5 ml, 5 mg/5 ml*
- *methadone oral tablet 10 mg, 5 mg*
- *morphine concentrate oral solution*
- **MORPHINE INTRAVENOUS SYRINGE 10 MG/ML, 8 MG/ML**
- *morphine intravenous syringe 2 mg/ml, 4 mg/ml*
- *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*
- *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*
- **NORCO**
- **OPANA ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 5 MG, 7.5 MG**
- **OPANA ORAL**
- *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, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG**
- *oxycodone-acetaminophen oral solution*
- *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg*
- *oxycodone-aspirin*
- **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 ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG**
- **PRIMLEV**
- **ROXICODONE ORAL TABLET 15 MG, 30 MG, 5 MG**
- **SYNALGOS-DC**
- *triazolam*
- **TYLENOL-CODEINE #3**
- **TYLENOL-CODEINE #4**
- *vicodin*
- *vicodin es*
- *vicodin hp*
- **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**
- **XODOL 10/300**
- **XODOL 5/300**
- **XODOL 7.5/300**
- **XTAMPZA ER**
- *zamicet*
- **ZOHYDRO ER ORAL CAPSULE, ORAL ONLY, ER 12HR**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For concomitant use of an opiate agonist and substance abuse therapy, documentation that the member has a documented 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 relaxant (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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Opiate+subs. abuse tx, approve opiate x 1mo. Opiate+benzo+carisoprodol, approve x 12mo.
Other Criteria	Opiate agonists will receive automatic approval if no recent claims for a substance abuse therapy (e.g, buprenorphine-naloxone) OR a benzodiazepine (e.g., triazolam, alprazolam) AND a centrally acting skeletal muscle relaxant (e.g., carisoprodol). Benzodiazepines (e.g, triazolam, alprazolam) will receive automatic approval if no recent claims for an opiate agonist (e.g., oxycodone, hydrocodone, oxymorphone) AND a centrally acting skeletal muscle relaxant (e.g., carisoprodol).

pristiq

Products Affected

- **FETZIMA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder and trial and failure of two other antidepressants.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

PROCYSBI

Products Affected

- **PROCYSBI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of nephropathic cystinosis AND previous trial and failure or intolerance to immediate-release cysteamine bitartrate (Cystagon)
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

prolia

Products Affected

- **PROLIA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy or women at high risk for fracture receiving adjuvant aromatase inhibitor therapy -OR- use for treatment of osteoporosis and the prevention of fractures in postmenopausal women and men having a T score of less than -2.5 and a trial and failure or contraindication to at least one bisphosphonate -OR- use to prevent fractures in men and postmenopausal women with a low bone mass (T score between -1.0 and -2.5) and history of previous osteoporotic fracture or those who are found to have a 10-year risk of major osteoporotic fracture greater than or equal to 20 percent or a risk of hip fracture greater than or equal to 3 percent and had a trial and failure or contraindication to at least one bisphosphonate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Covered under Part B for female 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

provigil

Products Affected

- *armodafinil*
- *modafinil*
- **PROVIGIL**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of 1 of the following. 1) Diagnosis of shift work sleep disorder (SWSD) as defined by a minimum of 5 night shifts per month with at least 3 of those nights occuring consecutively and the shift is 6 to 12 hours in duration occuring between 10pm and 8am. 2) Diagnosis of narcolepsy documented by MSLT less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) or other appropriate testing. 3) Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography. Diagnosis established in accordance with ICSD or DSM V criteria acceptable for all indications.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

pulmonary arterial hypertension

Products Affected

- **ADCIRCA**
- **LETAIRIS**
- **OPSUMIT**
- **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG**
- **REVATIO INTRAVENOUS**
- **REVATIO ORAL SUSPENSION FOR RECONSTITUTION**
- **REVATIO ORAL TABLET**
- *sildenafil (antihypertensive) intravenous*
- *sildenafil (antihypertensive) oral*
- **TRACLEER**
- **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
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization and/or direct measurement of pulmonary arterial pressure, defined as a mean pulmonary arterial pressure of greater than or equal to 25 mmHg at rest, with a pulmonary capillary wedge pressure of less than or equal to 15 mmHg, and a PVR greater than 3 Wood units -AND- WHO Group -AND- WHO/NYHA Functional Class ll or lll symptoms (Adcirca, Orenitram, Letairis, Revatio, Opsumit, Uptravi), WHO/NYHA Funtional Class ll, lll, or lV (Tracleer), WHO/NYHA Functional Class lll (Orenitram)
Age Restrictions	
Prescriber Restrictions	cardiologist, pulmonologist
Coverage Duration	12 months
Other Criteria	

radicava

Products Affected

- **RADICAVA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

RAGWITEK

Products Affected

- **RAGWITEK**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Asthma (severe, unstable or unconrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
Required Medical Information	Documentation of allergic rhinitis and use for ragweed pollen -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 18 years of age or greater than 65 years of age
Prescriber Restrictions	allergy specialist, otolaryngologist, immunologist
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector

rasuvo

Products Affected

- **RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to oral generic methotrexate tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

ravicti

Products Affected

- **RAVICTI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Urea cycle disorders due to N-acetylglutamatesynthetase deficiency
Required Medical Information	Documentation of chronic management of a urea cycle disorders (UCDs)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

relistor

Products Affected

- **RELISTOR ORAL**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation due to chronic non-cancer pain -AND- documentation of opioid medication use for at least one month -AND- trial and failure, contraindication, or intolerance to 2 of the following 1.)laxatives, 2.)Amitiza, 3.)Movantik.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

remicade

Products Affected

- **REMICADE**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Humira, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe psoriasis after failure of systemic therapy or phototherapy -OR- moderate to severe Crohn's disease after failure of two immunosuppressants -OR- moderate to severe ulcerative colitis after failure of two immunosuppressants
Age Restrictions	For Crohn's disease and ulcerative colitis, deny if less than 6 years old
Prescriber Restrictions	rheumatologist, dermatologist, or gastroenterologist
Coverage Duration	12 months
Other Criteria	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required. For Crohn's disease and ulcerative colitis, trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine, 6-mercaptopurine) is required.

renflexis

Products Affected

- **RENFLEXIS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Humira, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe psoriasis after failure of systemic therapy or phototherapy -OR- moderate to severe Crohn's disease after failure of two immunosuppressants -OR- moderate to severe ulcerative colitis after failure of two immunosuppressants
Age Restrictions	For Crohn's disease, deny if less than 6 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required. For Crohn's disease and ulcerative colitis, trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine, 6-mercaptopurine) is required.

repatha

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	1.Homozygous Familial Hypercholesterolemia(HoFH) supported by genetic confirmation of two mutant alleles at LDLR, APOB, OCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL(or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 yrs or heterozygous familial hypercholesterolemia (HeFH) in both parents AND Repatha will be used with a maximally tolerated statin unless all statins are contraindicated or not tolerated AND Repatha will not be used with lomitapide, mipomersen, or another PCSK9 inhibitor. 2.HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FD(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190mg/dL prior to lipid lowering therapy (greater than or equal to 160mg/dL if age less than 20) or LDL-C greater than or equal to 160mg/dL after treatment with antihyperlipidemic agents but prior to Repatha therapy AND Prior therapy with at least 2 trials of different high-intensity statins(e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance as defined by statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin. 3. Hypercholesterolemia ASCVD AND Prior therapy with at least 2 trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal(LDL-C is still greater than or equal to 100mg/dL) AND must be used with maximally tolerated statin dose OR documentation of statin intolerance as defined by statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin.
Age Restrictions	Deny if less than 18 years of age for HeFH and ASCVD or less than 13 years of age for HoFH

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. For HoFH diagnosis, 3 syringes per month will be approved aligned with recommended dosing regimen for this indication.

repatha pushtronex

Products Affected

- **REPATHA PUSHTRONEX**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	1.Homozygous Familial Hypercholesterolemia(HoFH) supported by genetic confirmation of two mutant alleles at LDLR, APOB, OCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL(or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 yrs or heterozygous familial hypercholesterolemia (HeFH) in both parents AND Repatha will be used with a maximally tolerated statin unless all statins are contraindicated or not tolerated AND Repatha will not be used with lomitapide, mipomersen, or another PCSK9 inhibitor. 2.HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FD(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190mg/dL prior to lipid lowering therapy (greater than or equal to 160mg/dL if age less than 20) or LDL-C greater than or equal to 160mg/dL after treatment with antihyperlipidemic agents but prior to Repatha therapy AND Prior therapy with at least 2 trials of different high-intensity statins(e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance as defined by statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin. 3. Hypercholesterolemia ASCVD AND Prior therapy with at least 2 trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal(LDL-C is still greater than or equal to 100mg/dL) AND must be used with maximally tolerated statin dose OR documentation of statin intolerance as defined by statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin.
Age Restrictions	Deny if less than 18 years of age for HeFH and ASCVD or less than 13 years of age for HoFH

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. Requests for greater than 1 Pushtronex System per month will not be approved.

revlimid

Products Affected

- **REVLIMID**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Documentation of severe neutropenia, severe thrombocytopenia, or treatment-related MDS
Required Medical Information	Diagnosis of multiple myeloma -OR- diagnosis of myelodyplastic syndrome (MDS) with 5-q deletion along with documentation of transfusion-dependent anemia or an anemia with documented hemoglobin of less than 10g/dL -OR- diagnosis of mantle cell lymphoma (MCL) in which disease has relapsed or progressed after two prior therapies (e.g. anthracycline, mitoxantrone, cyclophosphamide, rituximab, bortezomib) one of which included bortezomib
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

rubraca

Products Affected

- **RUBRACA ORAL TABLET 200 MG, 300 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of deleterious BRCA mutated, advanced ovarian cancer -AND- Rubraca will be used as monotherapy -AND- trial and failure of 2 prior chemotherapy regimens
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

ruconest

Products Affected

- **RUCONEST**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Acute hereditary angioedema (HAE) type I & II: Documentation that clinical laboratory performance C4 below lower limit of laboratory reference range -AND- C1 inhibitor level below lower limit of laboratory reference range -OR- normal C1 inhibitor level and a low C1INH functional level below laboratory reference range -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued. Acute hereditary angioedema (HAE) type III: Documentation that clinical laboratory performance C4, C1 inhibitor level and C1INH functional level are within normal limits of the laboratory's reference range -AND- documentation HAE family history -OR- FXL mutation -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued
Age Restrictions	Deny if less than 13 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

rydapt

Products Affected

- **RYDAPT**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of one of the following (1 or 2) 1)Diagnosis of FLT3 mutation-positive acute myeloid leukemia -AND- confirmation that therapy will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy regimens -OR- 2) Diagnosis of aggressive systemic mastocytosis (ASM) or systemic mastocytosis with associated hematological neoplasm (SM-AHN) or mast cell leukemia (MCL)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

savella

Products Affected

- **SAVELLA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	

signifor

Products Affected

- **SIGNIFOR**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	

siliq

Products Affected

- **SILIQ**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	History of or active Crohn's disease
Required Medical Information	Documentation of moderate to severe psoriasis -AND- (1 or 2) 1) Trial/failure or intolerance of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy. 2) Contraindication to all systemic therapies or phototherapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	4 months initial authorization, 12 months reauthorization
Other Criteria	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis. For psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For reauthorization, attestation supporting improvement in psoriatic lesions or disease stability is required.

simponi

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Actemra, Kineret, Remicade, Humira, Orencia, Enbrel, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe ulcerative colitis and an inadequate response to two immunosupressants or in those patients requiring continuous steroid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Alternatives for Ulcerative Colitis include immunosuppressants such as corticosteroids, azathioprine or 6-mercaptopurine. Patients must have an adequate trial or intolerance to the preferred product, Humira, for ulcerative colitis and the preferred products, Enbrel and Humira, for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis. For ulcerative colitis indication therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.

simponi aria

Products Affected

- **SIMPONI ARIA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Actemra, Kineret, Remicade, Humira, Orencia, Enbrel, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

sovaldi

Products Affected

- **SOVALDI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
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	Doses greater than or less than 400 mg/day will not be approved.

sprycel

Products Affected

- **SPRYCEL**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and failure of Gleevec therapy (failure of Gleevec is not necessary for the indication of newly diagnosed adults with chronic phase PH+ CML).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

stelara

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Simponi
Required Medical Information	Documentation of one of the following (1-3): 1) Moderate to severe plaque psoriasis and failure of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy. 2) Psoriatic arthritis. 3) Crohn's Disease and documentation of trial and failure, intolerance, or contraindication to an immunosuppressant (e.g. corticosteroids, azathioprine, 6-mercaptopurine, methotrexate) and Humira and documentation of clinical remission following IV administration of Stelara. -AND- Documentation of member weight and prescribed dose.
Age Restrictions	
Prescriber Restrictions	dermatologist, rheumatologist
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis and the preferred products, Enbrel and Humira, for psoriatic arthritis. Must follow recommended dosing guidelines based upon weight. Psoriasis: For patients weighing less than 100 kilograms (220 pounds), 45 mg dosing will be approved. For patients weighing more than 100 kilograms (220 pounds), 90 mg dosing will be approved. Psoriatic Arthritis: 45 mg dosing will be approved. For patients with co-existent moderate to severe plaque psoriasis weighing greater than 100 kilograms (220 pounds), 90 mg dosing will be approved.

stelara iv

Products Affected

- **STELARA INTRAVENOUS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Simponi
Required Medical Information	Documentation of Crohn's disease -AND- trial and failure, contraindication, or intolerance to at least 2 immunosuppressants (corticosteroids, azathioprine, 6-mercaptopurine, or methotrexate)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses greater than 520 mg single dose IV will not be approved

stivarga

Products Affected

- **STIVARGA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic colorectal cancer and trial of a fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy (i.e. FOLFIRINOX), AND an anti-VEGF therapy (i.e. aflibercept) AND if KRAS wild type, an anti-EGFR therapy (i.e. cetuximab, panitumumab) -OR- documentation of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) after treatment with both imatinib and sunitinib
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

strensiq

Products Affected

- **STRENSIQ**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of perinatal/infantile-onset or juvenile-onset hypophosphatasia (HPP)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

sutent

Products Affected

- **SUTENT**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis and failure of Gleevec therapy, if applicable
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

sylvant

Products Affected

- **SYLVANT INTRAVENOUS RECON SOLN 100 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documented diagnosis of multicentric Castleman's disease -AND- negative HIV and HHV-8 test -AND- baseline absolute neutrophil count greater than or equal to 1.0x10*9/L -AND- baseline platelet count greater than or equal to 75x10*9/L -AND- baseline hemoglobin less than 17g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

syndros

Products Affected

- **SYNDROS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	

tagrisso

Products Affected

- **TAGRISSO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic EGFR T790M mutation-positive NSCLC AND progression on or after EGFR TKI therapy
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

taltz

Products Affected

- **TALTZ AUTOINJECTOR (3 PACK)**
- **TALTZ SYRINGE**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Simponi, Stelara
Required Medical Information	Documentation of moderate to severe psoriasis and trial/failure or intolerance of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy-OR-contraindication to systemic therapies or phototherapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	dermatologist
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis. For psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.

tasigna

Products Affected

- **TASIGNA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and failure of Gleevec therapy (failure of Gleevec is not necessary for the indication of newly diagnosed adults with chronic phase PH+ CML).
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

tecfidera

Products Affected

- **TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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 (relapsing-remitting, relapsing secondary progressive, or progressive relapsing multiple sclerosis)
Age Restrictions	
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	Doses greater than 240 mg twice-daily will not be approved

technivie

Products Affected

- **TECHNIVIE**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe hepatic impairment (Child-Pugh C)
Required Medical Information	Documentation of chronic hepatitis C genotype 4 without cirrhosis AND using with ribavirin unless the member is treatement-naive and has a contraindication or intolerance to ribavirin
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	

testosterone (androgens)

Products Affected

- **ANDRODERM**
- **ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)**
- **ANDROGEL TRANSDERMAL GEL IN PACKET**
- **AVEED**
- **AXIRON**
- **DEPO-TESTOSTERONE**
- **FORTESTA**
- **METHITEST**
- **NATESTO**
- **STRIANT**
- **TESTIM**
- *testosterone cypionate*
- *testosterone enanthate*
- **TESTOSTERONE TRANSDERMAL GEL IN METERED-DOSE PUMP**
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram)*
- **TESTOSTERONE TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)**
- **TESTOSTERONE TRANSDERMAL SOLUTION IN METERED PUMP W/APP**
- **VOGELXO TRANSDERMAL GEL**
- **VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of primary or secondary hypogonadism in males with testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, radiation or toxic damage -OR- documentation of primary or secondary hypogonadism in males with multiple symptoms of hypogonadism including at least one of the following specific symptoms: height loss due to vertebral fractures, low trauma fractures, low bone density, incomplete or delayed sexual development, breast discomfort, loss of axillar and/or pubic body hair, hot flushes -OR- documentation of HIV infection in men with weight loss -OR- documentation of chronic steroid treatment in men. In all previously noted indications, members must also have documented low 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. Additional approvable indications include vulvar dystrophies in women (topical ointment only) -AND- palliative treatment in female patients with metastatic breast cancer (testosterone enanthate only), primary or secondary hypogonadism in males with testicular failure due to double orchidectomy

PA Criteria	Criteria Details
Age Restrictions	Deny if less than recommended age per FDA product labeling
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

thalomid

Products Affected

- **THALOMID**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of multiple myeloma -OR- documentation for use in the treatment or prophylaxis of cutaneous manifestations of moderate to severe erythema nodosum leprosum
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

thrombopoiesis stimulating agents

Products Affected

- **PROMACTA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis of chronic immune idiopathic thrombocytopenia purpura and trial and failure of corticosteroid or immunoglobulin therapy or splenectomy -OR- documentation of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy (eltrombopag only)-OR- severe aplastic anemia who have had an insufficient response to immunosuppressive therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Platelet count to be provided

tigan

Products Affected

- *trimethobenzamide oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

transmucosal fentanyl citrate

Products Affected

- **ABSTRAL SUBLINGUAL TABLET 100 MCG, 200 MCG, 300 MCG, 400 MCG, 600 MCG, 800 MCG**
- **ACTIQ BUCCAL LOZENGE ON A HANDLE 1,200 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**
- *fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg*
- **FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**
- **LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 300 MCG/SPRAY, 400 MCG/SPRAY**
- **SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of therapeutic use and long acting opioid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

tykerb

Products Affected

- **TYKERB**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of Tykerb in combination with Xeloda (capecitabine) for patients with advanced, metastatic breast cancer that is HER2 positive who have received prior therapy, including a taxane, an anthracycline and trastuzumab (Herceptin) -OR- documentation of Tykerb in combination with Femara (letrozole) for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that over expresses the HER2 receptor for whom hormonal therapy is indicated
Age Restrictions	
Prescriber Restrictions	oncologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

tymlos

Products Affected

- **TYMLOS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Diagnosis of underlying hypercalcemic disorder such as hypercalcemia, hyperparathyroidism or hypoparathyroidism, or high risk for osteosarcoma (Paget's disease, prior radiation therapy, bone metastases, open epiphyses, etc.). Treatment duration greater than 24 months.
Required Medical Information	Documentation to support use for treatment of osteoporosis and the prevention of fractures for patients meeting the following criteria (1 AND 2, 3, or 4) 1) documentation of trial, failure, or contraindication to at least one bisphosphonate -AND- 2) diagnosis of osteoporosis in postmenopausal women with a t-score of -2.5 or less-OR- 3) documentation of osteopenia with a t-score between -1 and -2.5 and a history of previous osteoporotic fracture or glucocorticoid use for at least 3 months at a dose of 5mg per day of prednisone (or equivalent) -OR- 4) documentation of a 10-year risk of major osteoporotic fracture greater than or equal to 20 percent or a risk of hip fracture greater than or equal to 3 percent
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Tymlos or Forteo will be limited to a coverage duration of 24 months.

VALCHLOR

Products Affected

- **VALCHLOR**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma who have limited localized or generalized skin involvement who received at least one prior skin directed therapy -OR- documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma who have limited localized or generalized skin involvement and mechlorethamine gel will be used in combination with other skin directed therapies. Skin directed therapies may include but are not limited to topical corticosteroids, topical chemotherapy, local radiation and topical retinoids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

veltassa

Products Affected

- **VELTASSA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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, when applicable -AND- trial and failure, intolerance, or contraindication to sodium polystyrene sulfonate
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For reauthorization, documentation of reduction in serum potassium levels following Veltassa administration is required.

venclexta

Products Affected

- **VENCLEXTA**
- **VENCLEXTA STARTING PACK**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of chronic lymphocytic leukemia (CLL) with 17p deletion -AND- previous treatment with at least one prior therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

viberzi

Products Affected

- **VIBERZI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Documentation of diarrhea predominant, irritable bowel syndrome (IBS-D) -AND- no alcohol abuse in the previous six months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

VIEKIRA PAK

Products Affected

- **VIEKIRA PAK**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12wk: gt 1a noncirr -OR- gt 1b. 24wk: gt1a cirr -OR- gt 1 in allograft
Other Criteria	Doses greater than four tablets per day will not be approved.

VIEKIRA XR

Products Affected

- **VIEKIRA XR**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12wk: gt 1a noncirr -OR- gt 1b. 24wk: gt1a cirr -OR- gt 1 in allograft
Other Criteria	Doses greater than three tablets per day will not be approved.

viibryd

Products Affected

- **TRINTELLIX**
-
- **VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis major depressive disorder and trial and failure of any two antidepressants
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

vimovo

Products Affected

- **VIMOVO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis (e.g., osteoarthritis, rheumatoid arthritis, and ankylosing spondylitis in adults or juvenile idiopathic arthritis in adolescent patients) -AND- Both of the following. 1) Trial/failure of naproxen used in combination with omeprazole. 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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

vosevi

Products Affected

- **VOSEVI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
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	Doses greater than one tablet per day will not be approved.

votrient

Products Affected

- **VOTRIENT**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis (renal cell carcinoma) -OR- documentation of advanced soft- tissue sarcoma excluding adipocytic soft tissue sarcoma or gastrointestinal stromal tumors after failure of at least one prior chemotherapy regimen
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

vraylar

Products Affected

- **VRAYLAR ORAL CAPSULE PACK**
- **VRAYLAR ORAL CAPSULE,DOSE**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of schizophrenia OR acute treatment of manic or mixed episodes associated with bipolar I disorder
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

vyxeos

Products Affected

- **VYXEOS**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of newly-diagnosed therapy-related acute myeloid leukemia (t-AML) -OR- documentation of myelodysplasia-related changes (AML-MRC)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

xalkori

Products Affected

- **XALKORI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

xeljanz

Products Affected

- **XELJANZ**
- **XELJANZ XR**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orencia, Stelara, Actemra, azathioprine, cyclosporine
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and an inadequate response or intolerance to methotrexate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses greater than 10 mg per day for Xeljanz and 11 mg per day for Xeljanz XR will not be approved. Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for rheumatoid arthritis.

xenazine

Products Affected

- *tetrabenazine*
- **XENAZINE**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patients with comorbid depression should be on an antidepressant medication.

xermelo

Products Affected

- **XERMELO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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	12 months
Other Criteria	

xifaxan

Products Affected

- **XIFAXAN ORAL TABLET 550 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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 two of the following medications for IBS-D or documentation of contraindication to all: loperamide, cholestyramine, Colestipol, dicyclomine, tricyclic antidepressants, selective serotonin reuptake inhibitors.
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.

xtandi

Products Affected

- **XTANDI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic castration-resistant prostate cancer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

xyrem

Products Affected

- **XYREM**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of excessive daytime sleepiness in patients with a diagnosis of narcolepsy as documented by MSLT less than 10 min or other appropriate testing -OR- documentation of cataplexy associated with narcolepsy as documented by MSLT or other appropriate testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

yosprala

Products Affected

- **YOSPRALA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation supporting requirement of secondary prevention of cardiovascular and cerebrovascular events -AND- one of the following (1 or 2): 1. risk of developing aspirin associated gastric ulcers due to age being 55. 2. risk of developing aspirin associated gastric ulcers due to a history of gastric ulcers. -AND- both of the following (3 and 4): 3. trial and failure of aspirin plus omeprazole taken concomitantly. 4. trial and failure of aspirin plus pantoprazole taken concomitantly.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

zejula

Products Affected

- **ZEJULA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients with a complete or partial response to platinum-based chemotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

zelboraf

Products Affected

- **TAFINLAR**
- **ZELBORAF**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	Documentation of unresectable or metastatic melanoma with BRAFV600E mutation-OR-unresectable or metastatic melanoma with BRAF V600E or V600K mutations in combination with trametinib (Mekinist) -OR- documentation of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation in use of dabrafenib (Tafinlar) in combination with trametinib (Mekinist)
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

zepatier

Products Affected

- **ZEPATIER**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12wk:gt1a without NS5A-OR-gt1b-OR-gt4 tx naive. 16wk:gt1a with NS5A-OR-gt4 tx exp.
Other Criteria	

zinbryta

Products Affected

- **ZINBRYTA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of relapsing forms of multiple sclerosis (relapsing-remitting, relapsing secondary progressive, or progressive relapsing multiple sclerosis) -AND- trial and failure, contraindication, or intolerance to two alternative treatments for MS (interferon, Copaxone, Tecfidera, Gilenya, Tysabri, etc.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Reauthorization or continuation of therapy will be approved when documentation of disease stability or improvement is provided

zinplava

Products Affected

- **ZINPLAVA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of high risk for Clostridium Difficile (C.diff) infection defined as meeting one or more of the following criteria: 1. 65 yo or older. 2. receipt one or more systemic antibacterial therapy in the past 3 months prior to current active C.diff infection. 3. one or more episodes of C. Diff within the six months prior to current active infection. 4. immunocompromised state. 5. clinically severe C.diff or C.diff ribotype 027 upon presentation. -AND- Zinplava is being used for the prevention of C.diff recurrence with standard of care antibacterial drugs such as metronidazole, vancomycin, or fidaxomycin
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	7 days
Other Criteria	Zinplava will only be approved for one dose per active Clostridium Difficile infection. Zinplava will not be approved for repeat doses for recurrence of the same active infection.

zolinza

Products Affected

- **ZOLINZA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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, extracorpeal photochemotherapy, PUVA, single agent or combination chemotherapies (e.g. cyclophosphamide, vinblastine, romidepsin)
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

ZYDELIG

Products Affected

- **ZYDELIG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of relapsed chronic lymphocytic leukemia (CLL) and use in combination with rituximab in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities -OR- documentation of relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies (e.g. alkylating agents, single or multi-drug chemotherapy, target immunotherapy) -OR- documentation of relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies (e.g. alkylating agents, single or multi-drug chemotherapy, target immunotherapy)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

zykadia

Products Affected

- **ZYKADIA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

zytiga

Products Affected

- **ZYTIGA ORAL TABLET 250 MG, 500 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic castration resistant prostate cancer and concurrent use with prednisone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

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