**2026 Retiree Pharmacy Prescription Drug Plan (PDP) Formulary**

**Medicare Part D: Compass Formulary 2026**

Please click here.

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

Please click here.

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

Please click here.

For more recent information or other questions, please contact:

Retiree Pharmacy PDP

Pharmacy Service at 1-877-461-9218.

For TTY users, 711 National Relay Service, Oct. 1 – March 31, 8 a.m. – 8 p.m. ET, seven days a week, and April 1 – Aug. 30, 8 a.m. – 8 p.m. ET, Monday – Sunday.

Visit **medicare.highmark.com**.

Formulary ID: 26019 Version: 22

Updated: 11/2026

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

When this Drug List (formulary) refers to “we,” “us,” or “our,” it means Highmark Blue Cross Blue Shield.

When it refers to “plan” or “our plan,” it means Highmark Blue Cross Blue Shield Retiree Pharmacy PDP.

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

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

## What is the Highmark Blue Cross Blue Shield Retiree Pharmacy PDP formulary?

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

## Can the formulary change?

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

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

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

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

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

  If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the Highmark Blue Cross Blue Shield Retiree Pharmacy PDP’s formulary?”

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

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 31-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Highmark Blue Cross Blue Shield Retiree Pharmacy PDP’s formulary?”

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

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

## How do I use the formulary?

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

### Medical Condition

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

### Alphabetical Listing

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

### What are generic drugs?

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

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

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

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

## Are there any restrictions on my coverage?

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

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

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

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Highmark Blue Cross Blue Shield Retiree Pharmacy PDP’s formulary?” on page 6 for information about how to request an exception.

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

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

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

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

## How do I request an exception to the Highmark Blue Cross Blue Shield Retiree Pharmacy PDP’s formulary?

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

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

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

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

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

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

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

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

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

## For more information

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

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

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

# Highmark Blue Cross Blue Shield Retiree Pharmacy PDP formulary.

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

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

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

*The following is a formulary Format Example Only:*

| Drug Name | Performance Drug Tier | Requirements/ Limits |
|---|---|---|
| Anti-Infectives | | |
| *XYZ DRUG* | NF | QL-28 |

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**lowercase italics** = Generic drugs
**UPPERCASE BOLD** = Brand name drugs

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

**Requirements/Limits**
**LA** = Limited access
**PA** = Prior authorization required
**PA-BvD** = This drug may be covered under Medicare part B or D depending on the circumstance. Information may need to be submitted describing the use and setting of the drug to make the determination.
**PA-NS** = Prior authorization required for new starts only
**QL** = Quantity limit applies. The quantity limit is noted for each drug. For example, if the quantity limit is QL (90 EA per 180 days), the quantity limit would be 90 units per 180-day supply.
**ST** = Step therapy applies
**ST-NS** = Step therapy applies to new starts only

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

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *amoxicillin-pot clavulanate oral tablet* | T2 | |
| *amoxicillin-pot clavulanate oral tablet extended release 12 hr* | T4 | |
| *amoxicillin-pot clavulanate oral tablet,chewable* | T2 | |
| *amphotericin b* | T4 | PA-BvD |
| *amphotericin b liposome* | T5 | PA-BvD |
| *ampicillin oral capsule 500 mg* | T2 | |
| *ampicillin sodium injection recon soln 1 gram, 10 gram* | T4 | |
| *ampicillin sodium injection recon soln 2 gram* | T2 | |
| *ampicillin-sulbactam injection* | T4 | |
| **ANCOBON** | T5 | PA |
| **APTIVUS** | T5 | |
| **ARIKAYCE** | T5 | PA |
| *atazanavir* | T4 | |
| *atovaquone* | T4 | |
| *atovaquone-proguanil* | T2 | |
| **AUGMENTIN ES-600** | T4 | |
| **AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML** | T4 | |
| **AVYCAZ** | T5 | |
| **AZACTAM INJECTION RECON SOLN 2 GRAM** | T4 | |
| *azithromycin intravenous* | T4 | |
| *azithromycin oral suspension for reconstitution* | T2 | |
| *azithromycin oral tablet* | T2 | |
| *aztreonam* | T4 | |
| **BACTRIM** | T4 | |
| **BACTRIM DS** | T4 | |
| **BARACLUDE** | T5 | |
| **BAXDELA** | T5 | |
| *benznidazole oral tablet 100 mg* | T4 | QL (120 EA per 30 days) |
| *benznidazole oral tablet 12.5 mg* | T4 | QL (180 EA per 30 days) |
| **BETHKIS** | T5 | PA |
| **BICILLIN C-R** | T3 | |
| **BICILLIN L-A** | T4 | |
| **BIKTARVY** | T5 | QL (31 EA per 31 days) |
| **BLUJEPA** | T4 | QL (20 EA per 5 days) |

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

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

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg* | T1 | |
| *ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml* | T4 | |
| *clarithromycin* | T2 | |
| **CLEOCIN PEDIATRIC** | T4 | |
| *clindamycin hcl* | T2 | |
| *clindamycin in 5 % dextrose* | T4 | |
| **CLINDAMYCIN PEDIATRIC** | T2 | |
| *clindamycin phosphate injection* | T2 | |
| *clotrimazole mucous membrane* | T2 | |
| **COARTEM** | T4 | |
| *colistin (colistimethate na)* | T4 | |
| **COMPLERA** | T5 | |
| **CRESEMBA ORAL** | T5 | |
| *cycloserine* | T4 | |
| *dalbavancin* | T5 | |
| **DALVANCE** | T5 | |
| *dapsone oral* | T3 | |
| *daptomycin intravenous recon soln 350 mg* | T4 | |
| *daptomycin intravenous recon soln 500 mg* | T5 | |
| **DARAPRIM** | T5 | PA |
| *darunavir oral tablet 600 mg* | T4 | |
| *darunavir oral tablet 800 mg* | T5 | |
| **DELSTRIGO** | T5 | QL (31 EA per 31 days) |
| *demeclocycline* | T4 | |
| **DESCOVY** | T5 | QL (31 EA per 31 days) |
| *dicloxacillin* | T2 | |
| **DIFICID ORAL SUSPENSION FOR RECONSTITUTION** | T5 | QL (136 ML per 12 days) |
| **DIFICID ORAL TABLET** | T5 | PA; QL (20 EA per 10 days) |
| **DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML** | T4 | |
| **DORYX MPC ORAL TABLET,DELAYED RELEASE (DR/EC) 60 MG** | T5 | |
| **DOVATO** | T5 | QL (31 EA per 31 days) |
| **DOXY-100** | T4 | |
| *doxycycline hyclate intravenous* | T2 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *doxycycline hyclate oral capsule 100 mg, 50 mg* | T2 | |
| *doxycycline hyclate oral tablet 100 mg, 150 mg, 50 mg, 75 mg* | T4 | |
| *doxycycline hyclate oral tablet 20 mg* | T2 | |
| *doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg, 150 mg, 200 mg, 50 mg, 75 mg* | T4 | |
| *doxycycline monohydrate oral capsule 100 mg, 50 mg* | T2 | |
| *doxycycline monohydrate oral capsule 150 mg, 75 mg* | T4 | |
| *doxycycline monohydrate oral capsule,ir - delay rel,biphase* | T4 | |
| *doxycycline monohydrate oral suspension for reconstitution* | T4 | |
| *doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg* | T2 | |
| *doxycycline monohydrate oral tablet 150 mg* | T4 | |
| **E.E.S. 400 ORAL TABLET** | T4 | |
| **EDURANT** | T5 | |
| **EDURANT PED** | T5 | |
| *efavirenz oral tablet* | T4 | |
| *efavirenz-emtricitabin-tenofov* | T5 | |
| *efavirenz-lamivu-tenofov disop* | T5 | QL (31 EA per 31 days) |
| **EMROSI** | T5 | PA; QL (31 EA per 31 days) |
| *emtricitabine* | T4 | |
| *emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 167-250 mg, 200-300 mg* | T4 | |
| *emtricitabine-tenofovir (tdf) oral tablet 133-200 mg* | T5 | |
| *emtricita-rilpivirine-tenof df* | T5 | |
| **EMTRIVA ORAL CAPSULE** | T4 | |
| **EMTRIVA ORAL SOLUTION** | T3 | |
| **EMVERM** | T5 | |
| *entecavir* | T4 | |
| **EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG** | T5 | PA; QL (28 EA per 28 days) |
| **EPCLUSA ORAL PELLETS IN PACKET 200-50 MG** | T5 | PA; QL (56 EA per 28 days) |
| **EPCLUSA ORAL TABLET** | T5 | PA; QL (28 EA per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **EPIVIR** | T4 | |
| **ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG** | T5 | |
| **ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 50 MG** | T4 | |
| *ertapenem* | T4 | |
| **ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG** | T4 | |
| *erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml* | T4 | |
| *erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml* | T5 | |
| *erythromycin oral* | T4 | |
| *ethambutol* | T2 | |
| *etravirine* | T5 | |
| **EVOTAZ** | T5 | |
| *famciclovir* | T2 | |
| *fidaxomicin* | T5 | QL (20 EA per 10 days) |
| **FIRVANQ** | T4 | |
| *fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml* | T4 | |
| *fluconazole oral suspension for reconstitution* | T3 | |
| *fluconazole oral tablet* | T2 | |
| *flucytosine* | T5 | |
| *fosamprenavir* | T5 | |
| *fosfomycin tromethamine* | T4 | |
| *gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml* | T4 | |
| *gentamicin injection* | T4 | |
| **GENVOYA** | T5 | |
| *griseofulvin microsize* | T4 | |
| *griseofulvin ultramicrosize oral tablet 125 mg, 250 mg* | T4 | |
| *griseofulvin ultramicrosize oral tablet 165 mg* | T5 | PA; QL (124 EA per 31 days) |
| **HARVONI** | T5 | PA; QL (28 EA per 28 days) |
| **HEPCLUDEX** | T5 | PA; QL (31 EA per 31 days) |
| **HUMATIN** | T4 | |
| *hydroxychloroquine oral tablet 100 mg* | T4 | QL (93 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *hydroxychloroquine oral tablet 200 mg* | T2 | QL (93 EA per 31 days) |
| *hydroxychloroquine oral tablet 300 mg* | T4 | QL (62 EA per 31 days) |
| *hydroxychloroquine oral tablet 400 mg* | T4 | QL (31 EA per 31 days) |
| **IDVYNSO** | T5 | QL (31 EA per 31 days) |
| *imipenem-cilastatin* | T4 | |
| **INTELENCE ORAL TABLET 200 MG** | T5 | |
| **INTELENCE ORAL TABLET 25 MG** | T4 | |
| **ISENTRESS HD** | T5 | |
| **ISENTRESS ORAL POWDER IN PACKET** | T5 | |
| **ISENTRESS ORAL TABLET** | T5 | |
| **ISENTRESS ORAL TABLET,CHEWABLE 100 MG** | T5 | |
| **ISENTRESS ORAL TABLET,CHEWABLE 25 MG** | T3 | |
| *isoniazid oral* | T2 | |
| *itraconazole oral capsule* | T4 | PA |
| *itraconazole oral solution* | T5 | PA |
| *ivermectin oral* | T2 | PA |
| **JULUCA** | T5 | |
| *ketoconazole oral* | T2 | |
| **KITABIS PAK** | T4 | PA |
| **KRINTAFEL** | T4 | |
| **LAGEVRIO (EUA)** | T3 | |
| *lamivudine* | T3 | |
| *lamivudine-zidovudine* | T3 | |
| **LAMPIT** | T4 | |
| *ledipasvir-sofosbuvir* | T5 | PA; QL (28 EA per 28 days) |
| *levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml* | T3 | |
| *levofloxacin oral* | T2 | |
| *linezolid in dextrose 5%* | T4 | |
| *linezolid oral suspension for reconstitution* | T5 | |
| *linezolid oral tablet* | T4 | |
| **LIVTENCITY** | T5 | PA; QL (372 EA per 31 days) |
| *lopinavir-ritonavir oral tablet* | T4 | |
| **MACROBID** | T4 | QL (90 EA per 365 days) |
| **MALARONE** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **MALARONE PEDIATRIC** | T4 | |
| *maraviroc oral tablet 150 mg* | T5 | |
| *maraviroc oral tablet 300 mg* | T3 | |
| **MAVYRET ORAL PELLETS IN PACKET** | T5 | PA; QL (140 EA per 28 days) |
| **MAVYRET ORAL TABLET** | T5 | PA; QL (84 EA per 28 days) |
| *mefloquine* | T2 | |
| **MEPRON** | T5 | |
| *meropenem intravenous recon soln 1 gram, 500 mg* | T3 | |
| *methenamine hippurate* | T2 | |
| *metronidazole in nacl (iso-os)* | T4 | |
| *metronidazole oral capsule* | T4 | |
| *metronidazole oral tablet 125 mg* | T4 | PA |
| *metronidazole oral tablet 250 mg, 500 mg* | T2 | |
| *micafungin* | T4 | |
| *minocycline oral capsule* | T2 | |
| *minocycline oral tablet* | T4 | |
| *minocycline oral tablet extended release 24 hr* | T4 | |
| *moxifloxacin oral* | T2 | |
| *moxifloxacin-sod.chloride(iso)* | T4 | |
| *nafcillin injection recon soln 1 gram, 2 gram* | T4 | |
| *nafcillin injection recon soln 10 gram* | T5 | |
| **NEBUPENT** | T4 | PA-BvD |
| *neomycin* | T2 | |
| *nevirapine oral suspension* | T4 | |
| *nevirapine oral tablet* | T3 | |
| *nevirapine oral tablet extended release 24 hr* | T4 | |
| *nitazoxanide* | T5 | |
| *nitrofurantoin macrocrystal oral capsule 100 mg* | T3 | QL (90 EA per 365 days) |
| *nitrofurantoin macrocrystal oral capsule 25 mg* | T4 | QL (360 EA per 365 days) |
| *nitrofurantoin macrocrystal oral capsule 50 mg* | T3 | QL (180 EA per 365 days) |
| *nitrofurantoin monohyd/m-cryst* | T3 | QL (90 EA per 365 days) |
| *nitrofurantoin oral suspension 25 mg/5 ml* | T5 | QL (1800 ML per 365 days) |
| *nitrofurantoin oral suspension 50 mg/5 ml* | T5 | QL (900 ML per 365 days) |
| **NORVIR ORAL TABLET** | T4 | |
| **NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON** | T5 | PA; QL (32 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **NUZYRA** | T5 | |
| *nystatin oral suspension* | T2 | |
| *nystatin oral tablet* | T2 | |
| **ODEFSEY** | T5 | QL (31 EA per 31 days) |
| *ofloxacin oral tablet 400 mg* | T4 | |
| **ORACEA** | T4 | PA; QL (31 EA per 31 days) |
| **ORLYNVAH** | T4 | QL (10 EA per 5 days) |
| *oseltamivir oral capsule 30 mg* | T2 | QL (170 EA per 365 days) |
| *oseltamivir oral capsule 45 mg, 75 mg* | T2 | QL (90 EA per 365 days) |
| *oseltamivir oral suspension for reconstitution* | T3 | QL (1080 ML per 365 days) |
| *oxacillin* | T4 | |
| *oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml* | T4 | |
| **PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (10)- 100 MG (10)** | T2 | QL (180 EA per 365 days) |
| **PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (6)- 100 MG (5)** | T2 | QL (99 EA per 365 days) |
| **PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG** | T2 | QL (270 EA per 365 days) |
| *penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml* | T4 | |
| *penicillin g potassium injection recon soln 20 million unit* | T4 | |
| *penicillin g sodium* | T5 | |
| *penicillin v potassium* | T2 | |
| **PENTAM** | T4 | |
| *pentamidine inhalation* | T4 | PA-BvD |
| *pentamidine injection* | T4 | |
| **PIFELTRO** | T5 | QL (62 EA per 31 days) |
| *piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram* | T4 | |
| **PLAQUENIL** | T4 | QL (93 EA per 31 days) |
| *polymyxin b sulfate* | T4 | |
| *posaconazole oral* | T5 | PA |
| *praziquantel* | T4 | |
| *pretomanid* | T4 | PA; QL (31 EA per 31 days) |
| **PREVYMIS ORAL PELLETS IN PACKET** | T5 | PA; QL (124 EA per 31 days) |
| **PREVYMIS ORAL TABLET** | T5 | QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **PREZCOBIX** | T5 | |
| **PREZISTA ORAL SUSPENSION** | T5 | |
| **PREZISTA ORAL TABLET 150 MG, 600 MG, 800 MG** | T5 | |
| **PREZISTA ORAL TABLET 75 MG** | T4 | |
| **PRIFTIN** | T4 | |
| *primaquine* | T3 | |
| *pyrazinamide* | T4 | |
| *pyrimethamine* | T5 | PA |
| *quinine sulfate* | T4 | PA; QL (42 EA per 28 days) |
| **RELENZA DISKHALER** | T4 | |
| **RETROVIR ORAL CAPSULE** | T4 | |
| **RETROVIR ORAL SYRUP** | T4 | |
| **REYATAZ ORAL CAPSULE 200 MG, 300 MG** | T5 | |
| **REYATAZ ORAL POWDER IN PACKET** | T5 | |
| *ribavirin oral capsule* | T3 | |
| *ribavirin oral tablet 200 mg* | T3 | |
| *rifabutin* | T4 | |
| *rifampin intravenous* | T4 | |
| *rifampin oral* | T3 | |
| *rifapentine* | T3 | |
| *rilpivirine hcl* | T5 | |
| *rimantadine* | T2 | |
| *ritonavir* | T3 | |
| **RUKOBIA** | T5 | QL (62 EA per 31 days) |
| **SELZENTRY ORAL TABLET 150 MG, 300 MG** | T5 | |
| **SEYSARA** | T5 | PA |
| **SIRTURO** | T5 | PA |
| **SIVEXTRO INTRAVENOUS** | T5 | |
| **SIVEXTRO ORAL** | T5 | QL (6 EA per 31 days) |
| *sofosbuvir-velpatasvir* | T5 | PA; QL (28 EA per 28 days) |
| **SOLOSEC** | T4 | |
| **SOVALDI** | T5 | PA; QL (28 EA per 28 days) |
| **SOVUNA ORAL TABLET 200 MG** | T4 | QL (93 EA per 31 days) |
| **SOVUNA ORAL TABLET 300 MG** | T4 | QL (62 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *streptomycin* | T5 | |
| **STRIBILD** | T5 | |
| **STROMECTOL** | T4 | PA |
| *sulfadiazine* | T4 | |
| *sulfamethoxazole-trimethoprim oral suspension* | T2 | |
| *sulfamethoxazole-trimethoprim oral tablet* | T1 | |
| **SUNLENCA** | T5 | |
| **SYMFI** | T5 | QL (31 EA per 31 days) |
| **SYMTUZA** | T5 | QL (31 EA per 31 days) |
| **TAMIFLU ORAL CAPSULE 75 MG** | T4 | QL (90 EA per 365 days) |
| **TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION** | T4 | QL (1080 ML per 365 days) |
| **TARGADOX** | T4 | |
| **TAZICEF INJECTION** | T4 | |
| **TEFLARO** | T5 | |
| *tenofovir disoproxil fumarate* | T3 | |
| *terbinafine hcl oral* | T2 | QL (90 EA per 180 days) |
| *tetracycline* | T4 | |
| *tigecycline* | T4 | |
| *tinidazole* | T2 | |
| **TIVICAY ORAL TABLET 50 MG** | T5 | |
| **TIVICAY PD** | T5 | |
| **TOBI** | T5 | PA |
| **TOBI PODHALER** | T5 | PA; QL (224 EA per 56 days) |
| *tobramycin in 0.225 % nacl* | T5 | PA |
| *tobramycin inhalation* | T5 | PA |
| *tobramycin sulfate injection solution* | T4 | |
| **TOLSURA** | T5 | PA; QL (130 EA per 31 days) |
| *trimethoprim* | T2 | |
| **TRIUMEQ** | T5 | |
| **TRIUMEQ PD** | T4 | QL (186 EA per 31 days) |
| **TRUVADA** | T5 | |
| **TYGACIL** | T4 | |
| **TYZAVAN INTRAVENOUS PIGGYBACK 1 GRAM/200 ML** | T4 | |
| **UNASYN INJECTION RECON SOLN 15 GRAM, 3 GRAM** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **VABOMERE** | T5 | |
| *valacyclovir* | T2 | |
| **VALCYTE ORAL RECON SOLN** | T5 | |
| *valganciclovir oral recon soln* | T4 | |
| *valganciclovir oral tablet* | T3 | |
| **VALTREX** | T4 | |
| **VANCOCIN ORAL CAPSULE 125 MG** | T4 | QL (124 EA per 31 days) |
| **VANCOCIN ORAL CAPSULE 250 MG** | T5 | QL (248 EA per 31 days) |
| *vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg* | T4 | |
| *vancomycin oral capsule 125 mg* | T4 | QL (124 EA per 31 days) |
| *vancomycin oral capsule 250 mg* | T4 | QL (248 EA per 31 days) |
| *vancomycin oral recon soln* | T4 | |
| **VEMLIDY** | T5 | QL (31 EA per 31 days) |
| **VFEND IV** | T4 | PA |
| **VFEND ORAL SUSPENSION FOR RECONSTITUTION** | T5 | |
| **VIRACEPT ORAL TABLET** | T5 | |
| **VIREAD** | T5 | |
| **VIVJOA** | T4 | PA; QL (18 EA per 84 days) |
| *voriconazole intravenous recon soln* | T5 | PA |
| *voriconazole oral* | T4 | |
| **VOSEVI** | T5 | PA; QL (28 EA per 28 days) |
| **XIFAXAN ORAL TABLET 200 MG** | T4 | QL (27 EA per 365 days) |
| **XIFAXAN ORAL TABLET 550 MG** | T5 | PA; QL (62 EA per 31 days) |
| **XOCOVA** | T5 | QL (63 EA per 365 days) |
| **XOFLUZA ORAL TABLET 40 MG, 80 MG** | T3 | QL (9 EA per 365 days) |
| **ZERBAXA** | T5 | |
| **ZEVTERA** | T5 | |
| **ZIAGEN ORAL SOLUTION** | T4 | |
| *zidovudine* | T2 | |
| **ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION 200 MG/5 ML** | T4 | |
| **ZITHROMAX TRI-PAK** | T4 | |
| **ZITHROMAX Z-PAK** | T4 | |
| **ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ZYVOX INTRAVENOUS PIGGYBACK 600 MG/300 ML** | T4 | |
| **ZYVOX ORAL SUSPENSION FOR RECONSTITUTION** | T4 | |
| **Antineoplastic / Immunosuppressant Drugs** | | |
| *abiraterone oral tablet 250 mg* | T5 | PA-NS; QL (124 EA per 31 days) |
| *abiraterone oral tablet 500 mg* | T5 | PA-NS; QL (62 EA per 31 days) |
| **ABIRTEGA** | T3 | PA-NS; QL (124 EA per 31 days) |
| **AFINITOR** | T5 | PA-NS; QL (31 EA per 31 days) |
| **AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 5 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **AKEEGA** | T5 | PA-NS; QL (62 EA per 31 days) |
| **ALECENSA** | T5 | PA-NS; QL (248 EA per 31 days) |
| **ALUNBRIG ORAL TABLET 180 MG, 90 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **ALUNBRIG ORAL TABLET 30 MG** | T5 | PA-NS; QL (186 EA per 31 days) |
| **ALUNBRIG ORAL TABLETS,DOSE PACK** | T5 | PA-NS; QL (60 EA per 365 days) |
| *anastrozole* | T2 | |
| **ARIMIDEX** | T5 | |
| **AROMASIN** | T5 | |
| **ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG** | T4 | PA-BvD |
| **ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 5 MG** | T5 | PA-BvD |
| **AUGTYRO ORAL CAPSULE 160 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **AUGTYRO ORAL CAPSULE 40 MG** | T5 | PA-NS; QL (186 EA per 31 days) |
| **AUKELSO** | T5 | PA-NS |
| **AVMAPKI-FAKZYNJA** | T5 | PA-NS; QL (66 EA per 28 days) |
| **AYVAKIT** | T5 | PA-NS; QL (31 EA per 31 days) |
| **AZASAN** | T4 | PA-BvD |
| *azathioprine oral tablet 100 mg, 75 mg* | T4 | PA-BvD |
| *azathioprine oral tablet 50 mg* | T2 | PA-BvD |
| **BALVERSA** | T5 | PA-NS |
| *bexarotene oral* | T5 | PA-NS |
| *bexarotene topical* | T5 | PA-NS; QL (60 GM per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *bicalutamide* | T2 | |
| **BILPREVDA** | T5 | PA-NS |
| **BOMYNTRA** | T5 | PA-NS |
| **BOSULIF ORAL CAPSULE 100 MG** | T5 | PA-NS; QL (186 EA per 31 days) |
| **BOSULIF ORAL CAPSULE 50 MG** | T5 | PA-NS; QL (341 EA per 31 days) |
| **BOSULIF ORAL TABLET 100 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **BOSULIF ORAL TABLET 400 MG, 500 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| *bosutinib oral tablet 400 mg* | T5 | PA-NS; QL (31 EA per 31 days) |
| **BRAFTOVI** | T5 | PA-NS; QL (186 EA per 31 days) |
| **BRUKINSA ORAL TABLET** | T5 | PA-NS; QL (62 EA per 31 days) |
| **CABOMETYX** | T5 | PA-NS; QL (31 EA per 31 days) |
| **CALQUENCE (ACALABRUTINIB MAL)** | T5 | PA-NS; QL (62 EA per 31 days) |
| **CAPRELSA ORAL TABLET 100 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **CAPRELSA ORAL TABLET 300 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **CASODEX** | T4 | |
| **CELLCEPT** | T5 | PA-BvD |
| **COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)** | T5 | PA-NS; QL (56 EA per 28 days) |
| **COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)** | T5 | PA-NS; QL (112 EA per 28 days) |
| **COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)** | T5 | PA-NS; QL (84 EA per 28 days) |
| **COPIKTRA** | T5 | PA-NS; QL (62 EA per 31 days) |
| **COTELLIC** | T5 | PA-NS; LA; QL (63 EA per 28 days) |
| *cyclophosphamide oral capsule* | T3 | PA-BvD |
| *cyclophosphamide oral tablet 50 mg* | T3 | PA-BvD |
| *cyclosporine modified oral capsule* | T2 | PA-BvD |
| *cyclosporine modified oral solution* | T5 | PA-BvD |
| *cyclosporine oral capsule* | T2 | PA-BvD |
| **DANZITEN** | T5 | PA-NS; QL (124 EA per 31 days) |
| *dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg* | T5 | PA-NS; QL (31 EA per 31 days) |
| *dasatinib oral tablet 20 mg* | T5 | PA-NS; QL (93 EA per 31 days) |
| **DAURISMO ORAL TABLET 100 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **DAURISMO ORAL TABLET 25 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **DROXIA** | T4 | |
| **ELIGARD** | T4 | QL (1 EA per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ELIGARD (3 MONTH)** | T4 | QL (1 EA per 90 days) |
| **ELIGARD (4 MONTH)** | T4 | QL (1 EA per 120 days) |
| **ELIGARD (6 MONTH)** | T4 | QL (1 EA per 180 days) |
| **ENSACOVE** | T5 | PA-NS; QL (62 EA per 31 days) |
| **ENSPRYNG** | T5 | PA; QL (1 ML per 28 days) |
| **ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG** | T4 | PA-BvD |
| **ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 4 MG** | T5 | PA-BvD |
| **ERIVEDGE** | T5 | PA-NS; QL (31 EA per 31 days) |
| **ERLEADA ORAL TABLET 240 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **ERLEADA ORAL TABLET 60 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| *erlotinib* | T5 | PA-NS; QL (31 EA per 31 days) |
| **EULEXIN** | T4 | |
| *everolimus (antineoplastic) oral tablet* | T5 | PA-NS; QL (31 EA per 31 days) |
| *everolimus (antineoplastic) oral tablet for suspension 2 mg, 5 mg* | T5 | PA-NS; QL (62 EA per 31 days) |
| *everolimus (antineoplastic) oral tablet for suspension 3 mg* | T5 | PA-NS; QL (93 EA per 31 days) |
| *everolimus (immunosuppressive) oral tablet 0.25 mg* | T4 | PA-BvD |
| *everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg* | T5 | PA-BvD |
| *exemestane* | T4 | |
| **FEMARA** | T4 | |
| **FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG** | T5 | PA-NS |
| **FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG** | T4 | PA-NS |
| **FOTIVDA** | T5 | PA-NS; QL (21 EA per 28 days) |
| **FRUZAQLA ORAL CAPSULE 1 MG** | T5 | PA-NS; QL (84 EA per 28 days) |
| **FRUZAQLA ORAL CAPSULE 5 MG** | T5 | PA-NS; QL (21 EA per 28 days) |
| **GAVRETO** | T5 | PA-NS; QL (124 EA per 31 days) |
| *gefitinib* | T5 | PA-NS; QL (31 EA per 31 days) |
| **GENGRAF ORAL CAPSULE** | T2 | PA-BvD |
| **GILOTRIF** | T5 | PA-NS; QL (31 EA per 31 days) |
| **GLEEVEC ORAL TABLET 100 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **GLEEVEC ORAL TABLET 400 MG** | T5 | PA-NS; QL (62 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **GLEOSTINE ORAL CAPSULE 10 MG, 40 MG** | T4 | PA-NS |
| **GLEOSTINE ORAL CAPSULE 100 MG** | T5 | PA-NS |
| **GOMEKLI ORAL CAPSULE 1 MG** | T5 | PA-NS; QL (126 EA per 28 days) |
| **GOMEKLI ORAL CAPSULE 2 MG** | T5 | PA-NS; QL (84 EA per 28 days) |
| **GOMEKLI ORAL TABLET FOR SUSPENSION** | T5 | PA-NS; QL (168 EA per 28 days) |
| **HERNEXEOS** | T5 | PA-NS; QL (93 EA per 31 days) |
| **HYDREA** | T4 | |
| *hydroxyurea* | T2 | |
| **HYRNUO** | T5 | PA-NS; QL (124 EA per 31 days) |
| **IBRANCE ORAL CAPSULE 125 MG** | T5 | PA-NS; QL (21 EA per 28 days) |
| **IBRANCE ORAL TABLET** | T5 | PA-NS; QL (21 EA per 28 days) |
| **IBTROZI** | T5 | PA-NS; QL (93 EA per 31 days) |
| **ICLUSIG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **IDHIFA** | T5 | PA-NS; QL (31 EA per 31 days) |
| *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 ORAL CAPSULE 140 MG** | T5 | PA-NS; QL (124 EA per 31 days) |
| **IMBRUVICA ORAL CAPSULE 70 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **IMBRUVICA ORAL SUSPENSION** | T5 | PA-NS; QL (216 ML per 25 days) |
| **IMBRUVICA ORAL TABLET** | T5 | PA-NS; QL (31 EA per 31 days) |
| **IMKELDI** | T5 | PA-NS; QL (280 ML per 28 days) |
| **IMURAN** | T4 | PA-BvD |
| **INLURIYO** | T5 | PA-NS; QL (62 EA per 31 days) |
| **INLYTA** | T5 | PA-NS; QL (124 EA per 31 days) |
| **INQOVI** | T5 | PA-NS; QL (5 EA per 28 days) |
| **INREBIC** | T5 | PA-NS; QL (124 EA per 31 days) |
| **IRESSA** | T5 | PA-NS; QL (31 EA per 31 days) |
| **ITOVEBI ORAL TABLET 3 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **ITOVEBI ORAL TABLET 9 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **IWILFIN** | T5 | PA-NS; QL (248 EA per 31 days) |
| **JAKAFI** | T5 | PA-NS; QL (62 EA per 31 days) |
| **JAKAFI XR** | T5 | PA-NS; QL (31 EA per 31 days) |
| **JAYPIRCA ORAL TABLET 100 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **JAYPIRCA ORAL TABLET 50 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **JIDEYTRO ORAL TABLET 100 MG** | T5 | PA-NS; QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **JIDEYTRO ORAL TABLET 25 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **JYLAMVO** | T4 | PA-BvD |
| **KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)** | T5 | PA-NS; QL (21 EA per 28 days) |
| **KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)** | T5 | PA-NS; QL (42 EA per 28 days) |
| **KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)** | T5 | PA-NS; QL (63 EA per 28 days) |
| **KLISYRI (250 MG)** | T5 | PA |
| **KOMZIFTI** | T5 | PA-NS; QL (90 EA per 30 days) |
| **KOSELUGO ORAL CAPSULE 10 MG** | T5 | PA-NS; QL (279 EA per 31 days) |
| **KOSELUGO ORAL CAPSULE 25 MG** | T5 | PA-NS; QL (124 EA per 31 days) |
| **KOSELUGO ORAL CAPSULE, SPRINKLE 5 MG** | T5 | PA-NS; QL (600 EA per 30 days) |
| **KOSELUGO ORAL CAPSULE, SPRINKLE 7.5 MG** | T5 | PA-NS; QL (360 EA per 30 days) |
| **KRAZATI** | T5 | PA-NS; QL (186 EA per 31 days) |
| *lapatinib* | T5 | PA-NS; QL (186 EA per 31 days) |
| **LAZCLUZE ORAL TABLET 240 MG** | T5 | PA-NS; QL (30 EA per 30 days) |
| **LAZCLUZE ORAL TABLET 80 MG** | T5 | PA-NS; QL (60 EA per 30 days) |
| *lenalidomide* | T5 | PA-NS; QL (21 EA per 28 days) |
| **LENVIMA** | T5 | PA-NS |
| *letrozole* | T2 | |
| *leucovorin calcium oral* | T3 | |
| **LEUKERAN** | T5 | |
| *leuprolide subcutaneous kit* | T4 | QL (2 EA per 28 days) |
| **LIFYORLI ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 125 MG/DAY(100 MG X1-25MG X3), 125 MG/DAY(100 MG X1-25MG X9)** | T5 | PA-NS; QL (18 EA per 28 days) |
| **LIFYORLI ORAL CAPSULE 150 MG/DAY(100 MG X1-25MG X2), 150 MG/DAY(100 MG X1-25MG X3), 150 MG/DAY(100 MG X1-25MG X9)** | T5 | PA-NS; QL (27 EA per 28 days) |
| *lomustine oral capsule 10 mg, 40 mg* | T4 | PA-NS |
| *lomustine oral capsule 100 mg* | T5 | PA-NS |
| **LONSURF** | T5 | PA-NS |
| **LORBRENA ORAL TABLET 100 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **LORBRENA ORAL TABLET 25 MG** | T5 | PA-NS; QL (93 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **LUMAKRAS ORAL TABLET 120 MG, 240 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **LUMAKRAS ORAL TABLET 320 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **LUPKYNIS** | T5 | PA; QL (186 EA per 31 days) |
| **LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG** | T5 | QL (1 EA per 90 days) |
| **LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 22.5 MG** | T5 | QL (1 EA per 84 days) |
| **LUPRON DEPOT (4 MONTH)** | T5 | QL (1 EA per 112 days) |
| **LUPRON DEPOT (6 MONTH)** | T5 | QL (1 EA per 168 days) |
| **LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG** | T5 | QL (1 EA per 30 days) |
| **LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG** | T5 | QL (1 EA per 28 days) |
| **LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG** | T5 | PA; QL (1 EA per 90 days) |
| **LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)** | T5 | PA; QL (1 EA per 30 days) |
| **LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT** | T5 | PA; QL (1 EA per 168 days) |
| **LUTRATE DEPOT (3 MONTH)** | T4 | QL (1 EA per 84 days) |
| **LYNPARZA** | T5 | PA-NS; QL (124 EA per 31 days) |
| **LYSODREN** | T5 | |
| **LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)** | T5 | PA-NS; QL (93 EA per 31 days) |
| **LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)** | T5 | PA-NS; QL (124 EA per 31 days) |
| **LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)** | T5 | PA-NS; QL (155 EA per 31 days) |
| **MATULANE** | T5 | |
| *megestrol oral suspension 400 mg/10 ml (40 mg/ml)* | T3 | PA |
| *megestrol oral suspension 625 mg/5 ml (125 mg/ml)* | T4 | PA |
| *megestrol oral tablet* | T3 | PA-NS |
| **MEKINIST ORAL RECON SOLN** | T5 | PA-NS; QL (1260 ML per 31 days) |
| **MEKINIST ORAL TABLET 0.5 MG** | T5 | PA-NS; QL (93 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **MEKINIST ORAL TABLET 2 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **MEKTOVI** | T5 | PA-NS; QL (186 EA per 31 days) |
| *mercaptopurine oral suspension* | T5 | |
| *mercaptopurine oral tablet* | T2 | |
| *mesna oral* | T4 | |
| **MESNEX ORAL** | T4 | |
| *methotrexate sodium* | T2 | PA-BvD |
| *methotrexate sodium (pf) injection solution* | T2 | PA-BvD |
| **MODEYSO** | T5 | PA-NS; QL (20 EA per 28 days) |
| **MYCAPSSA** | T5 | PA; QL (124 EA per 31 days) |
| *mycophenolate mofetil oral capsule* | T3 | PA-BvD |
| *mycophenolate mofetil oral suspension for reconstitution* | T5 | PA-BvD |
| *mycophenolate mofetil oral tablet* | T3 | PA-BvD |
| *mycophenolate sodium* | T4 | PA-BvD |
| **MYFORTIC ORAL TABLET,DELAYED RELEASE (DR/EC) 180 MG** | T4 | PA-BvD |
| **MYFORTIC ORAL TABLET,DELAYED RELEASE (DR/EC) 360 MG** | T5 | PA-BvD |
| **MYHIBBIN** | T5 | PA-BvD |
| **NEMLUVIO** | T5 | PA; QL (2 EA per 28 days) |
| **NEORAL** | T4 | PA-BvD |
| **NERLYNX** | T5 | PA-NS; QL (186 EA per 31 days) |
| **NEXAVAR** | T5 | PA-NS; QL (124 EA per 31 days) |
| *nilotinib d-tartrate* | T5 | PA-NS; QL (124 EA per 31 days) |
| *nilotinib hcl* | T5 | PA-NS; QL (124 EA per 31 days) |
| *nilutamide* | T5 | |
| **NINLARO** | T5 | PA-NS; QL (3 EA per 28 days) |
| **NUBEQA** | T5 | PA-NS; QL (124 EA per 31 days) |
| *octreotide acetate injection solution* | T4 | PA |
| **ODOMZO** | T5 | PA-NS; LA; QL (31 EA per 31 days) |
| **OGSIVEO ORAL TABLET 100 MG, 150 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **OJEMDA ORAL SUSPENSION FOR RECONSTITUTION** | T5 | PA-NS; QL (96 ML per 28 days) |
| **OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)** | T5 | PA-NS; QL (16 EA per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)** | T5 | PA-NS; QL (20 EA per 28 days) |
| **OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)** | T5 | PA-NS; QL (24 EA per 28 days) |
| **OJJAARA** | T5 | PA-NS; QL (31 EA per 31 days) |
| **ONUREG** | T5 | PA-NS; QL (14 EA per 28 days) |
| **ORGOVYX** | T5 | PA-NS; QL (31 EA per 31 days) |
| **ORSERDU ORAL TABLET 345 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **ORSERDU ORAL TABLET 86 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **OSENVELT** | T5 | PA-NS |
| **PALSONIFY** | T5 | PA; QL (62 EA per 31 days) |
| *pazopanib oral tablet 200 mg* | T5 | PA-NS; QL (124 EA per 31 days) |
| **PEMAZYRE** | T5 | PA-NS; QL (14 EA per 21 days) |
| **PHYRAGO ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **PHYRAGO ORAL TABLET 20 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)** | T5 | PA-NS; QL (28 EA per 28 days) |
| **PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)** | T5 | PA-NS; QL (56 EA per 28 days) |
| *pomalidomide* | T5 | PA-NS; QL (21 EA per 28 days) |
| **POMALYST** | T5 | PA-NS; QL (21 EA per 28 days) |
| **PROGRAF ORAL CAPSULE 0.5 MG, 1 MG** | T4 | PA-BvD |
| **PROGRAF ORAL CAPSULE 5 MG** | T5 | PA-BvD |
| **PROGRAF ORAL GRANULES IN PACKET** | T4 | PA-BvD |
| **PURIXAN** | T5 | |
| **QINLOCK** | T5 | PA-NS; QL (93 EA per 31 days) |
| **RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **RETEVMO ORAL TABLET 40 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **REVLIMID** | T5 | PA-NS; QL (21 EA per 28 days) |
| **REVUFORJ ORAL TABLET 110 MG** | T5 | PA-NS; QL (124 EA per 31 days) |
| **REVUFORJ ORAL TABLET 160 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **REVUFORJ ORAL TABLET 25 MG** | T5 | PA-NS; QL (248 EA per 31 days) |
| **REZLIDHIA** | T5 | PA-NS; QL (62 EA per 31 days) |
| **REZUROCK** | T5 | PA; QL (62 EA per 31 days) |
| **ROMVIMZA** | T5 | PA-NS; QL (8 EA per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ROZLYTREK ORAL CAPSULE 100 MG** | T5 | PA-NS; QL (155 EA per 31 days) |
| **ROZLYTREK ORAL CAPSULE 200 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **ROZLYTREK ORAL PELLETS IN PACKET** | T5 | PA-NS; QL (372 EA per 31 days) |
| **RUBRACA** | T5 | PA-NS; QL (124 EA per 31 days) |
| **RYDAPT** | T5 | PA-NS; QL (248 EA per 31 days) |
| **SANDIMMUNE ORAL CAPSULE** | T4 | PA-BvD |
| **SANDOSTATIN INJECTION SOLUTION 100 MCG/ML** | T5 | PA |
| **SANDOSTATIN INJECTION SOLUTION 50 MCG/ML, 500 MCG/ML** | T4 | PA |
| **SAPHNELO PEN** | T5 | PA; QL (3.2 ML per 28 days) |
| **SAPHNELO SUBCUTANEOUS** | T5 | PA; QL (3.2 ML per 28 days) |
| **SCEMBLIX ORAL TABLET 100 MG** | T5 | PA-NS; QL (124 EA per 31 days) |
| **SCEMBLIX ORAL TABLET 20 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **SCEMBLIX ORAL TABLET 40 MG** | T5 | PA-NS; QL (248 EA per 31 days) |
| **SIGNIFOR** | T5 | PA |
| **SIKLOS** | T4 | |
| *sirolimus* | T4 | PA-BvD |
| **SOLTAMOX** | T4 | |
| *sorafenib* | T5 | PA-NS; QL (124 EA per 31 days) |
| **SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **SPRYCEL ORAL TABLET 20 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **STIVARGA** | T5 | PA-NS; QL (84 EA per 28 days) |
| *sunitinib malate* | T5 | PA-NS; QL (31 EA per 31 days) |
| **SUTENT** | T5 | PA-NS; QL (31 EA per 31 days) |
| **TABLOID** | T4 | |
| **TABRECTA** | T5 | PA-NS; QL (124 EA per 31 days) |
| *tacrolimus oral capsule* | T2 | PA-BvD |
| *tacrolimus oral capsule,extended release 24hr 0.5 mg, 1 mg* | T4 | PA-BvD |
| *tacrolimus oral capsule,extended release 24hr 5 mg* | T5 | PA-BvD |
| **TAFINLAR ORAL CAPSULE** | T5 | PA-NS; QL (124 EA per 31 days) |
| **TAFINLAR ORAL TABLET FOR SUSPENSION** | T5 | PA-NS; QL (930 EA per 31 days) |
| **TAGRISSO** | T5 | PA-NS; LA; QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **TALZENNA** | T5 | PA-NS; QL (31 EA per 31 days) |
| *tamoxifen* | T2 | |
| **TARGRETIN ORAL** | T5 | PA-NS |
| **TARGRETIN TOPICAL** | T5 | PA-NS; QL (60 GM per 28 days) |
| **TASIGNA** | T5 | PA-NS; QL (124 EA per 31 days) |
| **TEPMETKO** | T5 | PA-NS; QL (62 EA per 31 days) |
| **THALOMID ORAL CAPSULE 100 MG** | T5 | PA-NS; QL (112 EA per 28 days) |
| **THALOMID ORAL CAPSULE 50 MG** | T5 | PA-NS; QL (28 EA per 28 days) |
| **TIBSOVO** | T5 | PA-NS; QL (62 EA per 31 days) |
| *toremifene* | T4 | |
| **TORPENZ** | T5 | PA-NS; QL (31 EA per 31 days) |
| **TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG** | T4 | QL (1 EA per 84 days) |
| **TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 22.5 MG** | T4 | QL (1 EA per 168 days) |
| **TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG** | T4 | QL (1 EA per 28 days) |
| *tretinoin (antineoplastic)* | T5 | |
| **TREXALL** | T4 | PA-BvD |
| **TRUQAP** | T5 | PA-NS; QL (64 EA per 28 days) |
| **TRUTAKNA** | T5 | PA; QL (4 ML per 28 days) |
| **TUKYSA ORAL TABLET 150 MG** | T5 | PA-NS; QL (124 EA per 31 days) |
| **TUKYSA ORAL TABLET 50 MG** | T5 | PA-NS; QL (248 EA per 31 days) |
| **TURALIO** | T5 | PA-NS; QL (124 EA per 31 days) |
| **TYKERB** | T5 | PA-NS; QL (186 EA per 31 days) |
| **VABRINTY (1 MONTH)** | T5 | ST-NS; QL (1 EA per 30 days) |
| **VABRINTY (3 MONTH)** | T5 | ST-NS; QL (1 EA per 90 days) |
| **VABRINTY (4 MONTH)** | T5 | ST-NS; QL (1 EA per 120 days) |
| **VABRINTY (6 MONTH)** | T5 | ST-NS; QL (1 EA per 180 days) |
| **VANFLYTA** | T5 | PA-NS; QL (62 EA per 31 days) |
| **VENCLEXTA ORAL TABLET 10 MG** | T3 | PA-NS; QL (62 EA per 31 days) |
| **VENCLEXTA ORAL TABLET 100 MG** | T5 | PA-NS; QL (186 EA per 31 days) |
| **VENCLEXTA ORAL TABLET 50 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **VENCLEXTA STARTING PACK** | T5 | PA-NS; QL (84 EA per 365 days) |
| **VERZENIO** | T5 | PA-NS; QL (62 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **VIJOICE ORAL GRANULES IN PACKET** | T5 | PA-NS; QL (31 EA per 31 days) |
| **VIJOICE ORAL TABLET 125 MG, 50 MG** | T5 | PA-NS; QL (28 EA per 28 days) |
| **VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)** | T5 | PA-NS; QL (56 EA per 28 days) |
| **VITRAKVI ORAL CAPSULE 100 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **VITRAKVI ORAL CAPSULE 25 MG** | T5 | PA-NS; QL (186 EA per 31 days) |
| **VITRAKVI ORAL SOLUTION** | T5 | PA-NS; QL (310 ML per 31 days) |
| **VONJO** | T5 | PA-NS; QL (124 EA per 31 days) |
| **VORANIGO ORAL TABLET 10 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **VORANIGO ORAL TABLET 40 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **VOTRIENT** | T5 | PA-NS; QL (124 EA per 31 days) |
| **VOYXACT** | T5 | PA; QL (2 ML per 28 days) |
| **WAYRILZ** | T5 | PA; QL (62 EA per 31 days) |
| **WELIREG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **WYOST** | T3 | PA-NS |
| **XALKORI ORAL CAPSULE** | T5 | PA-NS; QL (124 EA per 31 days) |
| **XALKORI ORAL PELLET 150 MG** | T5 | PA-NS; QL (186 EA per 31 days) |
| **XALKORI ORAL PELLET 20 MG, 50 MG** | T5 | PA-NS; QL (124 EA per 31 days) |
| **XATMEP** | T4 | PA-BvD |
| **XERMELO** | T5 | PA; QL (93 EA per 31 days) |
| **XGEVA** | T5 | PA-NS |
| **XOSPATA** | T5 | PA-NS; QL (124 EA per 31 days) |
| **XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2)** | T5 | PA-NS; QL (8 EA per 28 days) |
| **XPOVIO ORAL TABLET 40 MG/WEEK (10 MG X 4)** | T5 | PA-NS; QL (16 EA per 28 days) |
| **XPOVIO ORAL TABLET 60 MG/WEEK (60 MG X 1), 80 MG/WEEK (80 MG X 1)** | T5 | PA-NS; QL (4 EA per 28 days) |
| **XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)** | T5 | PA-NS; QL (24 EA per 28 days) |
| **XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)** | T5 | PA-NS; QL (32 EA per 28 days) |
| **XROMI** | T5 | |
| **XTANDI ORAL CAPSULE** | T5 | PA-NS; QL (124 EA per 31 days) |
| **XTANDI ORAL TABLET 40 MG** | T5 | PA-NS; QL (124 EA per 31 days) |
| **XTANDI ORAL TABLET 80 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **XTRENBO** | T3 | PA-NS |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **YONSA** | T5 | PA-NS; QL (124 EA per 31 days) |
| **YULITHIRA** | T3 | PA-NS; QL (31 EA per 31 days) |
| **ZEJULA** | T5 | PA-NS; QL (31 EA per 31 days) |
| **ZELBORAF** | T5 | PA-NS; QL (248 EA per 31 days) |
| **ZENBEXUS** | T5 | PA-NS; QL (21 EA per 28 days) |
| **ZOLINZA** | T5 | PA-NS |
| **ZORTRESS ORAL TABLET 0.25 MG** | T4 | PA-BvD |
| **ZORTRESS ORAL TABLET 0.5 MG, 0.75 MG, 1 MG** | T5 | PA-BvD |
| **ZYKADIA** | T5 | PA-NS; QL (93 EA per 31 days) |
| **ZYTIGA ORAL TABLET 250 MG** | T5 | PA-NS; QL (124 EA per 31 days) |
| **ZYTIGA ORAL TABLET 500 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **Autonomic / Cns Drugs, Neurology / Psych** | | |
| **ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML** | T5 | QL (2.4 ML per 56 days) |
| **ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML** | T5 | QL (3.2 ML per 56 days) |
| **ABILIFY MAINTENA** | T5 | QL (1 EA per 28 days) |
| **ABILIFY ORAL TABLET** | T4 | PA-NS |
| *acetaminophen-codeine oral solution 120-12 mg/5 ml* | T2 | PA; QL (5167 ML per 31 days) |
| *acetaminophen-codeine oral tablet* | T2 | PA; QL (403 EA per 31 days) |
| **ADDERALL ORAL TABLET 20 MG** | T4 | ST; QL (93 EA per 31 days) |
| **ADDERALL ORAL TABLET 5 MG, 7.5 MG** | T4 | ST; QL (62 EA per 31 days) |
| **ADDERALL XR** | T4 | ST; QL (31 EA per 31 days) |
| **ADZENYS XR-ODT** | T4 | ST; QL (31 EA per 31 days) |
| **AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML** | T3 | PA; QL (1 ML per 28 days) |
| **AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML** | T3 | PA; QL (2 ML per 28 days) |
| **AJOVY AUTOINJECTOR** | T4 | PA; QL (1.5 ML per 28 days) |
| **AJOVY SYRINGE** | T4 | PA; QL (1.5 ML per 28 days) |
| **ALLZITAL** | T4 | QL (372 EA per 31 days) |
| *almotriptan malate oral tablet 12.5 mg* | T4 | QL (8 EA per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *almotriptan malate oral tablet 6.25 mg* | T4 | QL (16 EA per 28 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) |
| **AMBIEN** | T4 | PA; QL (31 EA per 31 days) |
| **AMBIEN CR** | T4 | PA; QL (31 EA per 31 days) |
| *amitriptyline* | T2 | PA-NS |
| *amitriptyline-chlordiazepoxide* | T4 | PA-NS |
| *amoxapine* | T3 | |
| *amphetamine* | T4 | ST; QL (31 EA per 31 days) |
| *amphetamine sulfate* | T4 | PA |
| **AMPYRA** | T5 | PA; QL (62 EA per 31 days) |
| **AMRIX** | T5 | QL (31 EA per 31 days) |
| **ANAFRANIL** | T4 | PA-NS |
| **APLENZIN** | T5 | QL (31 EA per 31 days) |
| **APOKYN** | T5 | PA; QL (60 ML per 30 days) |
| *apomorphine* | T5 | PA; QL (60 ML per 30 days) |
| **APTIOM ORAL TABLET 200 MG** | T4 | QL (186 EA per 31 days) |
| **APTIOM ORAL TABLET 400 MG** | T5 | QL (93 EA per 31 days) |
| **APTIOM ORAL TABLET 600 MG, 800 MG** | T5 | QL (62 EA per 31 days) |
| **ARICEPT** | T4 | |
| *aripiprazole oral solution* | T4 | PA-NS |
| *aripiprazole oral tablet* | T2 | |
| *aripiprazole oral tablet,disintegrating 10 mg* | T4 | PA-NS |
| *aripiprazole oral tablet,disintegrating 15 mg* | T5 | PA-NS |
| **ARISTADA INITIO** | T5 | QL (4.8 ML per 365 days) |
| **ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML** | T5 | QL (3.9 ML per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML** | T5 | QL (1.6 ML per 28 days) |
| **ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML** | T5 | QL (2.4 ML per 28 days) |
| **ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML** | T5 | QL (3.2 ML per 28 days) |
| *armodafinil* | T4 | PA; QL (31 EA per 31 days) |
| **ARTHROTEC 50** | T4 | |
| **ARTHROTEC 75** | T4 | |
| **ARYNTA** | T4 | ST; QL (200 ML per 28 days) |
| **ASCOMP WITH CODEINE** | T4 | PA; QL (372 EA per 31 days) |
| *asenapine maleate* | T4 | PA-NS; QL (62 EA per 31 days) |
| **ATIVAN ORAL TABLET 0.5 MG** | T5 | PA; QL (124 EA per 31 days) |
| **ATIVAN ORAL TABLET 1 MG** | T5 | PA; QL (186 EA per 31 days) |
| **ATIVAN ORAL TABLET 2 MG** | T5 | PA; QL (155 EA per 31 days) |
| *atomoxetine oral capsule 10 mg, 25 mg, 40 mg* | T3 | QL (62 EA per 31 days) |
| *atomoxetine oral capsule 100 mg, 60 mg, 80 mg* | T3 | QL (31 EA per 31 days) |
| *atomoxetine oral capsule 18 mg* | T3 | QL (124 EA per 31 days) |
| *atomoxetine oral solution* | T5 | PA; QL (800 ML per 31 days) |
| **ATONCY** | T4 | PA; QL (800 ML per 31 days) |
| **AUBAGIO** | T5 | PA; QL (31 EA per 31 days) |
| **AUSTEDO ORAL TABLET 12 MG, 6 MG** | T5 | PA; QL (124 EA per 31 days) |
| **AUSTEDO ORAL TABLET 9 MG** | T5 | PA; QL (155 EA per 31 days) |
| **AUSTEDO XR** | T5 | PA; QL (31 EA per 31 days) |
| **AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG** | T5 | PA; QL (56 EA per 365 days) |
| **AUVELITY ORAL TABLET, IR AND ER, BIPHASIC** | T5 | PA-NS; QL (62 EA per 31 days) |
| **AZILECT ORAL TABLET 0.5 MG** | T4 | |
| **AZILECT ORAL TABLET 1 MG** | T5 | |
| **AZSTARYS** | T4 | ST; QL (31 EA per 31 days) |
| *baclofen oral solution 10 mg/5 ml (2 mg/ml)* | T4 | PA; QL (1240 ML per 31 days) |
| *baclofen oral solution 5 mg/5 ml* | T4 | PA; QL (2480 ML per 31 days) |
| *baclofen oral suspension* | T4 | PA; QL (496 ML per 31 days) |
| *baclofen oral tablet 10 mg, 20 mg, 5 mg* | T2 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *baclofen oral tablet 15 mg* | T4 | |
| **BAFIERTAM** | T5 | PA; QL (124 EA per 31 days) |
| **BANZEL** | T5 | PA-NS |
| **BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG** | T3 | PA; QL (62 EA per 31 days) |
| **BELBUCA BUCCAL FILM 750 MCG, 900 MCG** | T5 | PA; QL (62 EA per 31 days) |
| **BELSOMRA** | T4 | ST; QL (31 EA per 31 days) |
| *benztropine oral* | T2 | PA |
| **BREKIYA** | T5 | PA; QL (24 ML per 28 days) |
| *brivaracetam oral solution* | T5 | QL (620 ML per 31 days) |
| *brivaracetam oral tablet* | T5 | QL (62 EA per 31 days) |
| **BRIVIACT ORAL SOLUTION** | T5 | QL (620 ML per 31 days) |
| **BRIVIACT ORAL TABLET** | T5 | QL (62 EA per 31 days) |
| *bromocriptine* | T4 | |
| **BUCAPSOL ORAL CAPSULE 10 MG** | T5 | PA; QL (155 EA per 31 days) |
| **BUCAPSOL ORAL CAPSULE 15 MG** | T5 | PA; QL (124 EA per 31 days) |
| **BUCAPSOL ORAL CAPSULE 7.5 MG** | T5 | PA; QL (62 EA per 31 days) |
| *buprenorphine* | T4 | PA; QL (4 EA per 28 days) |
| *buprenorphine hcl sublingual* | T3 | |
| *buprenorphine-naloxone sublingual film* | T3 | |
| *buprenorphine-naloxone sublingual tablet* | T2 | |
| *bupropion hcl oral tablet* | T1 | |
| *bupropion hcl oral tablet extended release 24 hr 150 mg* | T2 | QL (93 EA per 31 days) |
| *bupropion hcl oral tablet extended release 24 hr 300 mg* | T2 | QL (31 EA per 31 days) |
| *bupropion hcl oral tablet extended release 24 hr 450 mg* | T4 | QL (31 EA per 31 days) |
| *bupropion hcl oral tablet sustained-release 12 hr* | T2 | QL (62 EA per 31 days) |
| *buspirone oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg* | T2 | |
| *buspirone oral tablet 12.5 mg, 2.5 mg* | T5 | PA; QL (62 EA per 31 days) |
| *butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg* | T4 | PA; QL (403 EA per 31 days) |
| *butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg* | T4 | PA; QL (372 EA per 31 days) |
| *butalbital-acetaminophen oral capsule* | T4 | QL (403 EA per 31 days) |
| *butalbital-acetaminophen oral tablet 50-300 mg* | T4 | QL (403 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *butalbital-acetaminophen oral tablet 50-325 mg* | T4 | QL (372 EA per 31 days) |
| *butalbital-acetaminophen-caff oral capsule 50-300-40 mg* | T4 | QL (403 EA per 31 days) |
| *butalbital-acetaminophen-caff oral capsule 50-325-40 mg* | T4 | QL (372 EA per 31 days) |
| *butalbital-acetaminophen-caff oral tablet* | T4 | QL (372 EA per 31 days) |
| *butalbital-aspirin-caffeine oral capsule* | T4 | |
| *butorphanol nasal* | T2 | QL (5 ML per 28 days) |
| **BUTRANS** | T4 | PA; QL (4 EA per 28 days) |
| **CAFERGOT** | T4 | PA |
| **CAMBIA** | T4 | |
| **CAPLYTA** | T5 | PA-NS; QL (31 EA per 31 days) |
| *carbamazepine oral capsule, er multiphase 12 hr* | T2 | |
| *carbamazepine oral suspension 100 mg/5 ml* | T2 | |
| *carbamazepine oral tablet* | T2 | |
| *carbamazepine oral tablet extended release 12 hr* | T2 | |
| *carbamazepine oral tablet,chewable 100 mg* | T2 | |
| *carbamazepine oral tablet,chewable 200 mg* | T4 | |
| **CARBATROL** | T4 | |
| *carbidopa* | T2 | |
| *carbidopa-levodopa oral capsule, extended release* | T4 | ST |
| *carbidopa-levodopa oral tablet* | T2 | |
| *carbidopa-levodopa oral tablet extended release* | T2 | |
| *carbidopa-levodopa oral tablet,disintegrating* | T2 | |
| *carbidopa-levodopa-entacapone* | T4 | |
| *carisoprodol* | T4 | PA |
| **CELEBREX** | T4 | ST; QL (62 EA per 31 days) |
| *celecoxib* | T2 | QL (62 EA per 31 days) |
| **CELEXA ORAL TABLET** | T4 | |
| **CELONTIN ORAL CAPSULE 300 MG** | T4 | |
| *chlordiazepoxide hcl* | T4 | PA |
| *chlorpromazine oral* | T4 | |
| *chlorzoxazone oral tablet 250 mg* | T5 | PA |
| *chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg* | T4 | PA |
| *citalopram oral capsule* | T4 | PA-NS; QL (31 EA per 31 days) |
| *citalopram oral solution* | T3 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *citalopram oral tablet* | T1 | |
| *cladribine(multiple sclerosis) oral tablet 10 mg (10 pack), 10 mg (4 pack), 10 mg (5 pack), 10 mg (6 pack), 10 mg (7 pack), 10 mg (8 pack), 10 mg (9 pack)* | T5 | PA; QL (40 EA per 365 days) |
| *clobazam oral suspension* | T4 | PA-NS; QL (496 ML per 31 days) |
| *clobazam oral tablet* | T3 | PA-NS; QL (62 EA per 31 days) |
| *clomipramine* | T4 | PA-NS |
| *clonazepam oral tablet 0.5 mg* | T2 | PA-NS; QL (93 EA per 31 days) |
| *clonazepam oral tablet 1 mg* | T2 | PA-NS; QL (124 EA per 31 days) |
| *clonazepam oral tablet 2 mg* | T2 | PA-NS; QL (310 EA per 31 days) |
| *clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg* | T2 | PA-NS; QL (93 EA per 31 days) |
| *clonazepam oral tablet,disintegrating 1 mg* | T2 | PA-NS; QL (124 EA per 31 days) |
| *clonazepam oral tablet,disintegrating 2 mg* | T2 | PA-NS; QL (310 EA per 31 days) |
| *clonidine hcl oral tablet extended release 12 hr* | T4 | PA |
| *clorazepate dipotassium oral tablet 15 mg* | T2 | PA-NS; QL (186 EA per 31 days) |
| *clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg* | T2 | PA-NS; QL (93 EA per 31 days) |
| *clozapine oral tablet 100 mg, 25 mg* | T3 | QL (279 EA per 31 days) |
| *clozapine oral tablet 200 mg* | T3 | QL (124 EA per 31 days) |
| *clozapine oral tablet 50 mg* | T3 | QL (93 EA per 31 days) |
| *clozapine oral tablet,disintegrating 100 mg, 25 mg* | T4 | QL (279 EA per 31 days) |
| *clozapine oral tablet,disintegrating 12.5 mg* | T4 | QL (93 EA per 31 days) |
| *clozapine oral tablet,disintegrating 150 mg* | T4 | QL (186 EA per 31 days) |
| *clozapine oral tablet,disintegrating 200 mg* | T4 | QL (124 EA per 31 days) |
| **CLOZARIL ORAL TABLET 100 MG, 25 MG** | T4 | QL (279 EA per 31 days) |
| **COBENFY** | T5 | PA-NS; QL (62 EA per 31 days) |
| **COBENFY STARTER PACK** | T5 | PA-NS; QL (112 EA per 365 days) |
| *codeine sulfate* | T4 | PA; QL (186 EA per 31 days) |
| *codeine-butalbital-asa-caff* | T4 | PA; QL (372 EA per 31 days) |
| **CONCERTA** | T4 | ST; QL (31 EA per 31 days) |
| **CONZIP** | T4 | PA; QL (30 EA per 30 days) |
| **COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML** | T5 | PA; QL (31 ML per 31 days) |
| **COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML** | T5 | PA; QL (12 ML per 28 days) |
| **COTEMPLA XR-ODT** | T4 | ST; QL (62 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **CREXONT** | T4 | ST |
| *cyclobenzaprine oral capsule,extended release 24hr* | T4 | QL (31 EA per 31 days) |
| *cyclobenzaprine oral tablet 10 mg, 7.5 mg* | T4 | QL (93 EA per 31 days) |
| *cyclobenzaprine oral tablet 5 mg* | T4 | QL (155 EA per 31 days) |
| *dalfampridine* | T5 | PA; QL (62 EA per 31 days) |
| **DANTRIUM ORAL CAPSULE 25 MG** | T4 | |
| *dantrolene oral* | T2 | |
| **DAYBUE** | T5 | PA; QL (3600 ML per 30 days) |
| **DAYBUE STIX ORAL POWDER IN PACKET 5,000 MG, 6,000 MG** | T5 | PA; QL (124 EA per 31 days) |
| **DAYBUE STIX ORAL POWDER IN PACKET 8,000 MG** | T5 | PA; QL (62 EA per 31 days) |
| **DAYTRANA** | T4 | PA; QL (30 EA per 30 days) |
| **DAYVIGO** | T4 | ST; QL (31 EA per 31 days) |
| **DEMEROL (PF) INJECTION SYRINGE 25 MG/ML** | T4 | PA; QL (496 ML per 31 days) |
| **DEMEROL INJECTION** | T4 | PA; QL (248 ML per 31 days) |
| **DEPAKOTE** | T4 | |
| **DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 250 MG** | T4 | |
| **DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 500 MG** | T5 | |
| **DEPAKOTE SPRINKLES** | T4 | |
| *desipramine* | T2 | |
| *desvenlafaxine oral tablet extended release 24 hr 100 mg* | T4 | QL (124 EA per 31 days) |
| *desvenlafaxine oral tablet extended release 24 hr 50 mg* | T4 | QL (31 EA per 31 days) |
| *desvenlafaxine succinate* | T2 | QL (31 EA per 31 days) |
| **DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG** | T5 | ST; QL (186 EA per 31 days) |
| *dexmethylphenidate oral capsule,er biphasic 50-50* | T4 | QL (31 EA per 31 days) |
| *dexmethylphenidate oral tablet 10 mg* | T2 | QL (62 EA per 31 days) |
| *dexmethylphenidate oral tablet 2.5 mg, 5 mg* | T2 | QL (93 EA per 31 days) |
| *dextroamphetamine sulfate oral capsule, extended release 10 mg* | T4 | ST; QL (155 EA per 31 days) |
| *dextroamphetamine sulfate oral capsule, extended release 15 mg* | T4 | ST; QL (124 EA per 31 days) |

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

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

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *diflunisal* | T2 | |
| *dihydroergotamine nasal* | T5 | PA; QL (8 ML per 28 days) |
| **DILANTIN** | T3 | |
| **DILANTIN EXTENDED** | T4 | |
| **DILANTIN INFATABS** | T4 | |
| **DILANTIN-125** | T4 | |
| **DILAUDID ORAL LIQUID** | T4 | PA; QL (1240 ML per 31 days) |
| **DILAUDID ORAL TABLET 2 MG, 4 MG** | T4 | PA; QL (186 EA per 31 days) |
| **DILAUDID ORAL TABLET 8 MG** | T5 | PA; QL (155 EA per 31 days) |
| *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg* | T4 | PA; QL (62 EA per 31 days) |
| *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)* | T5 | PA; QL (120 EA per 365 days) |
| *dimethyl fumarate oral capsule,delayed release(dr/ec) 240 mg* | T5 | PA; QL (62 EA per 31 days) |
| *divalproex* | T2 | |
| **DOLOBID ORAL TABLET 250 MG** | T4 | |
| **DOLOBID ORAL TABLET 375 MG** | T5 | |
| *donepezil oral tablet 10 mg, 5 mg* | T1 | |
| *donepezil oral tablet 23 mg* | T4 | QL (31 EA per 31 days) |
| *donepezil oral tablet,disintegrating* | T2 | |
| *doxepin oral capsule* | T2 | PA-NS |
| *doxepin oral concentrate* | T2 | PA-NS |
| *doxepin oral tablet* | T3 | PA |
| **DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG** | T3 | PA-NS; QL (93 EA per 31 days) |
| **DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 30 MG, 60 MG** | T3 | PA-NS; QL (62 EA per 31 days) |
| **DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG** | T3 | PA-NS; QL (31 EA per 31 days) |
| *duloxetine oral capsule,delayed release(dr/ec) 120 mg, 40 mg, 80 mg, 90 mg* | T4 | QL (31 EA per 31 days) |
| *duloxetine oral capsule,delayed release(dr/ec) 20 mg, 60 mg* | T2 | QL (62 EA per 31 days) |
| *duloxetine oral capsule,delayed release(dr/ec) 30 mg* | T2 | QL (31 EA per 31 days) |
| **DUOPA** | T5 | PA-BvD |
| **DYANAVEL XR ORAL SUSPEN, IR - ER, BIPHASIC 24HR** | T4 | ST; QL (248 ML per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **DYANAVEL XR ORAL TABLET, IR - ER, BIPHASIC 24HR** | T4 | ST; QL (31 EA per 31 days) |
| **EDLUAR** | T4 | PA; QL (31 EA per 31 days) |
| **EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 37.5 MG** | T4 | QL (31 EA per 31 days) |
| **EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 75 MG** | T4 | QL (93 EA per 31 days) |
| *eletriptan oral tablet 20 mg* | T4 | QL (12 EA per 28 days) |
| *eletriptan oral tablet 40 mg* | T4 | QL (6 EA per 28 days) |
| **ELYXYB** | T4 | PA |
| **EMGALITY PEN** | T3 | PA; QL (1 ML per 28 days) |
| **EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML** | T3 | PA; QL (1 ML per 28 days) |
| **EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)** | T5 | PA; QL (3 ML per 28 days) |
| **EMSAM** | T5 | QL (30 EA per 30 days) |
| *entacapone* | T3 | |
| **EPIDIOLEX** | T5 | PA-NS |
| **EPRONTIA** | T4 | PA-NS; QL (496 ML per 31 days) |
| **EQUETRO** | T4 | |
| **ERGOMAR** | T4 | PA |
| *ergotamine-caffeine* | T3 | PA |
| **ERZOFRI INTRAMUSCULAR SYRINGE 117 MG/0.75 ML** | T5 | QL (0.75 ML per 30 days) |
| **ERZOFRI INTRAMUSCULAR SYRINGE 156 MG/ML** | T5 | QL (1 ML per 30 days) |
| **ERZOFRI INTRAMUSCULAR SYRINGE 234 MG/1.5 ML** | T5 | QL (1.5 ML per 30 days) |
| **ERZOFRI INTRAMUSCULAR SYRINGE 351 MG/2.25 ML** | T5 | QL (4.5 ML per 365 days) |
| **ERZOFRI INTRAMUSCULAR SYRINGE 39 MG/0.25 ML** | T5 | QL (0.25 ML per 30 days) |
| **ERZOFRI INTRAMUSCULAR SYRINGE 78 MG/0.5 ML** | T5 | QL (0.5 ML per 30 days) |
| *escitalopram oxalate oral capsule* | T4 | PA-NS; QL (31 EA per 31 days) |
| *escitalopram oxalate oral solution* | T4 | QL (620 ML per 31 days) |
| *escitalopram oxalate oral tablet 10 mg* | T1 | QL (45 EA per 30 days) |
| *escitalopram oxalate oral tablet 20 mg, 5 mg* | T1 | QL (30 EA per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *eslicarbazepine oral tablet 200 mg* | T4 | QL (186 EA per 31 days) |
| *eslicarbazepine oral tablet 400 mg* | T5 | QL (93 EA per 31 days) |
| *eslicarbazepine oral tablet 600 mg, 800 mg* | T5 | QL (62 EA per 31 days) |
| *estazolam* | T4 | PA |
| *eszopiclone* | T4 | PA; QL (31 EA per 31 days) |
| *ethosuximide* | T2 | |
| *etodolac* | T2 | |
| **EVEKEO** | T4 | PA |
| **EVRYSDI ORAL RECON SOLN** | T5 | PA; QL (240 ML per 31 days) |
| **EVRYSDI ORAL TABLET** | T5 | PA; QL (31 EA per 31 days) |
| **EXELON PATCH** | T4 | QL (30 EA per 30 days) |
| **EXXUA ORAL TABLET EXTENDED RELEASE 24 HR** | T4 | PA-NS; QL (31 EA per 31 days) |
| **EXXUA ORAL TABLET, EXT REL 24HR DOSE PACK** | T4 | PA-NS; QL (64 EA per 365 days) |
| **FANAPT ORAL TABLET 1 MG** | T4 | PA-NS; QL (62 EA per 31 days) |
| **FANAPT ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **FANAPT TITRATION PACK A** | T4 | PA-NS; QL (16 EA per 365 days) |
| **FANAPT TITRATION PACK B** | T4 | PA-NS; QL (24 EA per 365 days) |
| **FANAPT TITRATION PACK C** | T4 | PA-NS; QL (16 EA per 365 days) |
| *felbamate* | T4 | |
| **FELBATOL ORAL TABLET** | T5 | |
| *fenoprofen oral capsule 200 mg, 300 mg* | T5 | |
| *fenoprofen oral capsule 400 mg* | T4 | |
| **FENOPRON** | T4 | |
| *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr* | T4 | PA; QL (10 EA per 30 days) |
| *fentanyl transdermal patch 72 hour 87.5 mcg/hour* | T5 | PA; QL (10 EA per 30 days) |
| **FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)** | T3 | PA-NS; QL (56 EA per 365 days) |
| **FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG** | T3 | PA-NS; QL (31 EA per 31 days) |
| **FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG** | T3 | PA-NS; QL (93 EA per 31 days) |
| **FEXMID** | T4 | QL (93 EA per 31 days) |
| *fingolimod* | T5 | PA; QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **FINTEPLA** | T5 | PA-NS; QL (360 ML per 30 days) |
| **FIORICET** | T4 | QL (403 EA per 31 days) |
| **FIRDAPSE** | T5 | PA; QL (248 EA per 31 days) |
| **FLECTOR** | T4 | PA; QL (62 EA per 31 days) |
| **FLEQSUVY** | T4 | PA; QL (496 ML per 31 days) |
| *fluoxetine (pmdd)* | T2 | |
| *fluoxetine oral capsule* | T1 | |
| *fluoxetine oral capsule,delayed release(dr/ec)* | T2 | |
| *fluoxetine oral solution* | T3 | |
| *fluoxetine oral tablet 10 mg, 20 mg* | T2 | |
| *fluoxetine oral tablet 60 mg* | T4 | |
| *fluphenazine decanoate* | T4 | |
| *fluphenazine hcl* | T4 | |
| *flurazepam* | T4 | PA |
| *flurbiprofen oral tablet 100 mg* | T2 | |
| *fluvoxamine oral capsule,extended release 24hr* | T4 | |
| *fluvoxamine oral tablet* | T2 | |
| **FOCALIN ORAL TABLET 10 MG** | T4 | ST; QL (62 EA per 31 days) |
| **FOCALIN ORAL TABLET 2.5 MG, 5 MG** | T4 | ST; QL (93 EA per 31 days) |
| **FOCALIN XR** | T4 | ST; QL (31 EA per 31 days) |
| *frovatriptan* | T4 | QL (12 EA per 28 days) |
| **FYCOMPA ORAL SUSPENSION** | T5 | QL (744 ML per 31 days) |
| **FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG** | T5 | QL (31 EA per 31 days) |
| **FYCOMPA ORAL TABLET 2 MG** | T4 | QL (31 EA per 31 days) |
| *gabapentin oral capsule 100 mg, 400 mg* | T1 | QL (270 EA per 30 days) |
| *gabapentin oral capsule 200 mg* | T5 | PA-NS; QL (93 EA per 31 days) |
| *gabapentin oral capsule 300 mg* | T1 | QL (360 EA per 30 days) |
| *gabapentin oral solution 250 mg/5 ml* | T2 | QL (2160 ML per 30 days) |
| *gabapentin oral tablet 600 mg* | T1 | QL (180 EA per 30 days) |
| *gabapentin oral tablet 800 mg* | T1 | QL (120 EA per 30 days) |
| *gabapentin oral tablet extended release 24 hr 300 mg* | T4 | PA; QL (155 EA per 31 days) |
| *gabapentin oral tablet extended release 24 hr 450 mg* | T4 | PA; QL (31 EA per 31 days) |
| *gabapentin oral tablet extended release 24 hr 600 mg* | T4 | PA; QL (93 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *gabapentin oral tablet extended release 24 hr 750 mg, 900 mg* | T4 | PA; QL (62 EA per 31 days) |
| **GABARONE ORAL TABLET 100 MG** | T5 | PA-NS; QL (558 EA per 31 days) |
| **GABARONE ORAL TABLET 400 MG** | T5 | PA-NS; QL (279 EA per 31 days) |
| *galantamine oral capsule,ext rel. pellets 24 hr* | T3 | |
| *galantamine oral solution* | T4 | |
| *galantamine oral tablet* | T3 | |
| **GEODON INTRAMUSCULAR** | T4 | |
| **GEODON ORAL** | T5 | QL (62 EA per 31 days) |
| **GILENYA** | T5 | PA; QL (31 EA per 31 days) |
| *glatiramer subcutaneous syringe 20 mg/ml* | T5 | PA; QL (31 ML per 31 days) |
| *glatiramer subcutaneous syringe 40 mg/ml* | T5 | PA; QL (12 ML per 28 days) |
| **GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML** | T5 | PA; QL (31 ML per 31 days) |
| **GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML** | T5 | PA; QL (12 ML per 28 days) |
| **GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG** | T5 | PA; QL (62 EA per 31 days) |
| **GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 68.5 MG** | T5 | PA; QL (124 EA per 31 days) |
| **GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG** | T4 | PA; QL (155 EA per 31 days) |
| **GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG** | T4 | PA; QL (31 EA per 31 days) |
| **GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG** | T4 | PA; QL (93 EA per 31 days) |
| **GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 750 MG, 900 MG** | T4 | PA; QL (62 EA per 31 days) |
| *guanfacine oral tablet extended release 24 hr* | T2 | PA |
| *haloperidol* | T1 | |
| *haloperidol decanoate* | T2 | |
| *haloperidol lactate injection* | T2 | |
| *haloperidol lactate oral* | T2 | |
| **HETLIOZ** | T5 | PA; QL (31 EA per 31 days) |
| **HETLIOZ LQ** | T5 | PA; QL (158 ML per 31 days) |
| **HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG** | T4 | PA; QL (90 EA per 30 days) |
| **HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG** | T4 | PA; QL (60 EA per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *hydrocodone bitartrate oral capsule, oral only, er 12hr* | T4 | PA; QL (100 EA per 31 days) |
| *hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr 100 mg, 120 mg* | T5 | PA; QL (31 EA per 31 days) |
| *hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr 20 mg, 30 mg, 40 mg, 60 mg, 80 mg* | T4 | PA; QL (31 EA per 31 days) |
| *hydrocodone-acetaminophen oral solution 10-300 mg/15 ml* | T3 | PA; QL (6200 ML per 31 days) |
| *hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml* | T3 | PA; QL (5723 ML per 31 days) |
| *hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg* | T3 | 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* | T3 | PA; QL (372 EA per 31 days) |
| *hydrocodone-ibuprofen* | T3 | PA; QL (155 EA per 31 days) |
| *hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml* | T4 | PA |
| *hydromorphone oral liquid* | T4 | PA; QL (1240 ML per 31 days) |
| *hydromorphone oral tablet 2 mg, 4 mg* | T3 | PA; QL (186 EA per 31 days) |
| *hydromorphone oral tablet 8 mg* | T3 | PA; QL (155 EA per 31 days) |
| *hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 8 mg* | T4 | PA; QL (62 EA per 31 days) |
| *hydromorphone oral tablet extended release 24 hr 32 mg* | T4 | PA; QL (31 EA per 31 days) |
| **HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 80 MG** | T5 | PA; QL (31 EA per 31 days) |
| **HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 20 MG, 30 MG, 40 MG, 60 MG** | T4 | PA; QL (31 EA per 31 days) |
| **IBU ORAL TABLET 600 MG, 800 MG** | T1 | |
| *ibuprofen oral suspension* | T2 | |
| *ibuprofen oral tablet 300 mg* | T4 | |
| *ibuprofen oral tablet 400 mg, 600 mg, 800 mg* | T1 | |
| *ibuprofen-famotidine* | T4 | PA; QL (93 EA per 31 days) |
| *imipramine hcl* | T4 | PA-NS |
| *imipramine pamoate* | T4 | PA-NS |
| **IMITREX ORAL TABLET 100 MG** | T4 | QL (9 EA per 28 days) |
| **IMITREX ORAL TABLET 25 MG** | T4 | QL (36 EA per 28 days) |
| **IMITREX ORAL TABLET 50 MG** | T4 | QL (18 EA per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **IMITREX STATDOSE PEN SUBCUTANEOUS PEN INJECTOR 4 MG/0.5 ML** | T4 | QL (6 ML per 28 days) |
| **IMITREX STATDOSE REFILL SUBCUTANEOUS CARTRIDGE 6 MG/0.5 ML** | T5 | QL (4 ML per 28 days) |
| **INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE** | T5 | PA; QL (300 EA per 30 days) |
| **INDOCIN ORAL** | T4 | |
| **INDOCIN RECTAL** | T5 | |
| *indomethacin oral capsule* | T1 | |
| *indomethacin oral capsule, extended release* | T2 | |
| *indomethacin oral suspension* | T4 | |
| *indomethacin rectal suppository 50 mg* | T5 | |
| **INGREZZA INITIATION PK(TARDIV)** | T5 | PA; QL (56 EA per 365 days) |
| **INGREZZA ORAL CAPSULE 40 MG** | T5 | PA; QL (62 EA per 31 days) |
| **INGREZZA ORAL CAPSULE 60 MG, 80 MG** | T5 | PA; QL (31 EA per 31 days) |
| **INGREZZA SPRINKLE** | T5 | PA; QL (31 EA per 31 days) |
| **INTUNIV ER** | T4 | PA |
| **INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML** | T5 | QL (3.5 ML per 180 days) |
| **INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML** | T5 | QL (5 ML per 180 days) |
| **INVEGA ORAL TABLET EXTENDED RELEASE 24HR 3 MG, 9 MG** | T4 | QL (31 EA per 31 days) |
| **INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG** | T4 | QL (62 EA per 31 days) |
| **INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML** | T5 | QL (0.75 ML per 28 days) |
| **INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML** | T5 | QL (1 ML per 28 days) |
| **INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML** | T5 | QL (1.5 ML per 28 days) |
| **INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML** | T4 | QL (0.25 ML per 28 days) |
| **INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML** | T5 | QL (0.5 ML per 28 days) |
| **INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML** | T5 | QL (0.88 ML per 84 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML** | T5 | QL (1.32 ML per 84 days) |
| **INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML** | T5 | QL (1.75 ML per 84 days) |
| **INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML** | T5 | QL (2.63 ML per 84 days) |
| **JORNAY PM** | T4 | ST; QL (31 EA per 31 days) |
| **JOURNAVX** | T4 | PA; QL (29 EA per 90 days) |
| **KEPPRA ORAL SOLUTION** | T5 | |
| **KEPPRA ORAL TABLET 1,000 MG** | T5 | |
| **KEPPRA ORAL TABLET 250 MG, 500 MG, 750 MG** | T4 | |
| **KEPPRA XR** | T4 | |
| **KESIMPTA PEN** | T5 | PA; QL (0.4 ML per 28 days) |
| *ketoprofen oral capsule 25 mg, 50 mg* | T4 | |
| *ketoprofen oral capsule 75 mg* | T5 | QL (124 EA per 31 days) |
| *ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg* | T4 | |
| *ketorolac oral* | T4 | |
| **KEVEYIS** | T5 | PA; QL (124 EA per 31 days) |
| **KLONOPIN ORAL TABLET 0.5 MG** | T4 | PA-NS; QL (93 EA per 31 days) |
| **KLONOPIN ORAL TABLET 1 MG** | T4 | PA-NS; QL (124 EA per 31 days) |
| **KLONOPIN ORAL TABLET 2 MG** | T4 | PA-NS; QL (310 EA per 31 days) |
| **KLOXXADO** | T3 | |
| *lacosamide oral* | T4 | |
| **LAMICTAL ODT ORAL TABLET,DISINTEGRATING 100 MG** | T5 | |
| **LAMICTAL ODT ORAL TABLET,DISINTEGRATING 200 MG, 25 MG, 50 MG** | T4 | |
| **LAMICTAL ORAL TABLET** | T5 | |
| **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** | T5 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR 250 MG, 300 MG, 50 MG** | T4 | |
| **LAMICTAL XR STARTER (BLUE)** | T4 | |
| **LAMICTAL XR STARTER (GREEN)** | T4 | |
| **LAMICTAL XR STARTER (ORANGE)** | T4 | |
| *lamotrigine oral tablet* | T1 | |
| *lamotrigine oral tablet disintegrating, dose pk* | T4 | |
| *lamotrigine oral tablet extended release 24hr* | T4 | |
| *lamotrigine oral tablet, chewable dispersible* | T2 | |
| *lamotrigine oral tablet,disintegrating* | T4 | |
| *lamotrigine oral tablets,dose pack* | T4 | |
| **LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG** | T5 | PA-NS; QL (31 EA per 31 days) |
| **LATUDA ORAL TABLET 80 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 360 MG/1.8 ML** | T5 | PA; QL (7.2 ML per 28 days) |
| **LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 500 MG/2.5 ML ( 250MG/1.25MLX2)** | T5 | PA; QL (10 ML per 28 days) |
| *levetiracetam oral solution 100 mg/ml* | T2 | |
| *levetiracetam oral tablet* | T2 | |
| *levetiracetam oral tablet extended release 24 hr* | T2 | |
| *levetiracetam oral tablet for suspension* | T4 | |
| *levorphanol tartrate* | T5 | PA; QL (186 EA per 31 days) |
| **LEXAPRO ORAL TABLET 10 MG** | T4 | QL (45 EA per 30 days) |
| **LEXAPRO ORAL TABLET 20 MG, 5 MG** | T4 | QL (30 EA per 30 days) |
| **LICART** | T4 | PA; QL (31 EA per 31 days) |
| *lisdexamfetamine* | T4 | ST; QL (31 EA per 31 days) |
| *lithium carbonate* | T1 | |
| *lithium citrate oral solution* | T1 | |
| **LITHOBID** | T4 | |
| **LODINE ORAL TABLET** | T4 | |
| **LODOSYN** | T4 | |
| **LOFENA** | T5 | |
| *lofexidine* | T5 | |
| **LORAZEPAM INTENSOL** | T2 | PA; QL (155 ML per 31 days) |
| *lorazepam oral tablet 0.5 mg* | T2 | PA; QL (124 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *lorazepam oral tablet 1 mg* | T2 | PA; QL (186 EA per 31 days) |
| *lorazepam oral tablet 2 mg* | T2 | PA; QL (155 EA per 31 days) |
| **LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1 MG, 3 MG** | T4 | PA; QL (93 EA per 31 days) |
| **LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1.5 MG, 2 MG** | T4 | PA; QL (155 EA per 31 days) |
| *loxapine succinate* | T2 | |
| **LUMRYZ** | T5 | PA; QL (31 EA per 31 days) |
| **LUMRYZ STARTER PACK** | T5 | PA; QL (56 EA per 365 days) |
| **LUNESTA** | T4 | PA; QL (31 EA per 31 days) |
| *lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg* | T4 | PA-NS; QL (31 EA per 31 days) |
| *lurasidone oral tablet 80 mg* | T4 | PA-NS; QL (62 EA per 31 days) |
| **LURBIRO** | T5 | |
| **LYBALVI** | T5 | PA-NS; QL (31 EA per 31 days) |
| **LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG** | T5 | PA; QL (31 EA per 31 days) |
| **LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 330 MG, 82.5 MG** | T4 | PA; QL (31 EA per 31 days) |
| **LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG** | T4 | PA-NS; QL (93 EA per 31 days) |
| **LYRICA ORAL CAPSULE 225 MG, 300 MG** | T4 | PA-NS; QL (62 EA per 31 days) |
| **LYRICA ORAL SOLUTION** | T4 | PA-NS; QL (930 ML per 31 days) |
| **MARPLAN** | T4 | |
| **MAVENCLAD (10 TABLET PACK)** | T5 | PA; QL (40 EA per 365 days) |
| **MAVENCLAD (4 TABLET PACK)** | T5 | PA; QL (40 EA per 365 days) |
| **MAVENCLAD (5 TABLET PACK)** | T5 | PA; QL (40 EA per 365 days) |
| **MAVENCLAD (6 TABLET PACK)** | T5 | PA; QL (40 EA per 365 days) |
| **MAVENCLAD (7 TABLET PACK)** | T5 | PA; QL (40 EA per 365 days) |
| **MAVENCLAD (8 TABLET PACK)** | T5 | PA; QL (40 EA per 365 days) |
| **MAVENCLAD (9 TABLET PACK)** | T5 | PA; QL (40 EA per 365 days) |
| **MAXALT ORAL TABLET 10 MG** | T4 | QL (12 EA per 28 days) |
| **MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG** | T4 | QL (12 EA per 28 days) |
| **MAYZENT ORAL TABLET 0.25 MG** | T5 | PA; QL (155 EA per 31 days) |
| **MAYZENT ORAL TABLET 1 MG, 2 MG** | T5 | PA; QL (31 EA per 31 days) |
| **MAYZENT STARTER(FOR 1MG MAINT)** | T4 | PA; QL (14 EA per 365 days) |
| **MAYZENT STARTER(FOR 2MG MAINT)** | T5 | PA; QL (24 EA per 365 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *meclofenamate* | T4 | |
| *mefenamic acid* | T4 | |
| *meloxicam oral suspension* | T5 | |
| *meloxicam oral tablet* | T1 | |
| *meloxicam submicronized* | T4 | PA; QL (31 EA per 31 days) |
| *memantine oral capsule,sprinkle,er 24hr* | T4 | |
| *memantine oral solution* | T3 | |
| *memantine oral tablet* | T2 | |
| *memantine-donepezil* | T3 | PA |
| *meperidine (pf) injection solution 100 mg/ml, 50 mg/ml* | T4 | PA; QL (248 ML per 31 days) |
| *meperidine (pf) injection solution 25 mg/ml* | T4 | PA; QL (496 ML per 31 days) |
| *meperidine oral solution* | T4 | PA; QL (1860 ML per 31 days) |
| *meperidine oral tablet 50 mg* | T4 | PA; QL (372 EA per 31 days) |
| *meprobamate oral tablet 200 mg* | T4 | QL (341 EA per 31 days) |
| *meprobamate oral tablet 400 mg* | T4 | QL (186 EA per 31 days) |
| **MESTINON ORAL** | T5 | |
| **MESTINON TIMESPAN** | T5 | |
| **METADATE CD** | T4 | ST; QL (31 EA per 31 days) |
| *metaxalone oral tablet 400 mg, 800 mg* | T4 | PA |
| *metaxalone oral tablet 640 mg* | T5 | PA |
| *methadone oral solution 10 mg/5 ml* | T3 | PA; QL (620 ML per 31 days) |
| *methadone oral solution 5 mg/5 ml* | T3 | PA; QL (1240 ML per 31 days) |
| *methadone oral tablet 10 mg* | T3 | PA; QL (124 EA per 31 days) |
| *methadone oral tablet 5 mg* | T3 | PA; QL (248 EA per 31 days) |
| *methamphetamine* | T4 | PA |
| *methocarbamol oral tablet 1,000 mg* | T5 | |
| *methocarbamol oral tablet 500 mg, 750 mg* | T4 | |
| *methsuximide* | T4 | |
| **METHYLIN ORAL SOLUTION 10 MG/5 ML** | T4 | ST; QL (930 ML per 31 days) |
| **METHYLIN ORAL SOLUTION 5 MG/5 ML** | T4 | ST; QL (465 ML per 31 days) |
| *methylphenidate hcl oral cap,er sprinkle,biphasic 40-60* | T4 | ST; QL (31 EA per 31 days) |
| *methylphenidate hcl oral capsule, er biphasic 30-70* | T4 | QL (31 EA per 31 days) |
| *methylphenidate hcl oral capsule,er biphasic 50-50 10 mg* | T4 | QL (186 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *methylphenidate hcl oral capsule,er biphasic 50-50 20 mg* | T4 | QL (93 EA per 31 days) |
| *methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 40 mg* | T4 | QL (62 EA per 31 days) |
| *methylphenidate hcl oral capsule,er biphasic 50-50 60 mg* | T4 | QL (31 EA per 31 days) |
| *methylphenidate hcl oral solution 10 mg/5 ml* | T2 | QL (930 ML per 31 days) |
| *methylphenidate hcl oral solution 5 mg/5 ml* | T2 | QL (465 ML per 31 days) |
| *methylphenidate hcl oral tablet* | T2 | QL (93 EA per 31 days) |
| *methylphenidate hcl oral tablet extended release* | T4 | QL (93 EA per 31 days) |
| *methylphenidate hcl oral tablet extended release 24hr* | T4 | QL (31 EA per 31 days) |
| *methylphenidate hcl oral tablet,chewable 10 mg* | T4 | QL (186 EA per 31 days) |
| *methylphenidate hcl oral tablet,chewable 2.5 mg, 5 mg* | T4 | QL (93 EA per 31 days) |
| *methylphenidate oral* | T4 | ST; QL (62 EA per 31 days) |
| *methylphenidate transdermal* | T4 | PA; QL (30 EA per 30 days) |
| **MIGERGOT** | T5 | |
| **MIPLYFFA** | T5 | PA; QL (93 EA per 31 days) |
| *mirtazapine oral tablet* | T1 | |
| *mirtazapine oral tablet,disintegrating* | T2 | |
| *modafinil* | T2 | PA; QL (31 EA per 31 days) |
| *molindone* | T2 | |
| *morphine concentrate oral solution* | T3 | PA; QL (310 ML per 31 days) |
| *morphine oral capsule, er multiphase 24 hr 120 mg* | T4 | PA; QL (51 EA per 31 days) |
| *morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg* | T4 | PA; QL (62 EA per 31 days) |
| *morphine oral capsule,extend.release pellets 10 mg, 100 mg, 20 mg, 50 mg, 60 mg, 80 mg* | T4 | PA; QL (62 EA per 31 days) |
| *morphine oral solution 10 mg/5 ml (2 mg/ml)* | T3 | PA; QL (2800 ML per 31 days) |
| *morphine oral solution 20 mg/5 ml (4 mg/ml)* | T3 | PA; QL (1400 ML per 31 days) |
| *morphine oral tablet* | T3 | PA; QL (186 EA per 31 days) |
| *morphine oral tablet extended release 100 mg* | T3 | PA; QL (62 EA per 31 days) |
| *morphine oral tablet extended release 15 mg, 30 mg, 60 mg* | T3 | PA; QL (100 EA per 31 days) |
| *morphine oral tablet extended release 200 mg* | T3 | PA; QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG** | T4 | PA-NS; QL (31 EA per 31 days) |
| **MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 200 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG, 60 MG** | T4 | PA; QL (100 EA per 31 days) |
| **MYDAYIS** | T4 | ST; QL (31 EA per 31 days) |
| **MYSOLINE** | T5 | |
| *nabumetone* | T2 | |
| **NALOCET** | T4 | PA; QL (403 EA per 31 days) |
| *naloxone injection solution* | T2 | |
| *naloxone injection syringe* | T2 | |
| *naltrexone* | T2 | |
| **NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR** | T4 | PA |
| **NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 375 MG, 500 MG** | T4 | |
| *naproxen oral suspension* | T4 | |
| *naproxen oral tablet* | T1 | |
| *naproxen oral tablet,delayed release (dr/ec)* | T2 | |
| *naproxen sodium oral tablet 275 mg, 550 mg* | T2 | |
| *naproxen sodium oral tablet, er multiphase 24 hr* | T4 | |
| *naproxen-esomeprazole* | T5 | PA; QL (62 EA per 31 days) |
| *naratriptan oral tablet 1 mg* | T3 | QL (20 EA per 28 days) |
| *naratriptan oral tablet 2.5 mg* | T3 | QL (9 EA per 28 days) |
| **NARDIL** | T4 | |
| **NAYZILAM** | T4 | PA-NS; QL (10 EA per 30 days) |
| *nefazodone* | T2 | |
| **NEUPRO** | T4 | |
| **NEURONTIN ORAL CAPSULE 100 MG** | T4 | PA-NS; QL (270 EA per 30 days) |
| **NEURONTIN ORAL CAPSULE 300 MG** | T5 | PA-NS; QL (360 EA per 30 days) |
| **NEURONTIN ORAL CAPSULE 400 MG** | T5 | PA-NS; QL (270 EA per 30 days) |
| **NEURONTIN ORAL SOLUTION** | T4 | PA-NS; QL (2160 ML per 30 days) |
| **NEURONTIN ORAL TABLET 600 MG** | T5 | PA-NS; QL (180 EA per 30 days) |
| **NEURONTIN ORAL TABLET 800 MG** | T4 | PA-NS; QL (120 EA per 30 days) |
| **NORGESIC** | T4 | PA; QL (248 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **NORGESIC FORTE** | T4 | PA; QL (124 EA per 31 days) |
| *nortriptyline* | T2 | |
| **NOURIANZ** | T5 | PA; QL (31 EA per 31 days) |
| **NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 150 MG, 200 MG, 250 MG** | T5 | PA; QL (62 EA per 31 days) |
| **NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 50 MG** | T4 | PA; QL (62 EA per 31 days) |
| **NUCYNTA ORAL TABLET 100 MG, 75 MG** | T5 | PA; QL (186 EA per 31 days) |
| **NUCYNTA ORAL TABLET 50 MG** | T4 | PA; QL (186 EA per 31 days) |
| **NUEDEXTA** | T5 | PA; QL (62 EA per 31 days) |
| **NUPLAZID** | T5 | PA-NS; QL (31 EA per 31 days) |
| **NURTEC ODT** | T3 | PA; QL (18 EA per 28 days) |
| **NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG** | T5 | PA; QL (31 EA per 31 days) |
| **NUVIGIL ORAL TABLET 50 MG** | T4 | PA; QL (31 EA per 31 days) |
| *olanzapine intramuscular* | T4 | |
| *olanzapine oral* | T2 | QL (31 EA per 31 days) |
| *olanzapine-fluoxetine* | T4 | |
| **ONAPGO** | T5 | PA; QL (620 ML per 31 days) |
| **ONFI ORAL SUSPENSION** | T5 | PA-NS; QL (496 ML per 31 days) |
| **ONFI ORAL TABLET** | T5 | PA-NS; QL (62 EA per 31 days) |
| **ONGENTYS** | T4 | PA; QL (31 EA per 31 days) |
| **ONTRALFY** | T4 | PA; QL (2790 ML per 31 days) |
| **ONYDA XR** | T4 | PA; QL (120 ML per 30 days) |
| **ONZETRA XSAIL** | T4 | QL (16 EA per 28 days) |
| **OPIPZA** | T5 | PA-NS |
| **OPVEE** | T4 | |
| **ORMALVI** | T5 | PA; QL (124 EA per 31 days) |
| *orphenadrine citrate oral* | T4 | PA |
| *orphenadrine-asa-caffeine oral tablet 25-385-30 mg* | T4 | PA; QL (248 EA per 31 days) |
| **ORUDIS** | T5 | QL (124 EA per 31 days) |
| *oxaprozin oral tablet* | T4 | |
| *oxazepam* | T4 | PA |
| *oxcarbazepine oral suspension* | T4 | |
| *oxcarbazepine oral tablet* | T3 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *oxcarbazepine oral tablet extended release 24 hr 150 mg, 300 mg* | T4 | |
| *oxcarbazepine oral tablet extended release 24 hr 600 mg* | T5 | |
| **OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG** | T4 | |
| **OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 600 MG** | T5 | |
| *oxycodone oral capsule* | T3 | PA; QL (186 EA per 31 days) |
| *oxycodone oral concentrate* | T4 | PA; QL (180 ML per 31 days) |
| *oxycodone oral solution* | T3 | PA; QL (4133 ML per 31 days) |
| *oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg* | T3 | 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* | T5 | PA; QL (186 EA per 31 days) |
| *oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg* | T5 | PA; QL (403 EA per 31 days) |
| *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | T3 | PA; QL (372 EA per 31 days) |
| **OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG** | T3 | PA; QL (100 EA per 31 days) |
| **OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 40 MG** | T5 | PA; QL (100 EA per 31 days) |
| **OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG** | T5 | PA; QL (69 EA per 31 days) |
| **OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG** | T5 | PA; QL (62 EA per 31 days) |
| *oxymorphone oral tablet* | T4 | 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* | T4 | PA; QL (100 EA per 31 days) |
| *oxymorphone oral tablet extended release 12 hr 30 mg* | T5 | PA; QL (69 EA per 31 days) |
| *oxymorphone oral tablet extended release 12 hr 40 mg* | T5 | PA; QL (51 EA per 31 days) |
| **OZOBAX DS** | T4 | PA; QL (1240 ML per 31 days) |
| *paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg* | T4 | QL (31 EA per 31 days) |
| *paliperidone oral tablet extended release 24hr 6 mg* | T4 | QL (62 EA per 31 days) |
| **PARLODEL** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **PARNATE** | T4 | |
| *paroxetine hcl oral suspension* | T4 | PA-NS |
| *paroxetine hcl oral tablet* | T1 | PA-NS |
| *paroxetine hcl oral tablet extended release 24 hr* | T4 | PA-NS |
| *paroxetine mesylate(menop.sym)* | T4 | PA |
| **PAXIL CR** | T4 | PA-NS |
| **PAXIL ORAL TABLET** | T4 | PA-NS |
| *pentazocine-naloxone* | T4 | QL (335 EA per 31 days) |
| *perampanel oral suspension* | T5 | QL (744 ML per 31 days) |
| *perampanel oral tablet 10 mg, 12 mg, 4 mg, 6 mg, 8 mg* | T5 | QL (31 EA per 31 days) |
| *perampanel oral tablet 2 mg* | T4 | QL (31 EA per 31 days) |
| **PERCOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG** | T5 | PA; QL (372 EA per 31 days) |
| *perphenazine* | T2 | |
| *perphenazine-amitriptyline* | T4 | PA-NS |
| *phenelzine* | T3 | |
| *phenobarbital* | T2 | PA-NS |
| **PHENYTEK** | T4 | |
| *phenytoin oral suspension 125 mg/5 ml* | T2 | |
| *phenytoin oral tablet,chewable* | T2 | |
| *phenytoin sodium extended oral capsule 100 mg* | T2 | |
| *pimozide* | T4 | |
| *piroxicam* | T2 | |
| **PONVORY** | T5 | PA; QL (31 EA per 31 days) |
| **PONVORY 14-DAY STARTER PACK** | T5 | PA; QL (28 EA per 365 days) |
| *pramipexole oral tablet* | T2 | |
| *pramipexole oral tablet extended release 24 hr* | T4 | |
| *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg* | T3 | PA-NS; QL (93 EA per 31 days) |
| *pregabalin oral capsule 225 mg, 300 mg* | T3 | PA-NS; QL (62 EA per 31 days) |
| *pregabalin oral solution* | T3 | PA-NS; QL (930 ML per 31 days) |
| *pregabalin oral tablet extended release 24 hr* | T4 | PA; QL (31 EA per 31 days) |
| *primidone oral tablet 125 mg* | T4 | |
| *primidone oral tablet 250 mg, 50 mg* | T2 | |
| **PRISTIQ** | T4 | QL (31 EA per 31 days) |
| **PROCENTRA** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **PROLATE ORAL SOLUTION** | T4 | PA; QL (2066 ML per 31 days) |
| **PROLATE ORAL TABLET 10-300 MG** | T5 | PA; QL (403 EA per 31 days) |
| **PROLATE ORAL TABLET 5-300 MG, 7.5-300 MG** | T4 | PA; QL (403 EA per 31 days) |
| *protriptyline* | T4 | |
| **PROVIGIL** | T5 | PA; QL (31 EA per 31 days) |
| *pyridostigmine bromide oral syrup* | T5 | |
| *pyridostigmine bromide oral tablet 30 mg* | T4 | |
| *pyridostigmine bromide oral tablet 60 mg* | T3 | |
| *pyridostigmine bromide oral tablet extended release 180 mg* | T3 | |
| **QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG** | T4 | PA; QL (93 EA per 31 days) |
| **QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG** | T4 | PA; QL (62 EA per 31 days) |
| *quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg* | T2 | QL (62 EA per 31 days) |
| *quetiapine oral tablet 150 mg* | T3 | QL (62 EA per 31 days) |
| *quetiapine oral tablet extended release 24 hr* | T2 | QL (62 EA per 31 days) |
| **QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 20 MG, 40 MG** | T4 | ST; QL (31 EA per 31 days) |
| **QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 30 MG** | T4 | ST; QL (62 EA per 31 days) |
| **QUILLIVANT XR** | T4 | ST; QL (360 ML per 30 days) |
| **QULIPTA** | T3 | PA; QL (31 EA per 31 days) |
| **QUVIVIQ** | T4 | ST; QL (31 EA per 31 days) |
| **RADICAVA ORS STARTER KIT SUSP** | T5 | PA; QL (70 ML per 28 days) |
| **RALDESY** | T5 | |
| *ramelteon* | T3 | QL (31 EA per 31 days) |
| *rasagiline* | T4 | |
| **RELAFEN DS** | T5 | |
| **RELEXXII** | T4 | ST; QL (31 EA per 31 days) |
| **RELGAABI ORAL CAPSULE 200 MG** | T5 | PA-NS; QL (93 EA per 31 days) |
| **RELGAABI ORAL CAPSULE 300 MG** | T2 | PA-NS; QL (360 EA per 30 days) |
| **RELGAABI ORAL CAPSULE 400 MG** | T2 | PA-NS; QL (270 EA per 30 days) |
| **RELPAX ORAL TABLET 20 MG** | T4 | QL (12 EA per 28 days) |
| **RELPAX ORAL TABLET 40 MG** | T4 | QL (6 EA per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **REMERON ORAL TABLET 15 MG, 30 MG** | T4 | |
| **REMERON SOLTAB** | T4 | |
| **RESTORIL** | T4 | PA; QL (31 EA per 31 days) |
| **REXULTI ORAL TABLET** | T5 | PA-NS; QL (31 EA per 31 days) |
| **REZENOPY** | T3 | |
| **RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML** | T4 | QL (2 EA per 28 days) |
| **RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML** | T5 | QL (2 EA per 28 days) |
| **RISPERDAL ORAL SOLUTION** | T4 | QL (496 ML per 31 days) |
| **RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG** | T4 | QL (31 EA per 31 days) |
| **RISPERDAL ORAL TABLET 3 MG** | T4 | QL (93 EA per 31 days) |
| **RISPERDAL ORAL TABLET 4 MG** | T4 | QL (124 EA per 31 days) |
| *risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml* | T4 | QL (2 EA per 28 days) |
| *risperidone microspheres intramuscular suspension,extended rel recon 25 mg/2 ml, 37.5 mg/2 ml, 50 mg/2 ml* | T5 | QL (2 EA per 28 days) |
| *risperidone oral solution* | T2 | QL (496 ML per 31 days) |
| *risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg* | T1 | QL (31 EA per 31 days) |
| *risperidone oral tablet 3 mg* | T1 | QL (93 EA per 31 days) |
| *risperidone oral tablet 4 mg* | T1 | QL (124 EA per 31 days) |
| *risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg* | T4 | QL (31 EA per 31 days) |
| *risperidone oral tablet,disintegrating 3 mg* | T4 | QL (93 EA per 31 days) |
| *risperidone oral tablet,disintegrating 4 mg* | T4 | QL (124 EA per 31 days) |
| **RITALIN** | T4 | ST; QL (93 EA per 31 days) |
| *rivastigmine* | T4 | QL (30 EA per 30 days) |
| *rivastigmine tartrate* | T3 | |
| *rizatriptan oral tablet 10 mg* | T2 | QL (12 EA per 28 days) |
| *rizatriptan oral tablet 5 mg* | T2 | QL (24 EA per 28 days) |
| *rizatriptan oral tablet,disintegrating 10 mg* | T3 | QL (12 EA per 28 days) |
| *rizatriptan oral tablet,disintegrating 5 mg* | T3 | QL (24 EA per 28 days) |
| *ropinirole oral tablet* | T2 | |
| *ropinirole oral tablet extended release 24 hr* | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ROWEEPRA** | T2 | |
| **ROXICODONE ORAL TABLET 15 MG** | T4 | PA; QL (186 EA per 31 days) |
| **ROXICODONE ORAL TABLET 30 MG** | T5 | PA; QL (138 EA per 31 days) |
| **ROXYBOND** | T5 | PA; QL (186 EA per 31 days) |
| **ROZEREM** | T4 | QL (31 EA per 31 days) |
| *rufinamide oral suspension* | T5 | PA-NS |
| *rufinamide oral tablet 200 mg* | T4 | PA-NS |
| *rufinamide oral tablet 400 mg* | T5 | PA-NS |
| **RYTARY** | T3 | ST |
| **SABRIL** | T5 | PA-NS |
| **SAPHRIS SUBLINGUAL TABLET 10 MG, 2.5 MG** | T4 | PA-NS; QL (62 EA per 31 days) |
| **SAPHRIS SUBLINGUAL TABLET 5 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **SECUADO** | T5 | PA-NS; QL (31 EA per 31 days) |
| *selegiline hcl* | T2 | |
| **SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG** | T4 | QL (62 EA per 31 days) |
| **SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG, 300 MG, 50 MG** | T4 | QL (62 EA per 31 days) |
| **SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 400 MG** | T5 | QL (62 EA per 31 days) |
| *sertraline oral capsule* | T4 | PA-NS; QL (31 EA per 31 days) |
| *sertraline oral concentrate* | T2 | |
| *sertraline oral tablet* | T1 | |
| **SILENOR** | T4 | PA |
| **SINEMET ORAL TABLET 10-100 MG, 25-100 MG** | T4 | |
| **SKYCLARYS** | T5 | PA; QL (93 EA per 31 days) |
| *sodium oxybate* | T5 | PA; QL (540 ML per 30 days) |
| **SOMA** | T4 | PA |
| **SPRITAM ORAL TABLET FOR SUSPENSION 250 MG, 500 MG** | T4 | |
| **SPRIX** | T5 | QL (5 EA per 31 days) |
| **SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 8-2 MG** | T4 | ST |
| **SUBOXONE SUBLINGUAL FILM 4-1 MG** | T5 | ST |
| **SUBVENITE ORAL SUSPENSION** | T5 | |
| **SUBVENITE ORAL TABLET** | T2 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **SUBVENITE STARTER (BLUE) KIT** | T4 | |
| **SUBVENITE STARTER (GREEN) KIT** | T5 | |
| **SUBVENITE STARTER (ORANGE) KIT** | T4 | |
| *sulindac* | T2 | |
| *sumatriptan nasal spray,non-aerosol 20 mg/actuation* | T4 | QL (8 EA per 28 days) |
| *sumatriptan nasal spray,non-aerosol 5 mg/actuation* | T4 | QL (32 EA per 28 days) |
| *sumatriptan succinate oral tablet 100 mg* | T2 | QL (9 EA per 28 days) |
| *sumatriptan succinate oral tablet 25 mg* | T2 | QL (36 EA per 28 days) |
| *sumatriptan succinate oral tablet 50 mg* | T2 | QL (18 EA per 28 days) |
| *sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml* | T4 | QL (4 ML per 28 days) |
| *sumatriptan succinate subcutaneous solution* | T4 | QL (4 ML per 28 days) |
| *sumatriptan-naproxen* | T4 | QL (9 EA per 28 days) |
| **SUNOSI** | T4 | PA; QL (31 EA per 31 days) |
| **SYMBRAVO** | T4 | QL (9 EA per 30 days) |
| **SYMPAZAN ORAL FILM 10 MG, 20 MG** | T5 | PA-NS; QL (62 EA per 31 days) |
| **SYMPAZAN ORAL FILM 5 MG** | T4 | PA-NS; QL (62 EA per 31 days) |
| **TANLOR** | T4 | |
| *tapentadol oral tablet 100 mg* | T5 | PA; QL (186 EA per 31 days) |
| *tapentadol oral tablet 50 mg, 75 mg* | T4 | PA; QL (186 EA per 31 days) |
| *tapentadol oral tablet extended release 12 hr 100 mg, 150 mg, 200 mg, 250 mg* | T5 | PA; QL (62 EA per 31 days) |
| *tapentadol oral tablet extended release 12 hr 50 mg* | T4 | PA; QL (62 EA per 31 days) |
| **TASCENSO ODT** | T5 | PA; QL (31 EA per 31 days) |
| *tasimelteon* | T5 | PA; QL (31 EA per 31 days) |
| **TASMAR ORAL TABLET 100 MG** | T5 | |
| **TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG (14)- 240 MG (46)** | T5 | PA; QL (120 EA per 365 days) |
| **TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 240 MG** | T5 | PA; QL (62 EA per 31 days) |
| **TEGRETOL ORAL SUSPENSION** | T4 | |
| **TEGRETOL ORAL TABLET** | T4 | |
| **TEGRETOL XR** | T4 | |
| *temazepam* | T2 | PA; QL (31 EA per 31 days) |
| **TENCON** | T4 | QL (372 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *teriflunomide* | T5 | PA; QL (31 EA per 31 days) |
| *tetrabenazine oral tablet 12.5 mg* | T5 | PA; QL (93 EA per 31 days) |
| *tetrabenazine oral tablet 25 mg* | T5 | PA; QL (124 EA per 31 days) |
| *thioridazine* | T3 | |
| *thiothixene* | T2 | |
| *tiagabine* | T4 | |
| *tizanidine oral capsule 2 mg, 4 mg, 6 mg* | T4 | |
| *tizanidine oral capsule 8 mg* | T5 | PA; QL (124 EA per 31 days) |
| *tizanidine oral tablet* | T2 | |
| *tolcapone* | T5 | |
| **TOLECTIN 600** | T5 | |
| **TOLECTIN DS** | T5 | |
| *tolmetin oral capsule* | T2 | |
| *tolmetin oral tablet 600 mg* | T5 | |
| **TONMYA** | T4 | PA; QL (60 EA per 30 days) |
| **TOPAMAX ORAL CAPSULE, SPRINKLE** | T4 | |
| **TOPAMAX ORAL TABLET 100 MG, 200 MG** | T5 | |
| **TOPAMAX ORAL TABLET 25 MG, 50 MG** | T4 | |
| *topiramate oral capsule, sprinkle 15 mg, 25 mg* | T2 | |
| *topiramate oral capsule, sprinkle 50 mg* | T4 | |
| *topiramate oral capsule,extended release 24hr 100 mg, 25 mg, 50 mg* | T4 | |
| *topiramate oral capsule,extended release 24hr 200 mg* | T5 | |
| *topiramate oral capsule,sprinkle,er 24hr* | T4 | |
| *topiramate oral solution* | T4 | PA-NS; QL (496 ML per 31 days) |
| *topiramate oral tablet* | T1 | |
| **TOSYMRA** | T4 | QL (12 EA per 28 days) |
| *tramadol oral capsule,er biphase 24 hr 17-83* | T4 | PA; QL (30 EA per 30 days) |
| *tramadol oral capsule,er biphase 24 hr 25-75 100 mg, 200 mg* | T4 | PA; QL (30 EA per 30 days) |
| *tramadol oral tablet 100 mg* | T4 | PA; QL (124 EA per 31 days) |
| *tramadol oral tablet 25 mg* | T4 | PA; QL (496 EA per 31 days) |
| *tramadol oral tablet 50 mg* | T2 | PA; QL (240 EA per 30 days) |
| *tramadol oral tablet 75 mg* | T4 | PA; QL (155 EA per 31 days) |
| *tramadol oral tablet extended release 24 hr* | T4 | PA; QL (30 EA per 30 days) |
| *tramadol-acetaminophen* | T2 | PA; QL (372 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *tranylcypromine* | T4 | |
| *trazodone oral tablet 100 mg, 150 mg, 50 mg* | T1 | |
| *trazodone oral tablet 300 mg* | T2 | |
| **TREXIMET** | T5 | QL (9 EA per 28 days) |
| *triazolam* | T4 | PA |
| *trifluoperazine* | T2 | |
| *trihexyphenidyl* | T4 | |
| **TRILEPTAL ORAL SUSPENSION** | T4 | |
| **TRILEPTAL ORAL TABLET 150 MG, 600 MG** | T5 | |
| **TRILEPTAL ORAL TABLET 300 MG** | T4 | |
| *trimipramine* | T4 | PA-NS |
| **TRINTELLIX** | T4 | PA-NS |
| **TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 50 MG** | T4 | |
| **TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 200 MG, 25 MG** | T5 | |
| **TRUDHESA** | T5 | PA; QL (12 ML per 28 days) |
| **UBRELVY ORAL TABLET 100 MG** | T3 | PA; QL (17 EA per 28 days) |
| **UBRELVY ORAL TABLET 50 MG** | T3 | PA; QL (34 EA per 28 days) |
| **UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 100 MG/0.28 ML** | T5 | QL (0.28 ML per 30 days) |
| **UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 125 MG/0.35 ML** | T5 | QL (0.35 ML per 30 days) |
| **UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 150 MG/0.42 ML** | T5 | QL (0.42 ML per 60 days) |
| **UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 200 MG/0.56 ML** | T5 | QL (0.56 ML per 60 days) |
| **UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 250 MG/0.7 ML** | T5 | QL (0.7 ML per 60 days) |
| **UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 50 MG/0.14 ML** | T5 | QL (0.14 ML per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 75 MG/0.21 ML** | T5 | QL (0.21 ML per 30 days) |
| **VALIUM** | T4 | PA-NS; QL (124 EA per 31 days) |
| *valproic acid* | T2 | |
| *valproic acid (as sodium salt) oral solution 250 mg/5 ml* | T2 | |
| **VALTOCO** | T5 | PA-NS; QL (10 EA per 30 days) |
| *venlafaxine besylate* | T4 | PA-NS; QL (62 EA per 31 days) |
| *venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg* | T2 | QL (31 EA per 31 days) |
| *venlafaxine oral capsule,extended release 24hr 75 mg* | T2 | QL (93 EA per 31 days) |
| *venlafaxine oral tablet* | T2 | |
| *venlafaxine oral tablet extended release 24hr* | T2 | QL (31 EA per 31 days) |
| **VERSACLOZ** | T5 | QL (558 ML per 31 days) |
| *vigabatrin* | T5 | PA-NS |
| **VIGADRONE** | T5 | PA-NS |
| **VIGAFYDE** | T5 | PA-NS |
| **VIIBRYD ORAL TABLET** | T4 | PA-NS; QL (31 EA per 31 days) |
| *vilazodone* | T3 | PA-NS; QL (31 EA per 31 days) |
| **VIMPAT ORAL SOLUTION** | T5 | |
| **VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG** | T5 | |
| **VIMPAT ORAL TABLET 50 MG** | T4 | |
| **VIVITROL** | T5 | |
| **VRAYLAR** | T5 | PA-NS; QL (31 EA per 31 days) |
| **VUMERITY** | T5 | PA; QL (124 EA per 31 days) |
| **VYSCOXA** | T4 | ST; QL (1240 ML per 31 days) |
| **VYVANSE** | T4 | ST; QL (31 EA per 31 days) |
| **VYVGART HYTRULO SUBCUTANEOUS SYRINGE** | T5 | PA; QL (20 ML per 28 days) |
| **WAINUA SUBCUTANEOUS AUTO-INJECTOR** | T5 | PA; QL (0.8 ML per 30 days) |
| **WAKIX** | T5 | PA; QL (62 EA per 31 days) |
| **WELLBUTRIN SR** | T4 | QL (62 EA per 31 days) |
| **WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG** | T5 | QL (93 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 300 MG** | T5 | QL (31 EA per 31 days) |
| **XANAX ORAL TABLET 0.25 MG, 0.5 MG** | T4 | PA; QL (93 EA per 31 days) |
| **XANAX ORAL TABLET 1 MG, 2 MG** | T4 | PA; QL (155 EA per 31 days) |
| **XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 2 MG** | T4 | PA; QL (155 EA per 31 days) |
| **XCOPRI** | T5 | PA-NS |
| **XCOPRI MAINTENANCE PACK** | T5 | PA-NS |
| **XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)** | T4 | PA-NS |
| **XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)** | T5 | PA-NS |
| **XELSTRYM** | T4 | ST; QL (30 EA per 30 days) |
| **XENAZINE ORAL TABLET 12.5 MG** | T5 | PA; QL (93 EA per 31 days) |
| **XENAZINE ORAL TABLET 25 MG** | T5 | PA; QL (124 EA per 31 days) |
| **XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 13.5 MG, 18 MG, 27 MG, 9 MG** | T4 | PA; QL (62 EA per 31 days) |
| **XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 36 MG** | T5 | PA; QL (62 EA per 31 days) |
| **XYREM** | T5 | PA; QL (540 ML per 30 days) |
| **XYWAV** | T5 | PA; QL (540 ML per 30 days) |
| *zaleplon oral capsule 10 mg* | T4 | PA; QL (62 EA per 31 days) |
| *zaleplon oral capsule 5 mg* | T4 | PA; QL (93 EA per 31 days) |
| **ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG** | T4 | |
| **ZANAFLEX ORAL CAPSULE 8 MG** | T5 | PA; QL (124 EA per 31 days) |
| **ZANAFLEX ORAL TABLET** | T4 | |
| **ZARONTIN** | T4 | |
| **ZAVZPRET** | T5 | PA; QL (8 EA per 30 days) |
| **ZELAPAR** | T5 | |
| **ZEMBRACE SYMTOUCH** | T5 | QL (8 ML per 28 days) |
| **ZENZEDI** | T4 | QL (62 EA per 31 days) |
| **ZEPOSIA** | T5 | PA; QL (31 EA per 31 days) |
| **ZEPOSIA STARTER KIT (28-DAY)** | T5 | PA; QL (56 EA per 365 days) |
| **ZEPOSIA STARTER PACK (7-DAY)** | T5 | PA; QL (14 EA per 365 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML** | T5 | PA; QL (11.648 ML per 28 days) |
| **ZILBRYSQ SUBCUTANEOUS SYRINGE 23 MG/0.574 ML** | T5 | PA; QL (16.072 ML per 28 days) |
| **ZILBRYSQ SUBCUTANEOUS SYRINGE 32.4 MG/0.81 ML** | T5 | PA; QL (22.68 ML per 28 days) |
| *ziprasidone hcl* | T2 | QL (62 EA per 31 days) |
| *ziprasidone mesylate* | T4 | |
| **ZIPSOR** | T5 | |
| *zolmitriptan nasal spray,non-aerosol 5 mg* | T4 | QL (8 EA per 28 days) |
| *zolmitriptan oral tablet 2.5 mg* | T4 | QL (16 EA per 28 days) |
| *zolmitriptan oral tablet 5 mg* | T4 | QL (8 EA per 28 days) |
| *zolmitriptan oral tablet,disintegrating 2.5 mg* | T4 | QL (16 EA per 28 days) |
| *zolmitriptan oral tablet,disintegrating 5 mg* | T4 | QL (8 EA per 28 days) |
| **ZOLOFT** | T4 | |
| *zolpidem oral capsule* | T4 | PA; QL (31 EA per 31 days) |
| *zolpidem oral tablet* | T2 | PA; QL (31 EA per 31 days) |
| *zolpidem oral tablet,ext release multiphase* | T4 | PA; QL (31 EA per 31 days) |
| *zolpidem sublingual* | T4 | PA; QL (31 EA per 31 days) |
| **ZOMIG NASAL SPRAY,NON-AEROSOL 2.5 MG** | T4 | QL (16 EA per 28 days) |
| **ZOMIG NASAL SPRAY,NON-AEROSOL 5 MG** | T4 | QL (8 EA per 28 days) |
| **ZOMIG ORAL TABLET 2.5 MG** | T4 | QL (16 EA per 28 days) |
| **ZOMIG ORAL TABLET 5 MG** | T4 | QL (8 EA per 28 days) |
| **ZONEGRAN ORAL CAPSULE 100 MG, 25 MG** | T5 | |
| **ZONISADE** | T5 | PA-NS; QL (930 ML per 31 days) |
| *zonisamide* | T2 | |
| **ZTALMY** | T5 | PA-NS; QL (1100 ML per 30 days) |
| **ZUBSOLV** | T3 | |
| **ZUNVEYL** | T4 | PA; QL (62 EA per 31 days) |
| **ZURNAI** | T4 | |
| **ZURZUVAE ORAL CAPSULE 20 MG, 25 MG** | T5 | PA-NS; QL (28 EA per 180 days) |
| **ZURZUVAE ORAL CAPSULE 30 MG** | T5 | PA-NS; QL (14 EA per 180 days) |
| **ZYBIC** | T5 | |
| **ZYPREXA INTRAMUSCULAR** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ZYPREXA ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG** | T4 | QL (31 EA per 31 days) |
| **ZYPREXA ORAL TABLET 15 MG, 20 MG** | T5 | QL (31 EA per 31 days) |
| **ZYPREXA ZYDIS ORAL TABLET,DISINTEGRATING 10 MG, 5 MG** | T4 | QL (31 EA per 31 days) |
| **ZYPREXA ZYDIS ORAL TABLET,DISINTEGRATING 15 MG, 20 MG** | T5 | QL (31 EA per 31 days) |
| **Cardiovascular, Hypertension / Lipids** | | |
| *acebutolol* | T2 | |
| **ALDACTONE ORAL TABLET 50 MG** | T4 | |
| *aliskiren* | T4 | |
| **ALVAIZ ORAL TABLET 18 MG, 9 MG** | T5 | PA; QL (31 EA per 31 days) |
| **ALVAIZ ORAL TABLET 36 MG, 54 MG** | T5 | PA; QL (62 EA per 31 days) |
| *amiloride* | T2 | |
| *amiloride-hydrochlorothiazide* | T2 | |
| *amiodarone oral* | T2 | |
| *amlodipine* | T1 | |
| *amlodipine-atorvastatin* | T2 | |
| *amlodipine-benazepril* | T1 | |
| *amlodipine-olmesartan* | T2 | QL (31 EA per 31 days) |
| *amlodipine-valsartan* | T2 | |
| *amlodipine-valsartan-hcthiazid* | T4 | |
| **ARBLI** | T4 | QL (330 ML per 31 days) |
| **ARIXTRA SUBCUTANEOUS SYRINGE 10 MG/0.8 ML, 5 MG/0.4 ML, 7.5 MG/0.6 ML** | T5 | |
| **ARIXTRA SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML** | T4 | |
| *aspirin-dipyridamole* | T4 | |
| **ATACAND** | T4 | |
| **ATACAND HCT** | T4 | |
| *atenolol* | T1 | |
| *atenolol-chlorthalidone* | T2 | |
| **ATORVALIQ** | T4 | PA; QL (600 ML per 30 days) |
| *atorvastatin* | T1 | |
| **ATTRUBY** | T5 | PA; QL (124 EA per 31 days) |
| **AVALIDE** | T4 | QL (31 EA per 31 days) |
| **AVAPRO ORAL TABLET 150 MG, 300 MG** | T4 | QL (31 EA per 31 days) |
| *azilsartan medoxomil* | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **AZOR** | T4 | QL (31 EA per 31 days) |
| **BAXFENDY** | T4 | PA; QL (31 EA per 31 days) |
| *benazepril* | T1 | |
| *benazepril-hydrochlorothiazide* | T1 | |
| **BENICAR HCT** | T4 | QL (31 EA per 31 days) |
| **BENICAR ORAL TABLET 20 MG, 40 MG** | T4 | QL (31 EA per 31 days) |
| **BENICAR ORAL TABLET 5 MG** | T4 | QL (93 EA per 31 days) |
| **BETAPACE AF** | T4 | |
| **BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG** | T4 | |
| *betaxolol oral* | T3 | |
| **BIDIL** | T4 | |
| *bisoprolol fumarate oral tablet 10 mg, 5 mg* | T2 | |
| *bisoprolol fumarate oral tablet 2.5 mg* | T3 | |
| *bisoprolol-hydrochlorothiazide* | T1 | |
| **BRILINTA** | T4 | |
| *bumetanide* | T2 | |
| **BYSTOLIC ORAL TABLET 10 MG, 2.5 MG** | T4 | QL (93 EA per 31 days) |
| **BYSTOLIC ORAL TABLET 20 MG** | T4 | QL (62 EA per 31 days) |
| **BYSTOLIC ORAL TABLET 5 MG** | T4 | QL (217 EA per 31 days) |
| **CABLIVI INJECTION KIT** | T5 | PA; QL (31 EA per 31 days) |
| **CADUET** | T4 | |
| **CAMZYOS** | T5 | PA; QL (31 EA per 31 days) |
| *candesartan* | T2 | |
| *candesartan-hydrochlorothiazid* | T2 | |
| *captopril* | T2 | |
| **CARDAMYST** | T5 | PA; QL (12 EA per 180 days) |
| **CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 180 MG** | T4 | |
| **CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 240 MG, 300 MG, 360 MG** | T5 | |
| **CARDIZEM LA** | T4 | |
| **CARDIZEM ORAL TABLET 120 MG** | T4 | |
| **CARDIZEM ORAL TABLET 30 MG, 60 MG** | T5 | |
| **CARDURA** | T4 | |
| **CARDURA XL** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **CAROSPIR** | T4 | |
| **CARTIA XT** | T2 | |
| *carvedilol* | T1 | |
| *carvedilol phosphate* | T4 | |
| *chlorthalidone oral tablet 25 mg, 50 mg* | T2 | |
| *cholestyramine (with sugar) oral powder in packet* | T2 | |
| **CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET** | T2 | |
| *cilostazol* | T2 | |
| *clonidine* | T4 | |
| *clonidine hcl oral tablet 0.05 mg* | T4 | QL (62 EA per 31 days) |
| *clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg* | T1 | |
| *clonidine hcl oral tablet extended release 24 hr* | T4 | ST |
| *clopidogrel* | T1 | |
| *colesevelam* | T4 | |
| **COLESTID ORAL TABLET** | T4 | |
| *colestipol oral packet* | T4 | |
| *colestipol oral tablet* | T4 | |
| **COREG** | T4 | |
| **COREG CR** | T5 | |
| **COZAAR ORAL TABLET 100 MG** | T4 | QL (31 EA per 31 days) |
| **COZAAR ORAL TABLET 25 MG** | T4 | QL (93 EA per 31 days) |
| **COZAAR ORAL TABLET 50 MG** | T4 | QL (62 EA per 31 days) |
| **CRESTOR** | T4 | |
| *dabigatran etexilate oral capsule 110 mg* | T4 | QL (124 EA per 31 days) |
| *dabigatran etexilate oral capsule 150 mg, 75 mg* | T4 | QL (62 EA per 31 days) |
| *digoxin oral solution* | T3 | QL (155 ML per 31 days) |
| *digoxin oral tablet 125 mcg (0.125 mg)* | T2 | QL (62 EA per 31 days) |
| *digoxin oral tablet 250 mcg (0.25 mg)* | T2 | QL (31 EA per 31 days) |
| *digoxin oral tablet 62.5 mcg (0.0625 mg)* | T4 | QL (124 EA per 31 days) |
| *diltiazem hcl oral capsule,extended release 12 hr* | T2 | |
| *diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg* | T2 | |
| *diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg* | T2 | |
| *diltiazem hcl oral tablet* | T2 | |
| *diltiazem hcl oral tablet extended release 24 hr* | T2 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **DILT-XR** | T2 | |
| **DIOVAN HCT** | T4 | QL (31 EA per 31 days) |
| **DIOVAN ORAL TABLET 160 MG, 40 MG, 80 MG** | T4 | QL (62 EA per 31 days) |
| **DIOVAN ORAL TABLET 320 MG** | T4 | QL (31 EA per 31 days) |
| *dipyridamole oral* | T4 | |
| *disopyramide phosphate oral capsule* | T4 | |
| *dofetilide* | T4 | |
| **DOPTELET (10 TAB PACK)** | T5 | PA |
| **DOPTELET (15 TAB PACK)** | T5 | PA |
| **DOPTELET (30 TAB PACK)** | T5 | PA |
| **DOPTELET SPRINKLE** | T5 | PA; QL (62 EA per 31 days) |
| *doxazosin* | T1 | |
| **DYRENIUM** | T4 | |
| **EDARBI** | T4 | |
| **EDARBYCLOR** | T4 | |
| **EDECRIN** | T5 | |
| **EFFIENT** | T4 | |
| **ELIQUIS DVT-PE TREAT 30D START** | T3 | QL (74 EA per 30 days) |
| **ELIQUIS ORAL TABLET 2.5 MG** | T3 | QL (60 EA per 30 days) |
| **ELIQUIS ORAL TABLET 5 MG** | T3 | QL (74 EA per 30 days) |
| **ELIQUIS ORAL TABLET FOR SUSPENSION 0.5 MG** | T3 | QL (112 EA per 28 days) |
| **ELIQUIS ORAL TABLET FOR SUSPENSION 1.5 MG (0.5 MG X 3)** | T3 | QL (336 EA per 28 days) |
| **ELIQUIS ORAL TABLET FOR SUSPENSION 2 MG (0.5 MG X 4)** | T3 | QL (560 EA per 28 days) |
| **ELIQUIS SPRINKLE** | T3 | QL (70 EA per 28 days) |
| *eltrombopag olamine oral powder in packet 12.5 mg* | T5 | PA; QL (372 EA per 31 days) |
| *eltrombopag olamine oral powder in packet 25 mg* | T5 | PA; QL (31 EA per 31 days) |
| *eltrombopag olamine oral tablet 12.5 mg, 25 mg* | T5 | PA; QL (31 EA per 31 days) |
| *eltrombopag olamine oral tablet 50 mg, 75 mg* | T5 | PA; QL (62 EA per 31 days) |
| *enalapril maleate oral solution* | T4 | |
| *enalapril maleate oral tablet* | T1 | |
| *enalapril-hydrochlorothiazide* | T1 | |
| **ENBUMYST** | T5 | PA; QL (24 EA per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *enoxaparin subcutaneous syringe* | T4 | |
| **ENTRESTO ORAL TABLET 24-26 MG** | T4 | ST; QL (186 EA per 31 days) |
| **ENTRESTO ORAL TABLET 49-51 MG** | T4 | ST; QL (93 EA per 31 days) |
| **ENTRESTO ORAL TABLET 97-103 MG** | T4 | ST; QL (62 EA per 31 days) |
| **ENTRESTO SPRINKLE** | T3 | PA; QL (248 EA per 31 days) |
| *eplerenone* | T2 | |
| *ethacrynic acid* | T4 | |
| **EXFORGE** | T4 | |
| **EXFORGE HCT** | T4 | |
| *ezetimibe* | T2 | |
| *ezetimibe-simvastatin* | T3 | QL (31 EA per 31 days) |
| *felodipine* | T2 | |
| *fenofibrate micronized oral capsule 130 mg* | T4 | |
| *fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg* | T2 | |
| *fenofibrate nanocrystallized* | T2 | |
| *fenofibrate oral capsule* | T4 | |
| *fenofibrate oral tablet 120 mg, 40 mg* | T4 | |
| *fenofibrate oral tablet 160 mg, 54 mg* | T2 | |
| *fenofibric acid (choline)* | T4 | |
| **FILSPARI ORAL TABLET 200 MG** | T5 | PA; QL (31 EA per 31 days) |
| **FILSPARI ORAL TABLET 400 MG** | T5 | PA; QL (62 EA per 31 days) |
| *flecainide* | T2 | |
| **FLOLIPID** | T4 | PA |
| *fluvastatin oral capsule* | T2 | |
| *fluvastatin oral tablet extended release 24 hr* | T4 | |
| *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* | T4 | |
| *fosinopril* | T1 | |
| *fosinopril-hydrochlorothiazide* | T2 | |
| **FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML** | T5 | |
| **FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 18,000 ANTI-XA UNIT/0.72 ML, 5,000 ANTI-XA UNIT/0.2 ML, 7,500 ANTI-XA UNIT/0.3 ML** | T5 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **FRAGMIN SUBCUTANEOUS SYRINGE 2,500 ANTI-XA UNIT/0.2 ML** | T4 | |
| **FUROSCIX** | T5 | PA; QL (8 EA per 30 days) |
| *furosemide injection* | T2 | |
| *furosemide oral solution* | T2 | |
| *furosemide oral tablet* | T1 | |
| *gemfibrozil* | T1 | |
| *guanfacine oral tablet* | T4 | |
| **HEMANGEOL** | T5 | PA; QL (360 ML per 31 days) |
| **HEMICLOR** | T4 | QL (248 EA per 31 days) |
| *heparin (porcine) injection solution* | T3 | PA-BvD |
| *hydralazine oral* | T2 | |
| *hydrochlorothiazide* | T1 | |
| **HYZAAR** | T4 | |
| *icosapent ethyl oral capsule 0.5 gram* | T2 | QL (248 EA per 31 days) |
| *icosapent ethyl oral capsule 1 gram* | T2 | QL (124 EA per 31 days) |
| *indapamide* | T1 | |
| **INDERAL LA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 60 MG, 80 MG** | T4 | |
| **INDERAL LA ORAL CAPSULE,EXTENDED RELEASE 24 HR 160 MG** | T5 | |
| **INNOPRAN XL** | T5 | |
| **INZIRQO** | T4 | QL (310 ML per 31 days) |
| *irbesartan* | T1 | QL (31 EA per 31 days) |
| *irbesartan-hydrochlorothiazide* | T1 | QL (31 EA per 31 days) |
| *isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg* | T2 | |
| *isosorbide dinitrate oral tablet 40 mg* | T4 | |
| *isosorbide mononitrate* | T1 | |
| *isosorbide-hydralazine* | T3 | |
| *isradipine* | T2 | |
| *ivabradine oral tablet 5 mg* | T3 | PA; QL (93 EA per 31 days) |
| *ivabradine oral tablet 7.5 mg* | T3 | PA; QL (62 EA per 31 days) |
| **JANTOVEN** | T1 | |
| **JAVADIN** | T5 | PA; QL (1000 ML per 30 days) |
| **JUXTAPID ORAL CAPSULE 10 MG, 2 MG, 5 MG** | T5 | PA; QL (28 EA per 28 days) |
| **JUXTAPID ORAL CAPSULE 20 MG, 30 MG** | T5 | PA; QL (56 EA per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **KATERZIA** | T4 | PA |
| **KERENDIA** | T4 | PA; QL (31 EA per 31 days) |
| *labetalol oral tablet 100 mg, 200 mg, 300 mg* | T2 | |
| *labetalol oral tablet 400 mg* | T1 | |
| **LANOXIN ORAL TABLET 125 MCG (0.125 MG)** | T4 | QL (62 EA per 31 days) |
| **LANOXIN ORAL TABLET 250 MCG (0.25 MG)** | T4 | QL (31 EA per 31 days) |
| **LANOXIN ORAL TABLET 62.5 MCG (0.0625 MG)** | T4 | QL (124 EA per 31 days) |
| **LASIX ONYU** | T5 | PA; QL (8 EA per 22 days) |
| **LEROCHOL** | T4 | PA; QL (1.2 ML per 30 days) |
| **LESCOL XL** | T4 | |
| **LIPFENDRA** | T4 | PA; QL (31 EA per 31 days) |
| **LIPITOR** | T4 | |
| **LIPOFEN** | T4 | |
| *lisinopril* | T1 | |
| *lisinopril-hydrochlorothiazide* | T1 | |
| **LIVALO** | T4 | |
| **LODOCO** | T4 | PA; QL (31 EA per 31 days) |
| **LOPRESSOR ORAL SOLUTION** | T4 | QL (1395 ML per 31 days) |
| **LOPRESSOR ORAL TABLET** | 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 | |
| **LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG** | T4 | |
| *lovastatin* | T1 | |
| **LOVAZA** | T4 | PA; QL (124 EA per 31 days) |
| **LOVENOX SUBCUTANEOUS SYRINGE 100 MG/ML** | T5 | |
| **LOVENOX SUBCUTANEOUS SYRINGE 120 MG/0.8 ML, 150 MG/ML, 30 MG/0.3 ML, 40 MG/0.4 ML, 60 MG/0.6 ML, 80 MG/0.8 ML** | T4 | |
| **MATZIM LA** | T2 | |
| *methyldopa* | T4 | |
| *metolazone* | T2 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *metoprolol succinate* | T1 | |
| *metoprolol ta-hydrochlorothiaz* | T2 | |
| *metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg* | T1 | |
| *metoprolol tartrate oral tablet 12.5 mg* | T4 | |
| *metyrosine* | T5 | PA |
| *mexiletine* | T3 | |
| **MICARDIS HCT** | T4 | |
| *minoxidil oral* | T2 | |
| *moexipril* | T1 | |
| **MULPLETA** | T5 | PA |
| **MULTAQ** | T3 | |
| **MYQORZO** | T5 | PA; QL (31 EA per 31 days) |
| *nadolol* | T2 | |
| *nebivolol oral tablet 10 mg, 2.5 mg* | T2 | QL (93 EA per 31 days) |
| *nebivolol oral tablet 20 mg* | T2 | QL (62 EA per 31 days) |
| *nebivolol oral tablet 5 mg* | T2 | QL (217 EA per 31 days) |
| **NEXICLON XR** | T4 | ST |
| **NEXLETOL** | T3 | PA; QL (31 EA per 31 days) |
| **NEXLIZET** | T4 | PA; QL (31 EA per 31 days) |
| *niacin oral tablet 500 mg* | T4 | |
| *niacin oral tablet extended release 24 hr 1,000 mg, 750 mg* | T4 | |
| *niacin oral tablet extended release 24 hr 500 mg* | T4 | QL (31 EA per 31 days) |
| **NIACOR** | T4 | |
| *nicardipine oral* | T4 | |
| *nifedipine oral capsule* | T4 | |
| *nifedipine oral tablet extended release* | T2 | |
| *nifedipine oral tablet extended release 24hr* | T2 | |
| *nimodipine oral capsule* | T4 | |
| *nimodipine oral solution* | T5 | |
| *nisoldipine oral tablet extended release 24 hr 17 mg, 34 mg, 8.5 mg* | T4 | |
| **NITRO-BID** | T2 | |
| **NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.4 MG/HR, 0.6 MG/HR** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR** | T5 | |
| *nitroglycerin sublingual* | T2 | |
| *nitroglycerin transdermal patch 24 hour* | T2 | |
| *nitroglycerin translingual* | T4 | |
| **NITROLINGUAL** | T4 | |
| **NITROSTAT** | T4 | |
| **NORLIQVA** | T4 | PA; QL (300 ML per 30 days) |
| **NORPACE** | T4 | |
| **NORVASC** | T4 | |
| **NYMALIZE ORAL SYRINGE 60 MG/10 ML** | T5 | |
| *olmesartan oral tablet 20 mg, 40 mg* | T1 | QL (31 EA per 31 days) |
| *olmesartan oral tablet 5 mg* | T1 | QL (93 EA per 31 days) |
| *olmesartan-amlodipin-hcthiazid* | T3 | |
| *olmesartan-hydrochlorothiazide* | T1 | QL (31 EA per 31 days) |
| *omega-3 acid ethyl esters* | T2 | QL (124 EA per 31 days) |
| **ORENITRAM MONTH 1 TITRATION KT** | T5 | PA; QL (336 EA per 365 days) |
| **ORENITRAM MONTH 2 TITRATION KT** | T5 | PA; QL (672 EA per 365 days) |
| **ORENITRAM MONTH 3 TITRATION KT** | T5 | PA; QL (504 EA per 365 days) |
| **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG** | T4 | PA; QL (93 EA per 31 days) |
| **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG** | T5 | PA; QL (186 EA per 31 days) |
| **ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG** | T5 | PA; QL (521 EA per 31 days) |
| **ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG** | T5 | PA; QL (261 EA per 31 days) |
| **PACERONE ORAL TABLET 100 MG, 200 MG** | T2 | |
| *pentoxifylline* | T2 | |
| *perindopril erbumine* | T1 | |
| *phenoxybenzamine* | T5 | PA |
| *pindolol* | T3 | |
| *pitavastatin calcium* | T3 | |
| **PLAVIX ORAL TABLET 75 MG** | T4 | |
| **PRADAXA ORAL CAPSULE 110 MG** | T4 | QL (124 EA per 31 days) |
| **PRADAXA ORAL CAPSULE 150 MG, 75 MG** | T4 | QL (62 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **PRADAXA ORAL PELLETS IN PACKET 110 MG, 30 MG, 40 MG, 50 MG** | T5 | QL (120 EA per 30 days) |
| **PRADAXA ORAL PELLETS IN PACKET 150 MG, 20 MG** | T5 | QL (60 EA per 30 days) |
| **PRALUENT PEN** | T4 | PA; QL (2 ML per 28 days) |
| *prasugrel hcl* | T2 | |
| *pravastatin* | T1 | |
| *prazosin* | T2 | |
| **PREVALITE ORAL POWDER IN PACKET** | T2 | |
| **PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24HR 30 MG, 60 MG** | T4 | |
| **PROMACTA ORAL POWDER IN PACKET 12.5 MG** | T5 | PA; QL (372 EA per 31 days) |
| **PROMACTA ORAL POWDER IN PACKET 25 MG** | T5 | PA; QL (31 EA per 31 days) |
| **PROMACTA ORAL TABLET 12.5 MG, 25 MG** | T5 | PA; QL (31 EA per 31 days) |
| **PROMACTA ORAL TABLET 50 MG, 75 MG** | T5 | PA; QL (62 EA per 31 days) |
| *propafenone oral capsule,extended release 12 hr* | T4 | |
| *propafenone oral tablet* | T2 | |
| *propranolol oral capsule,extended release 24 hr* | T2 | |
| *propranolol oral solution* | T2 | |
| *propranolol oral tablet* | T1 | |
| **QBRELIS** | T5 | |
| **QUESTRAN LIGHT** | T4 | |
| **QUESTRAN ORAL POWDER** | T4 | |
| *quinapril* | T1 | |
| *quinapril-hydrochlorothiazide* | T1 | |
| *quinidine gluconate oral* | T4 | |
| *quinidine sulfate oral tablet* | T2 | |
| *ramipril* | T1 | |
| *ranolazine* | T3 | QL (62 EA per 31 days) |
| **REDEMPLO** | T5 | PA; QL (0.5 ML per 90 days) |
| **REPATHA SURECLICK** | T3 | PA; QL (3 ML per 28 days) |
| **REPATHA SYRINGE** | T3 | PA; QL (3 ML per 28 days) |
| *rivaroxaban oral suspension for reconstitution* | T4 | QL (930 ML per 31 days) |
| *rivaroxaban oral tablet* | T4 | QL (62 EA per 31 days) |
| *rosuvastatin* | T1 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *sacubitril-valsartan oral tablet 24-26 mg* | T2 | QL (186 EA per 31 days) |
| *sacubitril-valsartan oral tablet 49-51 mg* | T2 | QL (93 EA per 31 days) |
| *sacubitril-valsartan oral tablet 97-103 mg* | T2 | QL (62 EA per 31 days) |
| **SAVAYSA** | T4 | QL (31 EA per 31 days) |
| **SDAMLO ORAL POWDER IN CONTAINER 5 MG** | T4 | PA; QL (30 EA per 30 days) |
| *simvastatin* | T1 | |
| **SOAANZ ORAL TABLET 40 MG** | T4 | ST |
| **SOTALOL AF** | T2 | |
| *sotalol oral* | T2 | |
| **SOTYLIZE** | T4 | |
| *spironolactone oral suspension* | T4 | |
| *spironolactone oral tablet* | T1 | |
| *spironolacton-hydrochlorothiaz* | T2 | |
| **SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG** | T4 | |
| **TAVALISSE** | T5 | PA; QL (62 EA per 31 days) |
| **TEKTURNA** | T4 | |
| *telmisartan* | T1 | |
| *telmisartan-amlodipine* | T2 | |
| *telmisartan-hydrochlorothiazid* | T1 | |
| **TENORMIN** | T4 | |
| *terazosin* | T1 | |
| **THALITONE** | T4 | |
| **TIADYLT ER** | T2 | |
| **TIAZAC** | T4 | |
| *ticagrelor* | T2 | |
| **TIKOSYN** | T4 | |
| *timolol maleate oral* | T2 | |
| **TOPROL XL** | T4 | |
| *torsemide oral* | T2 | |
| *trandolapril* | T1 | |
| *trandolapril-verapamil* | T2 | |
| *triamterene* | T4 | |
| *triamterene-hydrochlorothiazid* | T1 | |
| **TRIBENZOR** | T4 | |
| **TRYNGOLZA** | T5 | PA; QL (0.8 ML per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **TRYVIO** | T4 | PA; QL (31 EA per 31 days) |
| **UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG** | T5 | PA; QL (62 EA per 31 days) |
| **UPTRAVI ORAL TABLET 200 MCG** | T5 | PA; QL (224 EA per 28 days) |
| **UPTRAVI ORAL TABLETS,DOSE PACK** | T5 | PA; QL (400 EA per 365 days) |
| *valsartan oral solution* | T5 | QL (2480 ML per 31 days) |
| *valsartan oral tablet 160 mg, 40 mg, 80 mg* | T1 | QL (62 EA per 31 days) |
| *valsartan oral tablet 320 mg* | T1 | QL (31 EA per 31 days) |
| *valsartan-hydrochlorothiazide* | T1 | QL (31 EA per 31 days) |
| **VANRAFIA** | T5 | PA; QL (31 EA per 31 days) |
| **VASCEPA ORAL CAPSULE 0.5 GRAM** | T4 | QL (248 EA per 31 days) |
| **VASCEPA ORAL CAPSULE 1 GRAM** | T4 | QL (124 EA per 31 days) |
| **VASERETIC** | T4 | |
| **VASOTEC ORAL TABLET 10 MG** | T5 | |
| **VASOTEC ORAL TABLET 2.5 MG, 20 MG, 5 MG** | T4 | |
| **VECAMYL** | T5 | |
| *verapamil oral capsule, 24 hr er pellet ct* | T2 | |
| *verapamil oral capsule,ext rel. pellets 24 hr* | T2 | |
| *verapamil oral tablet* | T1 | |
| *verapamil oral tablet extended release* | T2 | |
| **VERQUVO** | T4 | PA; QL (31 EA per 31 days) |
| **VYNDAMAX** | T5 | PA; QL (31 EA per 31 days) |
| **VYTORIN 10-10** | T4 | QL (31 EA per 31 days) |
| **VYTORIN 10-20** | T4 | QL (31 EA per 31 days) |
| **VYTORIN 10-40** | T4 | QL (31 EA per 31 days) |
| **VYTORIN 10-80** | T4 | QL (31 EA per 31 days) |
| *warfarin* | T1 | |
| **WELCHOL** | T4 | |
| **XARELTO DVT-PE TREAT 30D START** | T3 | QL (51 EA per 30 days) |
| **XARELTO ORAL SUSPENSION FOR RECONSTITUTION** | T3 | QL (930 ML per 31 days) |
| **XARELTO ORAL TABLET 10 MG, 20 MG** | T3 | QL (31 EA per 31 days) |
| **XARELTO ORAL TABLET 15 MG** | T3 | QL (52 EA per 31 days) |
| **XARELTO ORAL TABLET 2.5 MG** | T3 | QL (62 EA per 31 days) |
| **ZESTORETIC** | T4 | |
| **ZESTRIL** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ZETIA** | T4 | |
| **ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG** | T4 | |
| **ZYPITAMAG** | T4 | |
| **Dermatologicals/Topical Therapy** | | |
| **ABSORICA** | T5 | |
| **ABSORICA LD** | T5 | |
| **ACANYA TOPICAL GEL WITH PUMP** | T4 | |
| **ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG** | T4 | |
| *acitretin* | T4 | PA |
| *acyclovir topical cream* | T4 | QL (5 GM per 28 days) |
| *acyclovir topical ointment* | T4 | QL (30 GM per 30 days) |
| **ACZONE TOPICAL GEL WITH PUMP** | T4 | QL (90 GM per 28 days) |
| *adapalene topical cream* | T4 | PA |
| *adapalene topical gel 0.3 %* | T4 | PA |
| *adapalene topical swab* | T4 | PA |
| *adapalene-benzoyl peroxide* | T4 | PA |
| **ADBRY** | T5 | PA; QL (4 ML per 28 days) |
| **AKLIEF** | T4 | PA |
| **ALA-CORT TOPICAL CREAM** | T2 | |
| **ALA-SCALP** | T4 | |
| *alclometasone* | T2 | |
| **ALTRENO** | T4 | PA; QL (45 GM per 28 days) |
| *amcinonide topical cream* | T4 | |
| *amcinonide topical ointment* | T2 | |
| *ammonium lactate* | T2 | |
| **AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG** | T4 | |
| **AMNESTEEM ORAL CAPSULE 30 MG** | T2 | |
| **AMZEEQ** | T4 | QL (30 GM per 28 days) |
| **ANALPRAM-HC TOPICAL** | T4 | |
| **ANZUPGO** | T5 | PA; QL (60 GM per 30 days) |
| **ARAZLO** | T4 | PA; QL (45 GM per 28 days) |
| **ATRALIN** | T4 | PA; QL (45 GM per 28 days) |
| *azelaic acid* | T4 | ST; QL (50 GM per 28 days) |
| **AZELEX** | T4 | QL (50 GM per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **BENZAMYCIN** | T4 | |
| *betamethasone dipropionate* | T2 | |
| *betamethasone valerate topical cream* | T2 | |
| *betamethasone valerate topical foam* | T4 | |
| *betamethasone valerate topical lotion* | T2 | |
| *betamethasone valerate topical ointment* | T2 | |
| *betamethasone, augmented* | T2 | |
| **BIMZELX AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 160 MG/ML** | T5 | PA; QL (1 ML per 28 days) |
| **BIMZELX AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 320 MG/2 ML** | T5 | PA; QL (2 ML per 28 days) |
| **BIMZELX SUBCUTANEOUS SYRINGE 160 MG/ML** | T5 | PA; QL (1 ML per 28 days) |
| **BIMZELX SUBCUTANEOUS SYRINGE 320 MG/2 ML** | T5 | PA; QL (2 ML per 28 days) |
| *brimonidine topical* | T4 | ST |
| **BRYHALI** | T4 | QL (100 GM per 28 days) |
| **CABTREO** | T4 | PA; QL (50 GM per 28 days) |
| *calcipotriene scalp* | T3 | QL (60 ML per 28 days) |
| *calcipotriene topical cream* | T4 | QL (60 GM per 28 days) |
| *calcipotriene topical foam* | T5 | ST; QL (120 GM per 28 days) |
| *calcipotriene topical ointment* | T4 | QL (60 GM per 28 days) |
| *calcipotriene-betamethasone topical ointment* | T4 | ST; QL (400 GM per 28 days) |
| *calcipotriene-betamethasone topical suspension* | T5 | ST; QL (400 GM per 28 days) |
| *calcitriol topical* | T4 | ST |
| **CIBINQO** | T5 | PA; QL (31 EA per 31 days) |
| *ciclopirox topical cream* | T2 | QL (90 GM per 28 days) |
| *ciclopirox topical gel* | T2 | QL (45 GM per 28 days) |
| *ciclopirox topical shampoo* | T2 | QL (120 ML per 28 days) |
| *ciclopirox topical solution* | T2 | |
| *ciclopirox topical suspension* | T2 | QL (60 ML per 28 days) |
| **CLARAVIS** | T4 | |
| **CLEOCIN T TOPICAL LOTION** | T4 | QL (60 ML per 28 days) |
| **CLINDACIN** | T2 | QL (100 GM per 28 days) |
| **CLINDACIN ETZ TOPICAL SWAB** | T4 | |
| **CLINDAGEL** | T5 | QL (75 ML per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *clindamycin phosphate topical foam* | T4 | QL (100 GM per 28 days) |
| *clindamycin phosphate topical gel* | T2 | QL (60 GM per 28 days) |
| *clindamycin phosphate topical gel, once daily* | T4 | QL (75 ML per 28 days) |
| *clindamycin phosphate topical lotion* | T3 | QL (60 ML per 28 days) |
| *clindamycin phosphate topical solution* | T3 | QL (60 ML per 28 days) |
| *clindamycin phosphate topical swab* | T4 | |
| *clindamycin-benzoyl peroxide topical gel* | T4 | |
| *clindamycin-benzoyl peroxide topical gel with pump 1.2 %(1 % base) -3.75 %, 1.2-2.5 %* | T4 | |
| *clindamycin-tretinoin* | T4 | PA; QL (60 GM per 28 days) |
| *clobetasol scalp* | T4 | QL (50 ML per 28 days) |
| *clobetasol topical cream 0.025 %* | T4 | QL (100 GM per 28 days) |
| *clobetasol topical cream 0.05 %* | T4 | QL (60 GM per 28 days) |
| *clobetasol topical foam* | T4 | QL (100 GM per 28 days) |
| *clobetasol topical gel* | T4 | QL (60 GM per 28 days) |
| *clobetasol topical lotion* | T4 | QL (118 ML per 28 days) |
| *clobetasol topical ointment* | T4 | QL (60 GM per 28 days) |
| *clobetasol topical shampoo* | T4 | QL (118 ML per 28 days) |
| *clobetasol topical spray,non-aerosol* | T4 | QL (125 ML per 28 days) |
| *clobetasol-emollient topical cream* | T4 | QL (60 GM per 28 days) |
| *clobetasol-emollient topical foam* | T4 | QL (100 GM per 28 days) |
| *clocortolone pivalate* | T4 | |
| **CLODAN** | T4 | QL (118 ML per 28 days) |
| *clotrimazole topical cream* | T2 | QL (45 GM per 28 days) |
| *clotrimazole topical solution* | T2 | QL (30 ML per 28 days) |
| *clotrimazole-betamethasone topical cream* | T2 | QL (45 GM per 28 days) |
| *clotrimazole-betamethasone topical lotion* | T2 | QL (60 ML per 28 days) |
| **CORDRAN TAPE LARGE ROLL** | T4 | |
| **COSENTYX (2 SYRINGES)** | T5 | PA; QL (2 ML per 28 days) |
| **COSENTYX PEN (2 PENS)** | T5 | PA; QL (2 ML per 28 days) |
| **COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML** | T5 | PA; QL (0.5 ML per 28 days) |
| **COSENTYX UNOREADY PEN** | T5 | PA; QL (2 ML per 28 days) |
| **CROTAN** | T4 | |
| *dapsone topical gel 5 %* | T4 | QL (90 GM per 28 days) |
| *dapsone topical gel with pump* | T4 | QL (90 GM per 28 days) |
| **DENAVIR** | T4 | QL (5 GM per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **DERMA-SMOOTHE/FS SCALP OIL** | T4 | QL (118.28 ML per 28 days) |
| *desonide topical cream* | T4 | QL (60 GM per 28 days) |
| *desonide topical gel* | T4 | QL (60 GM per 28 days) |
| *desonide topical lotion* | T4 | QL (118 ML per 28 days) |
| *desonide topical ointment* | T4 | QL (60 GM per 28 days) |
| *desoximetasone topical cream* | T4 | QL (100 GM per 28 days) |
| *desoximetasone topical gel* | T4 | QL (60 GM per 28 days) |
| *desoximetasone topical ointment* | T4 | QL (100 GM per 28 days) |
| *desoximetasone topical spray,non-aerosol* | T4 | QL (100 ML per 28 days) |
| *diclofenac sodium topical gel 3 %* | T4 | PA; QL (100 GM per 28 days) |
| **DIFFERIN TOPICAL GEL WITH PUMP** | T4 | PA |
| *diflorasone* | T4 | QL (60 GM per 28 days) |
| **DIPROLENE (AUGMENTED) TOPICAL OINTMENT** | T4 | |
| *doxepin topical* | T4 | PA; QL (45 GM per 28 days) |
| **DUOBRII** | T5 | PA; QL (200 GM per 28 days) |
| **DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML** | T5 | PA; QL (2.28 ML per 28 days) |
| **DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML** | T5 | PA; QL (8 ML per 28 days) |
| **DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML** | T5 | PA; QL (2.28 ML per 28 days) |
| **DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML** | T5 | PA; QL (8 ML per 28 days) |
| **EBGLYSS PEN** | T5 | PA; QL (2 ML per 28 days) |
| **EBGLYSS SYRINGE** | T5 | PA; QL (2 ML per 28 days) |
| *econazole nitrate topical cream* | T4 | QL (85 GM per 28 days) |
| *econazole nitrate topical foam* | T5 | ST; QL (70 GM per 28 days) |
| **ENSTILAR** | T5 | ST; QL (60 GM per 28 days) |
| **EPIDUO FORTE** | T4 | PA |
| **EPSOLAY** | T4 | ST; QL (30 GM per 28 days) |
| **ERTACZO** | T4 | ST; QL (60 GM per 28 days) |
| **ERY PADS** | T2 | |
| *erythromycin with ethanol topical gel* | T4 | QL (60 GM per 28 days) |
| *erythromycin with ethanol topical solution* | T2 | QL (60 ML per 28 days) |
| *erythromycin-benzoyl peroxide* | T4 | |
| **EUCRISA** | T5 | PA; QL (60 GM per 30 days) |
| **EURAX TOPICAL CREAM** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **EVESSE** | T4 | QL (118 ML per 28 days) |
| **EXELDERM TOPICAL CREAM** | T4 | ST; QL (60 GM per 28 days) |
| **FILSUVEZ** | T5 | PA |
| **FINACEA TOPICAL FOAM** | T4 | ST; QL (50 GM per 28 days) |
| *fluocinolone and shower cap* | T4 | QL (118.28 ML per 28 days) |
| *fluocinolone topical cream 0.01 %* | T4 | QL (60 GM per 28 days) |
| *fluocinolone topical cream 0.025 %* | T4 | QL (120 GM per 28 days) |
| *fluocinolone topical ointment* | T4 | QL (120 GM per 28 days) |
| *fluocinolone topical solution* | T4 | QL (90 ML per 28 days) |
| *fluocinonide topical cream 0.05 %* | T4 | QL (60 GM per 28 days) |
| *fluocinonide topical cream 0.1 %* | T4 | QL (120 GM per 28 days) |
| *fluocinonide topical gel* | T4 | QL (60 GM per 28 days) |
| *fluocinonide topical ointment* | T4 | QL (60 GM per 28 days) |
| *fluocinonide topical solution* | T4 | QL (60 ML per 28 days) |
| *fluocinonide-emollient* | T4 | QL (60 GM per 28 days) |
| *fluorouracil topical cream 0.5 %* | T5 | PA-NS |
| *fluorouracil topical cream 5 %* | T3 | |
| *fluorouracil topical solution* | T3 | |
| *flurandrenolide topical lotion* | T4 | QL (120 ML per 28 days) |
| *fluticasone propionate topical cream* | T4 | |
| *fluticasone propionate topical lotion* | T4 | QL (120 ML per 28 days) |
| *fluticasone propionate topical ointment* | T4 | |
| *gentamicin topical* | T2 | QL (60 GM per 28 days) |
| *halcinonide topical cream* | T4 | QL (60 GM per 28 days) |
| *halcinonide topical solution* | T4 | QL (120 ML per 28 days) |
| *halobetasol propionate topical cream* | T4 | QL (50 GM per 28 days) |
| *halobetasol propionate topical foam* | T4 | QL (200 GM per 28 days) |
| *halobetasol propionate topical lotion* | T5 | QL (60 ML per 28 days) |
| *halobetasol propionate topical ointment* | T4 | QL (50 GM per 28 days) |
| **HALOG TOPICAL CREAM** | T4 | QL (60 GM per 28 days) |
| **HALOG TOPICAL SOLUTION** | T4 | QL (120 ML per 28 days) |
| *hydrocortisone butyrate topical cream* | T4 | QL (45 GM per 28 days) |
| *hydrocortisone butyrate topical lotion* | T4 | QL (118 ML per 28 days) |
| *hydrocortisone butyrate topical ointment* | T4 | QL (45 GM per 28 days) |
| *hydrocortisone butyrate topical solution* | T4 | QL (60 ML per 28 days) |
| *hydrocortisone topical cream 1 %* | T2 | |
| *hydrocortisone topical lotion 2 %* | T4 | QL (118.4 ML per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *hydrocortisone topical lotion 2.5 %* | T2 | QL (118 ML per 28 days) |
| *hydrocortisone topical ointment 1 %, 2.5 %* | T2 | |
| *hydrocortisone topical solution* | T4 | |
| *hydrocortisone valerate* | T4 | QL (60 GM per 28 days) |
| **HYFTOR** | T5 | PA; QL (30 GM per 30 days) |
| **ICOTYDE** | T5 | PA; QL (31 EA per 31 days) |
| **ILUMYA** | T5 | PA; QL (1 ML per 84 days) |
| *imiquimod topical cream in metered-dose pump* | T4 | |
| *imiquimod topical cream in packet 5 %* | T2 | |
| **IMULDOSA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML** | T4 | PA; QL (0.5 ML per 84 days) |
| **IMULDOSA SUBCUTANEOUS SYRINGE 90 MG/ML** | T4 | PA; QL (1 ML per 56 days) |
| *isotretinoin* | T4 | |
| *ivermectin topical cream* | T2 | ST; QL (45 GM per 28 days) |
| **JUBLIA** | T5 | QL (8 ML per 28 days) |
| *ketoconazole topical cream* | T2 | QL (60 GM per 28 days) |
| *ketoconazole topical foam* | T4 | QL (100 GM per 28 days) |
| *ketoconazole topical shampoo* | T2 | QL (120 ML per 28 days) |
| **KETODAN** | T4 | ST; QL (100 GM per 28 days) |
| **KLARON** | T4 | |
| **LEXETTE** | T4 | QL (200 GM per 28 days) |
| *lidocaine hcl mucous membrane solution 2 %* | T2 | |
| *lidocaine hcl mucous membrane solution 4 % (40 mg/ml)* | T2 | PA; QL (50 ML per 28 days) |
| *lidocaine topical adhesive patch,medicated 5 %* | T2 | PA; QL (93 EA per 31 days) |
| *lidocaine topical ointment* | T4 | PA; QL (50 GM per 28 days) |
| *lidocaine-prilocaine topical cream* | T2 | PA; QL (30 GM per 28 days) |
| **LIDOCAN III** | T4 | PA; QL (93 EA per 31 days) |
| *luliconazole* | T4 | QL (60 GM per 28 days) |
| **LUZU** | T4 | QL (60 GM per 28 days) |
| *malathion* | T2 | |
| *methoxsalen* | T5 | |
| *metronidazole topical cream* | T4 | |
| *metronidazole topical gel* | T4 | |
| *metronidazole topical lotion* | T4 | |
| **MIRVASO** | T4 | ST |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *mometasone topical* | T2 | |
| *mupirocin* | T2 | |
| *mupirocin calcium* | T4 | ST |
| *naftifine topical cream 1 %* | T4 | ST; QL (90 GM per 28 days) |
| *naftifine topical cream 2 %* | T4 | ST; QL (60 GM per 28 days) |
| *naftifine topical gel* | T4 | ST; QL (60 GM per 28 days) |
| **NAFTIN TOPICAL GEL 2 %** | T4 | ST; QL (60 GM per 28 days) |
| **NATROBA** | T4 | |
| **NEO-SYNALAR** | T4 | |
| **NEUAC** | T4 | |
| **NORITATE** | T5 | ST |
| **NYAMYC** | T2 | QL (60 GM per 28 days) |
| *nystatin topical cream* | T2 | QL (30 GM per 28 days) |
| *nystatin topical ointment* | T2 | QL (30 GM per 28 days) |
| *nystatin topical powder* | T2 | QL (60 GM per 28 days) |
| *nystatin-triamcinolone* | T3 | QL (60 GM per 28 days) |
| **NYSTOP** | T2 | QL (60 GM per 28 days) |
| **ONEXTON TOPICAL GEL WITH PUMP** | T4 | |
| **OPZELURA** | T5 | PA; QL (240 GM per 28 days) |
| **OTULFI SUBCUTANEOUS SOLUTION** | T4 | PA; QL (0.5 ML per 84 days) |
| **OTULFI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML** | T4 | PA; QL (0.5 ML per 84 days) |
| **OTULFI SUBCUTANEOUS SYRINGE 90 MG/ML** | T5 | PA; QL (1 ML per 56 days) |
| **OVIDE** | T4 | |
| *oxiconazole* | T4 | ST; QL (90 GM per 28 days) |
| *oxymetazoline topical* | T4 | ST |
| **PANRETIN** | T5 | PA-NS |
| *penciclovir* | T3 | QL (5 GM per 28 days) |
| *permethrin* | T2 | |
| *pimecrolimus* | T4 | QL (100 GM per 28 days) |
| *podofilox topical gel* | T4 | |
| *podofilox topical solution* | T2 | |
| **PRAMOSONE TOPICAL CREAM 1-1 %** | T4 | |
| **PRAMOSONE TOPICAL LOTION** | T4 | |
| **PRUDOXIN** | T4 | PA; QL (45 GM per 28 days) |
| **PRURADIK** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **PYZCHIVA AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 45 MG/0.5 ML** | T4 | PA; QL (0.5 ML per 84 days) |
| **PYZCHIVA AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 90 MG/ML** | T5 | PA; QL (1 ML per 56 days) |
| **PYZCHIVA SUBCUTANEOUS SOLUTION** | T4 | PA; QL (0.5 ML per 84 days) |
| **PYZCHIVA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML** | T4 | PA; QL (0.5 ML per 84 days) |
| **PYZCHIVA SUBCUTANEOUS SYRINGE 90 MG/ML** | T5 | PA; QL (1 ML per 56 days) |
| **QBREXZA** | T4 | QL (30 EA per 30 days) |
| **RETIN-A** | T4 | PA; QL (45 GM per 28 days) |
| **RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %** | T4 | PA; QL (50 GM per 28 days) |
| **RHOFADE** | T4 | ST |
| **SANTYL** | T4 | QL (180 GM per 30 days) |
| **SELARSDI SUBCUTANEOUS SOLUTION** | T4 | PA; QL (0.5 ML per 84 days) |
| **SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML** | T4 | PA; QL (0.5 ML per 84 days) |
| **SELARSDI SUBCUTANEOUS SYRINGE 90 MG/ML** | T5 | PA; QL (1 ML per 56 days) |
| *selenium sulfide topical lotion* | T2 | |
| **SILIQ** | T5 | PA; QL (6 ML per 28 days) |
| **SILVADENE** | T4 | |
| *silver sulfadiazine* | T2 | |
| **SKYRIZI SUBCUTANEOUS PEN INJECTOR** | T5 | PA; QL (1 ML per 84 days) |
| **SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML** | T5 | PA; QL (1 ML per 84 days) |
| **SKYRIZI SUBCUTANEOUS SYRINGE 55 MG/0.37 ML** | T5 | PA; QL (0.37 ML per 84 days) |
| **SOFDRA** | T5 | QL (40.2 ML per 30 days) |
| **SOOLANTRA** | T4 | ST; QL (45 GM per 28 days) |
| **SORILUX** | T5 | ST; QL (120 GM per 28 days) |
| **SOTYKTU** | T5 | PA; QL (31 EA per 31 days) |
| **SPEVIGO SUBCUTANEOUS** | T5 | PA; QL (2 ML per 28 days) |
| *spinosad* | T4 | |
| **SSD** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **STARJEMZA SUBCUTANEOUS SOLUTION** | T4 | PA; QL (0.5 ML per 84 days) |
| **STARJEMZA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML** | T4 | PA; QL (0.5 ML per 84 days) |
| **STARJEMZA SUBCUTANEOUS SYRINGE 90 MG/ML** | T4 | PA; QL (1 ML per 56 days) |
| **STELARA SUBCUTANEOUS SOLUTION** | T5 | PA; QL (0.5 ML per 84 days) |
| **STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML** | T5 | PA; QL (0.5 ML per 84 days) |
| **STELARA SUBCUTANEOUS SYRINGE 90 MG/ML** | T5 | PA; QL (1 ML per 56 days) |
| **STEQEYMA SUBCUTANEOUS SOLUTION** | T3 | PA; QL (0.5 ML per 84 days) |
| **STEQEYMA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML** | T3 | PA; QL (0.5 ML per 84 days) |
| **STEQEYMA SUBCUTANEOUS SYRINGE 90 MG/ML** | T5 | PA; QL (1 ML per 56 days) |
| *sulfacetamide sodium (acne)* | T2 | |
| **SULFAMYLON TOPICAL CREAM** | T3 | |
| **SYNALAR TOPICAL CREAM** | T4 | QL (120 GM per 28 days) |
| **SYNALAR TOPICAL OINTMENT** | T4 | QL (120 GM per 28 days) |
| **TACLONEX TOPICAL SUSPENSION** | T5 | ST; QL (400 GM per 28 days) |
| *tacrolimus topical* | T4 | QL (100 GM per 28 days) |
| **TALTZ AUTOINJECTOR** | T5 | PA; QL (1 ML per 28 days) |
| **TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML** | T5 | PA; QL (0.25 ML per 28 days) |
| **TALTZ SYRINGE SUBCUTANEOUS SYRINGE 40 MG/0.5 ML** | T5 | PA; QL (0.5 ML per 28 days) |
| **TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML** | T5 | PA; QL (1 ML per 28 days) |
| *tavaborole* | T4 | QL (10 ML per 28 days) |
| *tazarotene topical cream* | T4 | PA; QL (60 GM per 28 days) |
| *tazarotene topical foam* | T4 | PA; QL (100 GM per 28 days) |
| *tazarotene topical gel 0.05 %* | T5 | PA; QL (100 GM per 28 days) |
| *tazarotene topical gel 0.1 %* | T4 | PA; QL (100 GM per 28 days) |
| **TAZORAC TOPICAL CREAM** | T4 | PA; QL (60 GM per 28 days) |
| **TAZORAC TOPICAL GEL** | T4 | PA; QL (100 GM per 28 days) |
| **TEXACORT** | T4 | |
| **TOPICORT TOPICAL OINTMENT 0.05 %** | T4 | QL (100 GM per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **TOPICORT TOPICAL SPRAY,NON-AEROSOL** | T4 | QL (100 ML per 28 days) |
| **TOVET EMOLLIENT** | T4 | QL (100 GM per 28 days) |
| **TREMFYA ONE-PRESS** | T5 | PA; QL (1 ML per 56 days) |
| **TREMFYA PEN INDUCTION PK(2PEN)** | T5 | PA; QL (24 ML per 365 days) |
| **TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML** | T5 | PA; QL (2 ML per 28 days) |
| **TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML** | T5 | PA; QL (1 ML per 56 days) |
| **TREMFYA SUBCUTANEOUS SYRINGE 200 MG/2 ML** | T5 | PA; QL (2 ML per 28 days) |
| *tretinoin microspheres topical gel* | T4 | PA; QL (50 GM per 28 days) |
| *tretinoin microspheres topical gel with pump 0.08 %* | T4 | PA; QL (50 GM per 28 days) |
| *tretinoin topical cream* | T4 | PA; QL (45 GM per 28 days) |
| *tretinoin topical gel* | T3 | PA; QL (45 GM per 28 days) |
| *triamcinolone acetonide topical cream* | T2 | |
| *triamcinolone acetonide topical lotion* | T2 | |
| *triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %* | T2 | |
| *triamcinolone acetonide topical ointment 0.05 %* | T4 | |
| **TRIDERM TOPICAL CREAM 0.5 %** | T2 | |
| **TRILITAS** | T4 | PA; QL (100 GM per 28 days) |
| **TWYNEO** | T4 | PA; QL (30 GM per 28 days) |
| **ULTRAVATE TOPICAL LOTION** | T4 | QL (60 ML per 28 days) |
| *ustekinumab subcutaneous solution* | T5 | PA; QL (0.5 ML per 84 days) |
| *ustekinumab subcutaneous syringe 45 mg/0.5 ml* | T5 | PA; QL (0.5 ML per 84 days) |
| *ustekinumab subcutaneous syringe 90 mg/ml* | T5 | PA; QL (1 ML per 56 days) |
| *ustekinumab-aauz subcutaneous syringe 45 mg/0.5 ml* | T4 | PA; QL (0.5 ML per 84 days) |
| *ustekinumab-aauz subcutaneous syringe 90 mg/ml* | T4 | PA; QL (1 ML per 56 days) |
| *ustekinumab-aekn subcutaneous syringe 45 mg/0.5 ml* | T4 | PA; QL (0.5 ML per 84 days) |
| *ustekinumab-aekn subcutaneous syringe 90 mg/ml* | T5 | PA; QL (1 ML per 56 days) |
| *ustekinumab-ttwe subcutaneous solution* | T5 | PA; QL (0.5 ML per 84 days) |
| *ustekinumab-ttwe subcutaneous syringe 45 mg/0.5 ml* | T4 | PA; QL (0.5 ML per 84 days) |
| *ustekinumab-ttwe subcutaneous syringe 90 mg/ml* | T5 | PA; QL (1 ML per 56 days) |
| **VALCHLOR** | T5 | PA-NS |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **VECTICAL** | T4 | ST |
| **VEREGEN** | T5 | QL (30 GM per 28 days) |
| **VTAMA** | T5 | PA; QL (60 GM per 28 days) |
| **WEZLANA SUBCUTANEOUS SOLUTION** | T5 | PA; QL (0.5 ML per 84 days) |
| **WEZLANA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML** | T5 | PA; QL (0.5 ML per 84 days) |
| **WEZLANA SUBCUTANEOUS SYRINGE 90 MG/ML** | T5 | PA; QL (1 ML per 56 days) |
| **WINLEVI** | T4 | PA; QL (60 GM per 28 days) |
| **XERESE** | T5 | |
| **YESINTEK SUBCUTANEOUS SOLUTION** | T3 | PA; QL (0.5 ML per 84 days) |
| **YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML** | T3 | PA; QL (0.5 ML per 84 days) |
| **YESINTEK SUBCUTANEOUS SYRINGE 90 MG/ML** | T5 | PA; QL (1 ML per 56 days) |
| **ZELSUVMI** | T5 | PA; QL (31 GM per 28 days) |
| **ZENATANE** | T4 | |
| **ZIANA** | T4 | PA; QL (60 GM per 28 days) |
| **ZILXI** | T4 | ST; QL (30 GM per 28 days) |
| **ZONALON** | T4 | PA; QL (30 GM per 28 days) |
| **ZORYVE** | T4 | PA; QL (60 GM per 28 days) |
| **ZOVIRAX TOPICAL CREAM** | T4 | QL (5 GM per 28 days) |
| **ZOVIRAX TOPICAL OINTMENT** | T4 | QL (30 GM per 30 days) |
| **ZTLIDO** | T4 | PA; QL (93 EA per 31 days) |
| **ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP 3.75 %** | T5 | |
| **Diagnostics / Miscellaneous Agents** | | |
| *acamprosate* | T4 | |
| **AGRYLIN** | T5 | |
| *anagrelide* | T2 | |
| **AQVESME** | T5 | PA; QL (62 EA per 31 days) |
| **ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG** | T5 | PA |
| *bupropion hcl (smoking deter)* | T2 | QL (62 EA per 31 days) |
| **CARBAGLU** | T5 | PA |
| *carglumic acid* | T5 | PA |
| **CARNITOR ORAL** | T4 | PA-BvD |
| *cevimeline* | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **CHANTIX** | T4 | QL (60 EA per 30 days) |
| **CHANTIX CONTINUING MONTH BOX** | T4 | QL (60 EA per 30 days) |
| **CHANTIX STARTING MONTH BOX** | T4 | QL (106 EA per 365 days) |
| **CHEMET** | T4 | |
| **CLINIMIX 4.25%/D5W SULFIT FREE** | T4 | PA-BvD |
| **CLINIMIX E 2.75%/D5W SULF FREE** | T4 | PA-BvD |
| **CUVRIOR** | T5 | PA; QL (310 EA per 31 days) |
| *d10 %-0.45 % sodium chloride* | T2 | |
| *d2.5 %-0.45 % sodium chloride* | T2 | |
| *d5 % and 0.9 % sodium chloride* | T2 | |
| *d5 %-0.45 % sodium chloride* | T2 | |
| *deferasirox oral granules in packet* | T5 | PA |
| *deferasirox oral tablet 180 mg, 360 mg* | T5 | PA |
| *deferasirox oral tablet 90 mg* | T3 | PA |
| *deferasirox oral tablet, dispersible 125 mg* | T3 | PA |
| *deferasirox oral tablet, dispersible 250 mg, 500 mg* | T5 | PA |
| *deferiprone* | T5 | PA |
| *dextrose 10 % and 0.2 % nacl* | T2 | |
| *dextrose 10 % in water (d10w)* | T2 | |
| *dextrose 5 % in water (d5w) intravenous parenteral solution* | T2 | |
| *dextrose 5%-0.2 % sod chloride* | T2 | |
| *disulfiram* | T2 | |
| *droxidopa oral capsule 100 mg* | T5 | PA; QL (465 EA per 31 days) |
| *droxidopa oral capsule 200 mg, 300 mg* | T5 | PA; QL (186 EA per 31 days) |
| **DUVYZAT** | T5 | PA; QL (420 ML per 35 days) |
| **EMPAVELI** | T5 | PA; QL (160 ML per 28 days) |
| **ENDARI** | T5 | PA; QL (180 EA per 30 days) |
| **EVOXAC** | T4 | |
| **EXJADE** | T5 | PA |
| **FABHALTA** | T5 | PA; QL (62 EA per 31 days) |
| **FERRIPROX (2 TIMES A DAY)** | T5 | PA |
| **FERRIPROX ORAL SOLUTION** | T5 | PA |
| **FERRIPROX ORAL TABLET 1,000 MG** | T5 | PA |
| **FORZINITY** | T5 | PA; QL (14 ML per 28 days) |
| **FOSRENOL** | T4 | PA-BvD |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **GLASSIA** | T5 | PA |
| *glutamine (sickle cell)* | T5 | PA; QL (180 EA per 30 days) |
| *glycerol phenylbutyrate* | T5 | PA |
| **HARLIKU** | T5 | PA; QL (31 EA per 31 days) |
| **INCRELEX** | T5 | PA |
| **JADENU** | T5 | PA |
| **JADENU SPRINKLE** | T5 | PA |
| **JOENJA ORAL TABLET 70 MG** | T5 | PA; QL (60 EA per 30 days) |
| **KIONEX ORAL SUSPENSION** | T2 | |
| **KYGEVVI** | T5 | PA; QL (496 EA per 30 days) |
| *lanthanum* | T4 | PA-BvD |
| *levocarnitine (with sugar)* | T2 | PA-BvD |
| *levocarnitine oral tablet* | T2 | PA-BvD |
| **LITFULO** | T5 | PA; QL (28 EA per 28 days) |
| **LITHOSTAT** | T4 | |
| **LOARGYS** | T5 | PA |
| **LOKELMA** | T3 | PA; QL (93 EA per 31 days) |
| *midodrine* | T2 | |
| **NICOTROL NS** | T4 | |
| *nitisinone* | T5 | PA |
| **NITYR** | T5 | PA |
| **NORTHERA ORAL CAPSULE 100 MG** | T5 | PA; QL (465 EA per 31 days) |
| **NORTHERA ORAL CAPSULE 200 MG, 300 MG** | T5 | PA; QL (186 EA per 31 days) |
| **OLPRUVA ORAL PELLETS IN PACKET 2 GRAM, 3 GRAM** | T5 | PA; QL (186 EA per 31 days) |
| **OLPRUVA ORAL PELLETS IN PACKET 4 GRAM** | T5 | PA; QL (155 EA per 31 days) |
| **OLPRUVA ORAL PELLETS IN PACKET 5 GRAM** | T5 | PA; QL (124 EA per 31 days) |
| **OLPRUVA ORAL PELLETS IN PACKET 6 GRAM** | T5 | PA; QL (93 EA per 31 days) |
| **OLPRUVA ORAL PELLETS IN PACKET 6.67 GRAM** | T5 | PA; QL (62 EA per 31 days) |
| **ORFADIN** | T5 | PA |
| **PHEBURANE** | T5 | PA; QL (620 GM per 31 days) |
| *pilocarpine hcl oral* | T2 | |
| **PROLASTIN-C INTRAVENOUS SOLUTION** | T5 | PA |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG** | T5 | PA; QL (56 EA per 28 days) |
| **PYRUKYND ORAL TABLET 5 MG** | T5 | PA; QL (14 EA per 365 days) |
| **PYRUKYND ORAL TABLETS,DOSE PACK** | T5 | PA; QL (28 EA per 365 days) |
| **RAVICTI** | T5 | PA |
| **REVCOVI** | T5 | |
| **REZDIFFRA** | T5 | PA; QL (31 EA per 31 days) |
| **RHAPSIDO** | T5 | PA; QL (62 EA per 31 days) |
| *riluzole* | T3 | |
| *risedronate oral tablet 30 mg* | T5 | |
| **SALAGEN (PILOCARPINE)** | T4 | |
| *sevelamer carbonate* | T3 | PA-BvD |
| *sevelamer hcl* | T3 | PA-BvD |
| *sodium chloride 0.9 % intravenous parenteral solution* | T2 | |
| *sodium chloride irrigation* | T2 | |
| *sodium phenylbutyrate* | T5 | PA |
| *sodium polystyrene sulfonate* | T2 | |
| **SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 5 MG** | T5 | PA; QL (31 EA per 31 days) |
| **SOHONOS ORAL CAPSULE 10 MG** | T5 | PA; QL (62 EA per 31 days) |
| **SPS (WITH SORBITOL) ORAL** | T2 | |
| **SYPRINE** | T5 | QL (248 EA per 31 days) |
| **TAVNEOS** | T5 | PA; QL (186 EA per 31 days) |
| **THIOLA** | T5 | PA |
| **THIOLA EC** | T5 | PA |
| **TIGLUTIK** | T5 | PA |
| *tiopronin* | T5 | PA |
| *trientine oral capsule 250 mg* | T5 | QL (248 EA per 31 days) |
| *trientine oral capsule 500 mg* | T5 | PA; QL (124 EA per 31 days) |
| *varenicline tartrate oral tablet* | T4 | QL (60 EA per 30 days) |
| *varenicline tartrate oral tablets,dose pack* | T4 | QL (106 EA per 365 days) |
| **VELPHORO** | T5 | PA-BvD |
| **VELTASSA ORAL POWDER IN PACKET 1 GRAM** | T5 | PA; QL (120 EA per 30 days) |
| **VELTASSA ORAL POWDER IN PACKET 16.8 GRAM, 25.2 GRAM** | T5 | PA; QL (30 EA per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **VELTASSA ORAL POWDER IN PACKET 8.4 GRAM** | T4 | PA; QL (30 EA per 30 days) |
| **VENXXIVA** | T5 | PA |
| **VOYDEYA** | T5 | PA; QL (180 EA per 30 days) |
| **VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG** | T5 | PA; QL (93 EA per 31 days) |
| **VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 25 MG** | T5 | PA; QL (124 EA per 31 days) |
| **VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 75 MG** | T5 | PA; QL (217 EA per 31 days) |
| **WEGOVY ORAL** | T5 | PA; QL (31 EA per 31 days) |
| **WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML** | T5 | PA; QL (2 ML per 28 days) |
| **WEGOVY SUBCUTANEOUS PEN INJECTOR 1.7 MG/0.75 ML, 2.4 MG/0.75 ML** | T5 | PA; QL (3 ML per 28 days) |
| **ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG** | T5 | PA |
| **ZEPBOUND KWIKPEN** | T4 | PA; QL (2.4 ML per 28 days) |
| **ZEPBOUND SUBCUTANEOUS PEN INJECTOR 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 5 MG/0.5 ML** | T4 | PA; QL (2 ML per 28 days) |
| **ZEPBOUND SUBCUTANEOUS PEN INJECTOR 2.5 MG/0.5 ML, 7.5 MG/0.5 ML** | T5 | PA; QL (2 ML per 28 days) |
| **ZOKINVY** | T5 | PA |
| **Ear, Nose / Throat Medications** | | |
| *acetic acid otic (ear)* | T2 | |
| *azelastine nasal spray,non-aerosol 137 mcg (0.1 %)* | T3 | QL (30 ML per 25 days) |
| *chlorhexidine gluconate mucous membrane* | T1 | |
| **CIPRO HC** | T4 | |
| *ciprofloxacin hcl otic (ear)* | T2 | |
| *ciprofloxacin-dexamethasone* | T3 | |
| *ciprofloxacin-hydrocortisone* | T4 | |
| **CLOTIC** | T5 | PA; QL (112 EA per 365 days) |
| **DERMOTIC OIL** | T4 | |
| *fluocinolone acetonide oil* | T4 | |
| *hydrocortisone-acetic acid* | T2 | |
| *ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)* | T2 | QL (30 ML per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)* | T2 | QL (15 ML per 28 days) |
| **KOURZEQ** | T2 | |
| *neomycin-polymyxin-hc otic (ear)* | T2 | |
| *ofloxacin otic (ear)* | T2 | |
| *olopatadine nasal* | T4 | QL (30.5 GM per 30 days) |
| **PERIOGARD** | T1 | |
| *triamcinolone acetonide dental* | T2 | |
| **XTORO** | T4 | |
| **Endocrine/Diabetes** | | |
| *acarbose* | T2 | QL (93 EA per 31 days) |
| **ACTHAR** | T5 | PA |
| **ACTHAR SELFJECT** | T5 | PA |
| **ACTOPLUS MET** | T4 | QL (93 EA per 31 days) |
| **ACTOS** | T4 | QL (31 EA per 31 days) |
| **ADMELOG SOLOSTAR U-100 INSULIN** | T4 | |
| **ADMELOG U-100 INSULIN LISPRO** | T4 | |
| **AFREZZA INHALATION CARTRIDGE WITH INHALER 12 UNIT, 4 UNIT (90)/ 8 UNIT (90), 4 UNIT/8 UNIT/ 12 UNIT (60), 8 UNIT (90)/ 12 UNIT (90)** | T5 | ST |
| **AFREZZA INHALATION CARTRIDGE WITH INHALER 4 UNIT, 8 UNIT** | T4 | ST |
| **AGAMREE** | T5 | PA; QL (300 ML per 40 days) |
| **ALCOHOL PADS** | T2 | PA |
| **ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG** | T4 | PA |
| **ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 1 MG, 2 MG, 5 MG** | T5 | PA |
| *alogliptin* | T4 | PA; QL (31 EA per 31 days) |
| *alogliptin-metformin* | T4 | PA; QL (62 EA per 31 days) |
| *alogliptin-pioglitazone* | T4 | PA; QL (31 EA per 31 days) |
| **APIDRA SOLOSTAR U-100 INSULIN** | T4 | |
| **APIDRA U-100 INSULIN** | T4 | |
| **AVEED** | T4 | PA |
| **AWIQLI FLEXTOUCH** | T4 | |
| **BAQSIMI** | T4 | |
| **BASAGLAR KWIKPEN U-100 INSULIN** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **BRYNOVIN** | T4 | PA; QL (124 ML per 31 days) |
| *cabergoline* | T3 | |
| *calcitonin (salmon) nasal* | T2 | PA-BvD |
| *calcitriol oral* | T2 | PA-BvD |
| **CERDELGA** | T5 | PA; QL (62 EA per 31 days) |
| *cinacalcet oral tablet 30 mg, 60 mg* | T4 | PA-BvD; QL (62 EA per 31 days) |
| *cinacalcet oral tablet 90 mg* | T4 | PA-BvD; QL (124 EA per 31 days) |
| **CORTEF** | T4 | |
| **CORTROPHIN GEL** | T5 | PA |
| **CRENESSITY ORAL CAPSULE 100 MG** | T5 | PA; QL (124 EA per 31 days) |
| **CRENESSITY ORAL CAPSULE 50 MG** | T5 | PA; QL (62 EA per 31 days) |
| **CRENESSITY ORAL SOLUTION** | T5 | PA; QL (124 ML per 31 days) |
| **CYCLOSET** | T4 | |
| **CYTOMEL** | T4 | |
| *danazol* | T4 | |
| *dapagliflozin* | T3 | QL (31 EA per 31 days) |
| *dapagliflozin-metformin oral tablet, ir - er, biphasic 24hr 10-1,000 mg, 10-500 mg, 5-500 mg* | T4 | ST; QL (31 EA per 31 days) |
| *dapagliflozin-metformin oral tablet, ir - er, biphasic 24hr 5-1,000 mg* | T4 | ST; QL (62 EA per 31 days) |
| *dapagliflozin-saxagliptin* | T4 | PA; QL (31 EA per 31 days) |
| **DDAVP ORAL** | T4 | |
| *deflazacort* | T5 | PA |
| **DEPO-TESTOSTERONE** | T4 | PA |
| **DESMODA** | T5 | PA; QL (725 ML per 30 days) |
| *desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)* | T3 | |
| *desmopressin oral* | T3 | |
| *dexamethasone oral solution* | T2 | |
| *dexamethasone oral tablet* | T1 | |
| *dexamethasone oral tablets,dose pack* | T4 | |
| **DEXLYT** | T5 | |
| *diazoxide* | T4 | |
| *doxercalciferol oral* | T4 | PA-BvD |
| **DUETACT** | T4 | QL (31 EA per 31 days) |
| **EMFLAZA** | T5 | PA |
| **FARXIGA** | T4 | ST; QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **FIASP FLEXTOUCH U-100 INSULIN** | T3 | |
| **FIASP PENFILL U-100 INSULIN** | T3 | |
| **FIASP U-100 INSULIN** | T3 | |
| *fludrocortisone* | T1 | |
| **GALAFOLD** | T5 | PA; QL (14 EA per 28 days) |
| *glimepiride oral tablet 1 mg, 2 mg, 4 mg* | T1 | |
| *glimepiride oral tablet 3 mg* | T4 | |
| *glipizide oral tablet 10 mg, 5 mg* | T1 | |
| *glipizide oral tablet 15 mg* | T4 | |
| *glipizide oral tablet 2.5 mg* | T3 | |
| *glipizide oral tablet extended release 24hr* | T1 | |
| *glipizide-metformin* | T1 | |
| **GLUCAGON EMERGENCY KIT (HUMAN)** | T3 | |
| **GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 5 MG** | T4 | |
| *glyburide* | T4 | |
| *glyburide-metformin* | T4 | |
| **GLYXAMBI** | T3 | QL (31 EA per 31 days) |
| **GVOKE** | T3 | |
| **GVOKE HYPOPEN 2-PACK** | T3 | |
| **GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML** | T3 | |
| **HEMADY** | T4 | PA-NS |
| **HUMALOG JUNIOR KWIKPEN U-100** | T3 | |
| **HUMALOG KWIKPEN INSULIN** | T3 | |
| **HUMALOG MIX 50-50 KWIKPEN** | T3 | |
| **HUMALOG MIX 75-25 KWIKPEN** | T3 | |
| **HUMALOG MIX 75-25(U-100)INSULN** | T3 | |
| **HUMALOG U-100 INSULIN** | T3 | |
| **HUMULIN 70/30 U-100 INSULIN** | T3 | |
| **HUMULIN 70/30 U-100 KWIKPEN** | T3 | |
| **HUMULIN N NPH INSULIN KWIKPEN** | T3 | |
| **HUMULIN N NPH U-100 INSULIN** | T3 | |
| **HUMULIN R REGULAR U-100 INSULN** | T3 | |
| **HUMULIN R U-500 (CONC) KWIKPEN** | T3 | |
| *hydrocortisone oral* | T2 | |
| **INPEFA** | T4 | ST; QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *insulin glargine u-300 conc* | T4 | |
| *insulin glargine-yfgn* | T4 | |
| *insulin lispro* | T3 | |
| *insulin lispro protamin-lispro* | T3 | |
| **INVOKAMET** | T4 | ST; QL (62 EA per 31 days) |
| **INVOKAMET XR** | T4 | ST; QL (62 EA per 31 days) |
| **INVOKANA ORAL TABLET 100 MG** | T4 | ST; QL (62 EA per 31 days) |
| **INVOKANA ORAL TABLET 300 MG** | T4 | ST; QL (31 EA per 31 days) |
| **ISTURISA ORAL TABLET 1 MG** | T5 | PA; QL (558 EA per 31 days) |
| **ISTURISA ORAL TABLET 5 MG** | T5 | PA; QL (372 EA per 31 days) |
| **JANUMET** | T3 | QL (62 EA per 31 days) |
| **JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG** | T3 | QL (31 EA per 31 days) |
| **JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG** | T3 | QL (62 EA per 31 days) |
| **JANUVIA ORAL TABLET 100 MG, 50 MG** | T3 | QL (31 EA per 31 days) |
| **JANUVIA ORAL TABLET 25 MG** | T3 | QL (93 EA per 31 days) |
| **JARDIANCE ORAL TABLET 10 MG** | T3 | QL (62 EA per 31 days) |
| **JARDIANCE ORAL TABLET 25 MG** | T3 | QL (31 EA per 31 days) |
| **JATENZO ORAL CAPSULE 158 MG, 198 MG** | T4 | PA; QL (124 EA per 31 days) |
| **JATENZO ORAL CAPSULE 237 MG** | T4 | PA; QL (62 EA per 31 days) |
| **JAVYGTOR** | T5 | PA |
| **JAYTHARI** | T5 | PA |
| **JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG** | T3 | QL (62 EA per 31 days) |
| **JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG** | T3 | QL (62 EA per 31 days) |
| **JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG** | T3 | QL (31 EA per 31 days) |
| **JYNARQUE ORAL TABLET** | T5 | PA; QL (112 EA per 28 days) |
| **JYNARQUE ORAL TABLETS, SEQUENTIAL** | T5 | PA; QL (56 EA per 28 days) |
| **KHINDIVI** | T5 | PA |
| **KIRSTY** | T4 | ST |
| **KIRSTY PEN** | T4 | ST |
| **KORLYM** | T5 | PA; QL (124 EA per 31 days) |
| **KUVAN** | T5 | PA |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **KYMBEE** | T5 | PA |
| **KYZATREX ORAL CAPSULE 150 MG, 200 MG** | T4 | PA; QL (124 EA per 31 days) |
| **LANTUS SOLOSTAR U-100 INSULIN** | T3 | |
| **LANTUS U-100 INSULIN** | T3 | |
| *levothyroxine oral capsule* | T4 | |
| *levothyroxine oral tablet* | T1 | |
| **LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG** | T3 | |
| **LIOMNY** | T2 | |
| *liothyronine oral* | T2 | |
| *liraglutide* | T4 | PA; QL (9 ML per 30 days) |
| **LYUMJEV KWIKPEN U-100 INSULIN** | T4 | |
| **LYUMJEV KWIKPEN U-200 INSULIN** | T4 | |
| **LYUMJEV U-100 INSULIN** | T4 | |
| **MEDROL (PAK)** | T4 | |
| **MEDROL ORAL TABLET 16 MG, 2 MG, 4 MG, 8 MG** | T4 | |
| **MERILOG** | T4 | ST |
| **MERILOG SOLOSTAR** | T4 | ST |
| *metformin oral solution* | T4 | ST; QL (791 ML per 31 days) |
| *metformin oral tablet 1,000 mg, 500 mg, 850 mg* | T1 | |
| *metformin oral tablet 625 mg* | T4 | ST; QL (124 EA per 31 days) |
| *metformin oral tablet 750 mg* | T5 | ST; QL (93 EA per 31 days) |
| *metformin oral tablet extended release 24 hr* | T1 | |
| *metformin oral tablet extended release 24hr 1,000 mg* | T4 | ST; QL (62 EA per 31 days) |
| *metformin oral tablet extended release 24hr 500 mg* | T4 | ST; QL (31 EA per 31 days) |
| *metformin oral tablet,er gast.retention 24 hr 1,000 mg* | T4 | ST; QL (62 EA per 31 days) |
| *metformin oral tablet,er gast.retention 24 hr 500 mg* | T4 | ST; QL (31 EA per 31 days) |
| *methimazole oral tablet 10 mg, 5 mg* | T1 | |
| **METHITEST** | T5 | PA |
| *methylprednisolone* | T2 | |
| *methyltestosterone oral capsule* | T5 | PA |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *mifepristone oral tablet 300 mg* | T5 | PA; QL (124 EA per 31 days) |
| *miglitol* | T4 | |
| *miglustat* | T5 | PA; QL (93 EA per 31 days) |
| **MOUNJARO** | T3 | PA; QL (2 ML per 28 days) |
| **MYALEPT** | T5 | PA |
| *nateglinide* | T2 | QL (93 EA per 31 days) |
| **NOVOLIN 70/30 U-100 INSULIN** | T4 | ST |
| **NOVOLIN 70-30 FLEXPEN U-100** | T4 | ST |
| **NOVOLIN N FLEXPEN** | T4 | ST |
| **NOVOLIN N NPH U-100 INSULIN** | T4 | ST |
| **NOVOLIN R FLEXPEN** | T4 | ST |
| **NOVOLIN R REGULAR U100 INSULIN** | T4 | ST |
| **NOVOLOG FLEXPEN U-100 INSULIN** | T3 | |
| **NOVOLOG MIX 70-30 U-100 INSULN** | T3 | |
| **NOVOLOG MIX 70-30FLEXPEN U-100** | T3 | |
| **NOVOLOG PENFILL U-100 INSULIN** | T3 | |
| **NOVOLOG U-100 INSULIN ASPART** | T3 | |
| **ORAPRED ODT** | T4 | |
| **ORILISSA ORAL TABLET 150 MG** | T5 | PA; QL (31 EA per 31 days) |
| **ORILISSA ORAL TABLET 200 MG** | T5 | PA; QL (62 EA per 31 days) |
| **OZEMPIC ORAL** | T3 | PA; QL (31 EA per 31 days) |
| **OZEMPIC SUBCUTANEOUS** | T3 | PA; QL (3 ML per 28 days) |
| **PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML** | T5 | PA; QL (15 ML per 30 days) |
| **PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML** | T5 | PA; QL (4 ML per 30 days) |
| **PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML** | T5 | PA; QL (90 ML per 30 days) |
| *paricalcitol oral* | T4 | PA-BvD |
| *pioglitazone* | T1 | QL (31 EA per 31 days) |
| *pioglitazone-glimepiride* | T4 | QL (31 EA per 31 days) |
| *pioglitazone-metformin* | T4 | QL (93 EA per 31 days) |
| *prednisolone oral solution* | T2 | |
| *prednisolone oral tablet* | T4 | |
| *prednisolone sodium phosphate oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)* | T4 | |
| *prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)* | T2 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *prednisolone sodium phosphate oral tablet,disintegrating* | T2 | |
| **PREDNISONE INTENSOL** | T2 | |
| *prednisone oral solution* | T2 | |
| *prednisone oral tablet* | T1 | |
| *prednisone oral tablet,delayed release (dr/ec)* | T5 | |
| *prednisone oral tablets,dose pack* | T1 | |
| **PROGLYCEM** | T4 | |
| *propylthiouracil* | T2 | |
| **PYQUVI** | T5 | PA |
| **RAYALDEE** | T5 | QL (62 EA per 31 days) |
| **RECORLEV** | T5 | PA; QL (248 EA per 31 days) |
| *repaglinide oral tablet 0.5 mg, 1 mg* | T2 | QL (124 EA per 31 days) |
| *repaglinide oral tablet 2 mg* | T2 | QL (248 EA per 31 days) |
| **REZVOGLAR KWIKPEN** | T4 | |
| **ROCALTROL** | T4 | PA-BvD |
| **SAMSCA** | T5 | PA |
| *sapropterin* | T5 | PA |
| *saxagliptin* | T4 | PA; QL (31 EA per 31 days) |
| *saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg* | T4 | PA; QL (62 EA per 31 days) |
| *saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg* | T4 | PA; QL (31 EA per 31 days) |
| **SEGLUROMET** | T4 | ST; QL (62 EA per 31 days) |
| **SEMGLEE(INSULIN GLARGINE-YFGN)** | T4 | |
| **SEMGLEE(INSULIN GLARG-YFGN)PEN** | T4 | |
| **SEPHIENCE ORAL POWDER IN PACKET 1,000 MG** | T5 | PA |
| **SEPHIENCE ORAL POWDER IN PACKET 250 MG** | T5 | PA; QL (90 EA per 30 days) |
| *sitagliptin oral tablet 100 mg, 50 mg* | T3 | QL (31 EA per 31 days) |
| *sitagliptin oral tablet 25 mg* | T3 | QL (93 EA per 31 days) |
| *sitagliptin phos-metformin oral tablet* | T3 | QL (62 EA per 31 days) |
| *sitagliptin phos-metformin oral tablet, er multiphase 24 hr 100-1,000 mg, 50-500 mg* | T3 | QL (31 EA per 31 days) |
| *sitagliptin phos-metformin oral tablet, er multiphase 24 hr 50-1,000 mg* | T3 | QL (62 EA per 31 days) |
| *sitagliptin phosphate oral tablet 100 mg, 50 mg* | T3 | QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *sitagliptin phosphate oral tablet 25 mg* | T3 | QL (93 EA per 31 days) |
| *sitagliptin-metformin oral tablet* | T3 | QL (62 EA per 31 days) |
| *sitagliptin-metformin oral tablet, er multiphase 24 hr 100-1,000 mg, 50-500 mg* | T3 | QL (31 EA per 31 days) |
| *sitagliptin-metformin oral tablet, er multiphase 24 hr 50-1,000 mg* | T3 | QL (62 EA per 31 days) |
| **SOLIQUA 100/33** | T3 | QL (18 ML per 30 days) |
| **SOMAVERT** | T5 | PA |
| **STEGLATRO** | T4 | ST; QL (31 EA per 31 days) |
| **STEGLUJAN** | T4 | PA; QL (31 EA per 31 days) |
| **SYNAREL** | T5 | PA |
| **SYNJARDY** | T3 | QL (62 EA per 31 days) |
| **SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG** | T3 | QL (62 EA per 31 days) |
| **SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG** | T3 | QL (31 EA per 31 days) |
| **SYNTHROID** | T4 | |
| **TARPEYO** | T5 | PA; QL (124 EA per 31 days) |
| **TESTIM** | T4 | PA |
| *testosterone cypionate* | T3 | PA |
| *testosterone enanthate* | T3 | PA |
| *testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)* | T4 | PA |
| *testosterone transdermal gel in packet* | T4 | PA |
| *testosterone transdermal solution in metered pump w/app* | T4 | PA |
| **THYQUIDITY** | T4 | |
| **TIROSINT** | T4 | |
| **TIROSINT-SOL** | T4 | |
| **TLANDO** | T4 | PA; QL (124 EA per 31 days) |
| *tolvaptan* | T5 | PA |
| *tolvaptan (polycys kidney dis) oral tablet* | T5 | PA; QL (112 EA per 28 days) |
| *tolvaptan (polycys kidney dis) oral tablets, sequential* | T5 | PA; QL (56 EA per 28 days) |
| **TOUJEO MAX U-300 SOLOSTAR** | T3 | |
| **TOUJEO SOLOSTAR U-300 INSULIN** | T3 | |
| **TRADJENTA** | T3 | QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **TRESIBA FLEXTOUCH U-100** | T4 | |
| **TRESIBA FLEXTOUCH U-200** | T4 | |
| **TRESIBA U-100 INSULIN** | T4 | |
| **TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG** | T3 | QL (31 EA per 31 days) |
| **TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG** | T3 | QL (62 EA per 31 days) |
| **TRULICITY** | T3 | PA; QL (2 ML per 28 days) |
| **UNITHROID** | T3 | |
| **VICTOZA 3-PAK** | T4 | PA; QL (9 ML per 30 days) |
| **VOGELXO TRANSDERMAL GEL** | T4 | PA |
| **VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP** | T4 | PA |
| **VOXZOGO** | T5 | PA; QL (31 EA per 31 days) |
| **XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 5-500 MG** | T3 | QL (31 EA per 31 days) |
| **XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG** | T3 | QL (62 EA per 31 days) |
| **XULTOPHY 100/3.6** | T3 | QL (15 ML per 30 days) |
| **XYOSTED** | T4 | PA |
| **YARGESA** | T5 | PA; QL (93 EA per 31 days) |
| **YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML** | T5 | PA; QL (1.12 ML per 28 days) |
| **YORVIPATH SUBCUTANEOUS PEN INJECTOR 294 MCG/0.98 ML** | T5 | PA; QL (1.96 ML per 28 days) |
| **YORVIPATH SUBCUTANEOUS PEN INJECTOR 420 MCG/1.4 ML** | T5 | PA; QL (2.8 ML per 28 days) |
| **YUVIWEL SUBCUTANEOUS RECON SOLN 1.3 MG, 2.8 MG** | T5 | PA; QL (4 EA per 28 days) |
| **YUVIWEL SUBCUTANEOUS RECON SOLN 5.5 MG** | T5 | PA; QL (8 EA per 28 days) |
| **ZAVESCA** | T5 | PA; QL (93 EA per 31 days) |
| **ZELVYSIA** | T5 | PA |
| **ZITUVIMET** | T4 | PA; QL (62 EA per 31 days) |
| **ZITUVIMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG** | T4 | PA; QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ZITUVIMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG** | T4 | PA; QL (62 EA per 31 days) |
| **ZITUVIO ORAL TABLET 100 MG, 50 MG** | T4 | PA; QL (31 EA per 31 days) |
| **ZITUVIO ORAL TABLET 25 MG** | T4 | PA; QL (93 EA per 31 days) |
| **Gastroenterology** | | |
| **ACIPHEX** | T4 | QL (62 EA per 31 days) |
| *alosetron oral tablet 0.5 mg* | T4 | PA; QL (93 EA per 31 days) |
| *alosetron oral tablet 1 mg* | T5 | PA; QL (62 EA per 31 days) |
| **AMITIZA** | T4 | PA; QL (62 EA per 31 days) |
| *amoxicil-clarithromy-lansopraz* | T4 | |
| **ANALPRAM-HC RECTAL CREAM 1-1 %** | T4 | |
| **ANALPRAM-HC SINGLES** | T4 | |
| **ANUSOL-HC TOPICAL** | T4 | |
| *aprepitant oral capsule 125 mg* | T5 | PA-BvD |
| *aprepitant oral capsule 40 mg, 80 mg* | T4 | PA-BvD |
| *aprepitant oral capsule,dose pack* | T4 | PA-BvD |
| **APRISO** | T4 | PA; QL (124 EA per 31 days) |
| **AZULFIDINE** | T4 | |
| **AZULFIDINE EN-TABS** | T4 | |
| *balsalazide* | T2 | |
| *betaine* | T5 | |
| *bismuth subcit k-metronidz-tcn* | T4 | |
| **BONJESTA** | T4 | PA; QL (62 EA per 31 days) |
| *budesonide oral capsule,delayed,extend.release* | T4 | |
| *budesonide oral tablet,delayed and ext.release* | T5 | |
| *budesonide rectal* | T4 | |
| **BYLVAY ORAL CAPSULE 1,200 MCG** | T5 | PA; QL (186 EA per 31 days) |
| **BYLVAY ORAL CAPSULE 400 MCG** | T5 | PA; QL (558 EA per 31 days) |
| **BYLVAY ORAL PELLET 200 MCG** | T5 | PA; QL (1116 EA per 31 days) |
| **BYLVAY ORAL PELLET 600 MCG** | T5 | PA; QL (372 EA per 31 days) |
| **CANASA** | T5 | PA; QL (31 EA per 31 days) |
| **CARAFATE ORAL TABLET** | T4 | |
| *chlordiazepoxide-clidinium* | T4 | |
| **CHOLBAM** | T5 | PA |
| *cimetidine* | T2 | |
| *cimetidine hcl oral* | T2 | |
| **CIMZIA** | T5 | PA; QL (2 EA per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **CIMZIA POWDER FOR RECONST** | T5 | PA; QL (2 EA per 28 days) |
| **CIMZIA STARTER KIT** | T5 | PA; QL (6 EA per 365 days) |
| **CLENPIQ ORAL SOLUTION 10 MG-3.5 GRAM- 12 GRAM/175 ML** | T4 | |
| **COMPRO** | T2 | |
| **CONSTULOSE** | T2 | |
| **CREON** | T3 | |
| *cromolyn oral* | T4 | |
| **CTEXLI** | T5 | PA; QL (93 EA per 31 days) |
| **CUVPOSA** | T4 | |
| **CYSTADANE** | T5 | |
| **CYTOTEC** | T4 | |
| **DEXILANT** | T4 | QL (31 EA per 31 days) |
| *dexlansoprazole* | T4 | QL (31 EA per 31 days) |
| **DICLEGIS** | T4 | PA; QL (124 EA per 31 days) |
| *dicyclomine oral capsule* | T2 | |
| *dicyclomine oral solution* | T2 | |
| *dicyclomine oral tablet 20 mg* | T2 | |
| *dicyclomine oral tablet 40 mg* | T4 | PA; QL (124 EA per 31 days) |
| **DIPENTUM** | T5 | |
| *diphenoxylate-atropine* | T2 | |
| *doxylamine-pyridoxine (vit b6)* | T4 | PA; QL (124 EA per 31 days) |
| *dronabinol oral capsule* | T4 | PA-BvD |
| **EMEND ORAL CAPSULE 80 MG** | T4 | PA-BvD |
| **EMEND ORAL CAPSULE,DOSE PACK** | T4 | PA-BvD |
| **EMEND ORAL SUSPENSION FOR RECONSTITUTION** | T4 | PA-BvD |
| **ENTYVIO PEN** | T5 | PA; QL (1.36 ML per 28 days) |
| **ENULOSE** | T2 | |
| **EOHILIA** | T5 | PA; QL (1800 ML per 365 days) |
| *esomeprazole magnesium oral capsule,delayed release(dr/ec)* | T2 | QL (31 EA per 31 days) |
| *esomeprazole magnesium oral granules dr for susp in packet* | T4 | QL (31 EA per 31 days) |
| *famotidine oral suspension for reconstitution* | T2 | |
| *famotidine oral tablet 20 mg, 40 mg* | T1 | |
| **GASTROCROM** | T4 | |
| **GATTEX 30-VIAL** | T5 | PA |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **GAVILYTE-C** | T1 | |
| **GAVILYTE-G** | T1 | |
| **GAVILYTE-N** | T1 | |
| **GENERLAC** | T2 | |
| **GIMOTI** | T5 | PA; QL (9.8 ML per 28 days) |
| **GLYCATE** | T4 | PA; QL (155 EA per 31 days) |
| *glycopyrrolate oral solution* | T4 | |
| *glycopyrrolate oral tablet 1 mg, 2 mg* | T3 | |
| *glycopyrrolate oral tablet 1.5 mg* | T4 | PA; QL (155 EA per 31 days) |
| **GOLYTELY** | T4 | |
| *granisetron hcl oral* | T2 | PA-BvD |
| **GRANISOL** | T5 | PA-BvD |
| *hydrocortisone acetate topical cream with perineal applicator* | T5 | |
| *hydrocortisone rectal* | T4 | |
| *hydrocortisone topical cream with perineal applicator 2.5 %* | T2 | |
| *hydrocortisone-pramoxine rectal cream 1-1 %* | T4 | |
| **IBSRELA** | T5 | PA; QL (62 EA per 31 days) |
| **IQIRVO** | T5 | PA; QL (31 EA per 31 days) |
| **KONVOMEP** | T4 | |
| **KRISTALOSE** | T4 | ST |
| *lactulose oral packet 10 gram* | T5 | ST |
| *lactulose oral packet 20 gram* | T4 | ST |
| *lactulose oral solution* | T2 | |
| *lansoprazole oral capsule,delayed release(dr/ec) 15 mg* | T2 | QL (31 EA per 31 days) |
| *lansoprazole oral capsule,delayed release(dr/ec) 30 mg* | T2 | QL (62 EA per 31 days) |
| *lansoprazole oral tablet,disintegrat, delay rel 15 mg* | T4 | QL (31 EA per 31 days) |
| *lansoprazole oral tablet,disintegrat, delay rel 30 mg* | T4 | QL (62 EA per 31 days) |
| **LIALDA** | T5 | PA; QL (124 EA per 31 days) |
| **LIBRAX (WITH CLIDINIUM)** | T5 | |
| **LINZESS** | T3 | QL (31 EA per 31 days) |
| **LIVDELZI** | T5 | PA; QL (31 EA per 31 days) |
| **LIVMARLI ORAL SOLUTION 19 MG/ML** | T5 | PA; QL (60 ML per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **LIVMARLI ORAL SOLUTION 9.5 MG/ML** | T5 | PA; QL (90 ML per 30 days) |
| **LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG** | T5 | PA; QL (62 EA per 31 days) |
| **LIVMARLI ORAL TABLET 30 MG** | T5 | PA; QL (31 EA per 31 days) |
| **LOMOTIL** | T4 | |
| *loperamide oral capsule* | T2 | |
| **LOTRONEX ORAL TABLET 0.5 MG** | T5 | PA; QL (93 EA per 31 days) |
| **LOTRONEX ORAL TABLET 1 MG** | T5 | PA; QL (62 EA per 31 days) |
| *lubiprostone* | T4 | QL (62 EA per 31 days) |
| **MARINOL ORAL CAPSULE 2.5 MG** | T4 | PA-BvD |
| *meclizine oral tablet 12.5 mg, 25 mg* | T2 | |
| *meclizine oral tablet 50 mg* | T4 | |
| *meclizine oral tablet,chewable* | T4 | |
| *mesalamine oral capsule (with del rel tablets)* | T4 | QL (186 EA per 31 days) |
| *mesalamine oral capsule, extended release 250 mg* | T4 | QL (496 EA per 31 days) |
| *mesalamine oral capsule, extended release 500 mg* | T4 | PA; QL (248 EA per 31 days) |
| *mesalamine oral capsule,extended release 24hr* | T4 | QL (124 EA per 31 days) |
| *mesalamine oral tablet,delayed release (dr/ec) 1.2 gram* | T4 | QL (124 EA per 31 days) |
| *mesalamine oral tablet,delayed release (dr/ec) 800 mg* | T4 | PA; QL (186 EA per 31 days) |
| *mesalamine rectal enema* | T4 | QL (1860 ML per 31 days) |
| *mesalamine rectal suppository* | T4 | PA; QL (31 EA per 31 days) |
| *methscopolamine* | T4 | |
| *metoclopramide hcl oral solution* | T2 | |
| *metoclopramide hcl oral tablet* | T1 | |
| *misoprostol* | T3 | |
| **MOTEGRITY** | T4 | PA; QL (31 EA per 31 days) |
| **MOTOFEN** | T4 | |
| **MOVANTIK** | T3 | QL (31 EA per 31 days) |
| **MOVIPREP** | T4 | |
| **MYTESI** | T5 | QL (62 EA per 31 days) |
| **NEREUS** | T4 | PA; QL (60 EA per 365 days) |
| **NEXIUM** | T4 | QL (31 EA per 31 days) |
| **NEXIUM PACKET** | T4 | QL (31 EA per 31 days) |
| *nitroglycerin rectal* | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *nizatidine oral capsule* | T2 | |
| *omeprazole oral capsule,delayed release(dr/ec)* | T1 | |
| *omeprazole-sodium bicarbonate oral capsule* | T4 | |
| *omeprazole-sodium bicarbonate oral packet* | T5 | |
| **OMVOH PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML** | T5 | PA; QL (2 ML per 28 days) |
| **OMVOH PEN SUBCUTANEOUS PEN INJECTOR 300MG/3ML(100MG /ML-200 MG/2ML)** | T5 | PA; QL (3 ML per 28 days) |
| **OMVOH SUBCUTANEOUS SYRINGE 200 MG/2 ML** | T5 | PA; QL (2 ML per 28 days) |
| **OMVOH SUBCUTANEOUS SYRINGE 300MG/3ML(100MG /ML-200 MG/2ML)** | T5 | PA; QL (3 ML per 28 days) |
| *ondansetron hcl oral solution* | T2 | PA-BvD |
| *ondansetron hcl oral tablet 4 mg, 8 mg* | T2 | PA-BvD |
| *ondansetron oral tablet,disintegrating 4 mg, 8 mg* | T2 | PA-BvD |
| **PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,500-35,500- 61,500 UNIT, 16,800-56,800- 98,400 UNIT, 2,600-8,800- 15,200 UNIT, 4,200-14,200- 24,600 UNIT** | T4 | ST |
| **PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 21,000-54,700- 83,900 UNIT, 37,000-97,300- 149,900 UNIT** | T5 | ST |
| *pantoprazole oral granules dr for susp in packet* | T4 | |
| *pantoprazole oral tablet,delayed release (dr/ec)* | T1 | |
| *peg 3350-electrolytes* | T1 | |
| *peg3350-sod sul-nacl-kcl-asb-c* | T4 | |
| *peg-electrolyte soln* | T1 | |
| **PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG** | T3 | QL (496 EA per 31 days) |
| **PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG** | T5 | PA; QL (248 EA per 31 days) |
| **PEPCID ORAL TABLET** | T4 | |
| **PERTZYE** | T4 | ST |
| **PREVACID** | T4 | QL (62 EA per 31 days) |
| **PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 15 MG** | T4 | QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 30 MG** | T4 | QL (62 EA per 31 days) |
| **PRILOSEC ORAL SUSP,DELAYED RELEASE FOR RECON** | T4 | |
| *prochlorperazine* | T2 | |
| *prochlorperazine maleate* | T2 | |
| **PROCTOFOAM HC** | T4 | |
| **PROCTO-MED HC** | T2 | |
| **PROCTOSOL HC TOPICAL** | T2 | |
| **PROCTOZONE-HC** | T2 | |
| **PROTONIX ORAL** | T4 | |
| *prucalopride* | T4 | PA; QL (31 EA per 31 days) |
| **PYLERA** | T4 | |
| *rabeprazole oral tablet,delayed release (dr/ec)* | T4 | QL (62 EA per 31 days) |
| *ranitidine hcl oral tablet* | T2 | |
| **REGLAN ORAL** | T4 | |
| **RELISTOR ORAL** | T5 | PA; QL (93 EA per 31 days) |
| **RELISTOR SUBCUTANEOUS SOLUTION** | T5 | PA; QL (18.6 ML per 31 days) |
| **RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML** | T5 | PA; QL (18.6 ML per 31 days) |
| **RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML** | T5 | PA; QL (12.4 ML per 31 days) |
| **RELTONE** | T5 | ST |
| **ROWASA RECTAL ENEMA KIT** | T4 | PA; QL (4 EA per 28 days) |
| **SANCUSO** | T5 | |
| *scopolamine base* | T3 | QL (10 EA per 30 days) |
| **SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)** | T5 | PA; QL (1.2 ML per 56 days) |
| **SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)** | T5 | PA; QL (2.4 ML per 56 days) |
| *sodium,potassium,mag sulfates* | T4 | |
| **SUCRAID** | T5 | PA |
| *sucralfate oral suspension* | T4 | |
| *sucralfate oral tablet* | T2 | |
| **SUFLAVE** | T4 | |
| *sulfasalazine* | T2 | |
| **SUPREP BOWEL PREP KIT** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **SUTAB** | T4 | |
| **SYMPROIC** | T4 | PA; QL (31 EA per 31 days) |
| **TALICIA** | T4 | PA |
| **TRANSDERM-SCOP** | T4 | QL (10 EA per 30 days) |
| *trimethobenzamide oral* | T4 | PA |
| **TRULANCE** | T4 | PA; QL (31 EA per 31 days) |
| **UCERIS ORAL** | T5 | |
| **UCERIS RECTAL** | T4 | |
| *ursodiol oral capsule 200 mg, 400 mg* | T4 | ST |
| *ursodiol oral capsule 300 mg* | T3 | |
| *ursodiol oral tablet* | T3 | |
| **URSOLIGN** | T5 | ST |
| **VARUBI** | T5 | PA-BvD |
| **VELSIPITY** | T5 | PA; QL (31 EA per 31 days) |
| **VIBERZI** | T5 | PA; QL (62 EA per 31 days) |
| **VIOKACE** | T4 | |
| **VOQUEZNA DUAL PAK** | T4 | PA; QL (112 EA per 14 days) |
| **VOQUEZNA ORAL TABLET 10 MG** | T4 | PA; QL (31 EA per 31 days) |
| **VOQUEZNA ORAL TABLET 20 MG** | T4 | PA; QL (62 EA per 31 days) |
| **VOQUEZNA TRIPLE PAK** | T4 | PA; QL (112 EA per 14 days) |
| **VOWST** | T5 | PA; QL (12 EA per 14 days) |
| **ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT** | T3 | |
| **ZYMFENTRA** | T5 | PA; QL (1 EA per 28 days) |
| **Immunology, Vaccines / Biotechnology** | | |
| **ABRYSVO (PF)** | T3 | QL (1 EA per 365 days) |
| **ACTHIB (PF)** | T3 | |
| **ACTIMMUNE** | T5 | PA |
| **ADACEL(TDAP ADOLESN/ADULT)(PF)** | T3 | |
| **ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 60 MCG/ML** | T5 | PA-BvD; ST |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML** | T4 | PA-BvD; ST |
| **ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML** | T4 | PA-BvD; ST |
| **ARANESP (IN POLYSORBATE) INJECTION SYRINGE 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML, 60 MCG/0.3 ML** | T5 | PA-BvD; ST |
| **ARCALYST** | T5 | PA |
| **AREXVY (PF)** | T3 | QL (1 EA per 365 days) |
| **ARMLUPEG** | T5 | ST |
| **AVONEX INTRAMUSCULAR PEN INJECTOR KIT** | T5 | PA; QL (1 EA per 28 days) |
| **AVONEX INTRAMUSCULAR SYRINGE KIT** | T5 | PA; QL (1 EA per 28 days) |
| *bcg vaccine, live (pf)* | T3 | |
| **BESREMI** | T5 | PA-NS; QL (2 ML per 28 days) |
| **BESREMI PEN** | T5 | PA-NS; QL (1 ML per 28 days) |
| **BETASERON SUBCUTANEOUS KIT** | T5 | PA; QL (14 EA per 28 days) |
| **BEXSERO** | T3 | |
| **BIVIGAM** | T5 | PA |
| **BOOSTRIX TDAP INTRAMUSCULAR SYRINGE** | T3 | |
| **DAPTACEL (DTAP PEDIATRIC) (PF)** | T3 | |
| **EGRIFTA SV** | T5 | PA |
| **EGRIFTA WR** | T5 | PA; QL (4 EA per 28 days) |
| **ENGERIX-B (PF)** | T3 | PA-BvD |
| **ENGERIX-B PEDIATRIC (PF)** | T3 | PA-BvD |
| **EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML** | T4 | PA-BvD; ST |
| **FULPHILA** | T5 | ST |
| **FYLNETRA** | T5 | ST |
| **GAMMAGARD LIQUID** | T5 | PA |
| **GAMMAGARD LIQUID ERC** | T5 | PA |
| **GAMMAGARD S-D (IGA < 1 MCG/ML)** | T5 | PA |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)** | T5 | PA |
| **GAMMAPLEX** | T5 | PA |
| **GAMMAPLEX (WITH SORBITOL)** | T5 | PA |
| **GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)** | T5 | PA |
| **GARDASIL 9 (PF)** | T3 | |
| **GENOTROPIN** | T5 | PA |
| **GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML** | T4 | PA |
| **GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML** | T5 | PA |
| **GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML** | T5 | ST |
| **GRANIX SUBCUTANEOUS SYRINGE** | T5 | ST |
| **GRASTEK** | T4 | PA |
| **HAVRIX (PF)** | T3 | |
| **HEPLISAV-B (PF)** | T3 | PA-BvD |
| **HIBERIX (PF)** | T3 | |
| **HUMATROPE INJECTION CARTRIDGE** | T5 | PA |
| **IMOVAX RABIES VACCINE (PF)** | T3 | PA-BvD |
| **INFANRIX (DTAP) (PF)** | T3 | |
| **IPOL** | T3 | |
| **IXIARO (PF)** | T3 | |
| **JYNNEOS (PF)** | T3 | PA-BvD |
| **KINRIX (PF)** | T3 | |
| **LEUKINE INJECTION RECON SOLN** | T5 | PA |
| **MENQUADFI (PF)** | T3 | |
| **MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT** | T3 | |
| **MIRCERA** | T4 | ST |
| **M-M-R II (PF)** | T3 | |
| **MRESVIA (PF)** | T3 | QL (1 ML per 365 days) |
| **NEULASTA SUBCUTANEOUS SYRINGE** | T5 | ST |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **NEUPOGEN** | T5 | ST |
| **NGENLA** | T5 | PA |
| **NIVESTYM** | T5 | |
| **NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)** | T5 | PA |
| **NYVEPRIA** | T5 | ST |
| **OCTAGAM** | T5 | PA |
| **ODACTRA** | T4 | PA |
| **OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)** | T5 | PA |
| **OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)** | T4 | PA |
| **OMNITROPE SUBCUTANEOUS RECON SOLN** | T5 | PA |
| **PANZYGA** | T5 | PA |
| **PEDIARIX (PF)** | T3 | |
| **PEDVAX HIB (PF)** | T3 | |
| **PEGASYS** | T5 | PA |
| **PENBRAYA (PF)** | T3 | |
| **PENMENVY MEN A-B-C-W-Y (PF)** | T3 | |
| **PENTACEL (PF)** | T3 | |
| **PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML** | T5 | PA; QL (1 ML per 28 days) |
| **PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML** | T5 | PA; QL (1 ML per 28 days) |
| **PRIORIX (PF)** | T3 | |
| **PRIVIGEN** | T5 | PA |
| **PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML** | T3 | PA-BvD |
| **PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML** | T5 | PA-BvD |
| **PROQUAD (PF)** | T3 | |
| **QIVIGY** | T5 | PA |
| **QUADRACEL (PF)** | T3 | |
| **RABAVERT (PF)** | T3 | PA-BvD |
| **REBIF (WITH ALBUMIN)** | T5 | PA; QL (6 ML per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML** | T5 | PA; QL (6 ML per 28 days) |
| **REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)** | T5 | PA; QL (4.2 ML per 365 days) |
| **REBIF TITRATION PACK** | T5 | PA; QL (8.4 ML per 365 days) |
| **RECOMBIVAX HB (PF)** | T3 | PA-BvD |
| **RELEUKO SUBCUTANEOUS** | T4 | ST |
| **RETACRIT** | T3 | PA-BvD |
| **ROLVEDON** | T5 | ST |
| **ROTARIX** | T3 | |
| **ROTATEQ VACCINE** | T3 | |
| **SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG** | T5 | PA |
| **SHINGRIX (PF)** | T3 | QL (2 EA per 999 days) |
| **SKYTROFA** | T5 | PA |
| **SOGROYA** | T5 | PA |
| **STIMUFEND** | T5 | ST |
| **TENIVAC (PF)** | T3 | |
| **TICOVAC** | T3 | |
| **TRUMENBA** | T3 | |
| **TWINRIX (PF)** | T3 | |
| **TYPHIM VI INTRAMUSCULAR SYRINGE** | T3 | |
| **UDENYCA** | T5 | ST |
| **UDENYCA AUTOINJECTOR** | T5 | ST |
| **VAQTA (PF)** | T3 | |
| **VARIVAX (PF)** | T3 | |
| **VAXCHORA VACCINE** | T3 | QL (200 ML per 365 days) |
| **VIMKUNYA (PF)** | T3 | |
| **VIVOTIF** | T3 | |
| **XOLREMDI** | T5 | PA; QL (124 EA per 31 days) |
| **YF-VAX (PF)** | T3 | |
| **YIMMUGO** | T5 | PA |
| **ZARXIO** | T5 | |
| **ZIEXTENZO** | T5 | ST |
| **ZOMACTON** | T4 | PA |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **Miscellaneous Supplies** | | |
| **ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"** | T4 | PA |
| **GAUZE PAD TOPICAL BANDAGE 2 X 2 "** | T3 | PA |
| *insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge* | T3 | |
| *pen needle, diabetic needle 29 gauge x 1/2"* | T4 | PA |
| **Musculoskeletal / Rheumatology** | | |
| **ABRILADA(CF)** | T5 | PA; QL (2 EA per 28 days) |
| **ABRILADA(CF) PEN** | T5 | PA; QL (2 EA per 28 days) |
| **ACTEMRA ACTPEN** | T5 | PA; QL (3.6 ML per 28 days) |
| **ACTEMRA SUBCUTANEOUS** | T5 | PA; QL (3.6 ML per 28 days) |
| **ACTONEL ORAL TABLET 150 MG, 35 MG** | T4 | |
| *adalimumab-aacf subcutaneous pen injector kit* | T5 | PA; QL (2 EA per 28 days) |
| *adalimumab-aacf subcutaneous syringe kit* | T5 | PA; QL (2 EA per 28 days) |
| **ADALIMUMAB-AACF(CF) PEN CROHNS** | T5 | PA; QL (12 EA per 365 days) |
| **ADALIMUMAB-AACF(CF) PEN PS-UV** | T5 | PA; QL (8 EA per 365 days) |
| *adalimumab-aaty* | T5 | PA; QL (2 EA per 28 days) |
| **ADALIMUMAB-AATY(CF) AI CROHNS** | T5 | PA; QL (6 EA per 365 days) |
| *adalimumab-adaz subcutaneous pen injector 40 mg/0.4 ml* | T5 | PA; QL (0.8 ML per 28 days) |
| *adalimumab-adaz subcutaneous pen injector 80 mg/0.8 ml* | T5 | PA; QL (1.6 ML per 28 days) |
| *adalimumab-adaz subcutaneous syringe 10 mg/0.1 ml* | T5 | PA; QL (0.2 ML per 28 days) |
| *adalimumab-adaz subcutaneous syringe 20 mg/0.2 ml* | T5 | PA; QL (0.4 ML per 28 days) |
| *adalimumab-adaz subcutaneous syringe 40 mg/0.4 ml* | T5 | PA; QL (0.8 ML per 28 days) |
| *adalimumab-adbm* | T5 | PA; QL (2 EA per 28 days) |
| *adalimumab-bwwd* | T5 | PA; QL (0.8 ML per 28 days) |
| *adalimumab-fkjp subcutaneous pen injector kit* | T5 | PA; QL (2 EA per 28 days) |
| *adalimumab-fkjp subcutaneous syringe kit* | T5 | PA; QL (2 EA per 28 days) |
| *adalimumab-ryvk* | T5 | PA; QL (2 EA per 28 days) |
| *alendronate oral solution* | T2 | |
| *alendronate oral tablet 10 mg, 35 mg, 70 mg* | T1 | |
| *allopurinol oral tablet 100 mg, 300 mg* | T1 | |
| *allopurinol oral tablet 200 mg* | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML** | T5 | PA; QL (0.8 ML per 28 days) |
| **AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.8 ML** | T5 | PA; QL (1.6 EA per 28 days) |
| **AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 80 MG/0.8 ML** | T5 | PA; QL (1.6 ML per 28 days) |
| **AMJEVITA(CF) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML, 20 MG/0.2 ML** | T5 | PA; QL (0.4 ML per 28 days) |
| **AMJEVITA(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML** | T5 | PA; QL (0.8 ML per 28 days) |
| **AMJEVITA(CF) SUBCUTANEOUS SYRINGE 40 MG/0.8 ML** | T5 | PA; QL (1.6 EA per 28 days) |
| **ATELVIA** | T4 | |
| *auranofin* | T5 | |
| **AVTOZMA AUTOINJECTOR** | T5 | PA; QL (3.6 ML per 28 days) |
| **AVTOZMA SUBCUTANEOUS** | T5 | PA; QL (3.6 ML per 28 days) |
| **BENLYSTA SUBCUTANEOUS** | T5 | PA; QL (4 ML per 28 days) |
| **BILDYOS** | T4 | PA; QL (1 ML per 180 days) |
| **BONSITY** | T5 | PA; QL (2.24 ML per 28 days) |
| **BOSAYA** | T4 | PA; QL (1 ML per 180 days) |
| *colchicine oral capsule* | T4 | QL (62 EA per 31 days) |
| *colchicine oral tablet* | T2 | QL (62 EA per 31 days) |
| **CONEXXENCE** | T4 | PA; QL (1 ML per 180 days) |
| **CUPRIMINE** | T5 | |
| **CYLTEZO(CF)** | T5 | PA; QL (2 EA per 28 days) |
| **CYLTEZO(CF) PEN** | T5 | PA; QL (2 EA per 28 days) |
| **DEPEN TITRATABS** | T5 | |
| **ENBREL MINI** | T5 | PA; QL (8 ML per 28 days) |
| **ENBREL SUBCUTANEOUS SOLUTION** | T5 | PA; QL (4 ML per 28 days) |
| **ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)** | T5 | PA; QL (4 ML per 28 days) |
| **ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)** | T5 | PA; QL (8 ML per 28 days) |
| **ENBREL SURECLICK** | T5 | PA; QL (8 ML per 28 days) |
| **ENOBY** | T3 | PA; QL (1 ML per 180 days) |
| **EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML ( 105MG/1.17MLX2)** | T5 | PA; QL (2.34 ML per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **EVISTA** | T4 | |
| *febuxostat* | T3 | PA |
| **FORTEO** | T5 | PA; QL (2.4 ML per 28 days) |
| **FOSAMAX ORAL TABLET 70 MG** | T4 | |
| **FOSAMAX PLUS D** | T4 | |
| **GLOPERBA** | T4 | QL (300 ML per 30 days) |
| **HADLIMA** | T5 | PA; QL (1.6 ML per 28 days) |
| **HADLIMA PUSHTOUCH** | T5 | PA; QL (1.6 ML per 28 days) |
| **HADLIMA(CF)** | T5 | PA; QL (0.8 ML per 28 days) |
| **HADLIMA(CF) PUSHTOUCH** | T5 | PA; QL (0.8 ML per 28 days) |
| **HUMIRA PEN** | T5 | PA; QL (2 EA per 28 days) |
| **HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML** | T5 | PA; QL (2 EA per 28 days) |
| **HUMIRA(CF)** | T5 | PA; QL (2 EA per 28 days) |
| **HUMIRA(CF) PEN** | T5 | PA; QL (2 EA per 28 days) |
| **HUMIRA(CF) PEN CROHNS-UC-HS** | T5 | PA; QL (6 EA per 365 days) |
| **HUMIRA(CF) PEN PSOR-UV-ADOL HS** | T5 | PA; QL (6 EA per 365 days) |
| **HYRIMOZ PEN CROHN'S-UC STARTER** | T5 | PA; QL (4.8 ML per 365 days) |
| **HYRIMOZ PEN PSORIASIS STARTER** | T5 | PA; QL (3.2 ML per 365 days) |
| **HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML** | T5 | PA; QL (0.8 ML per 28 days) |
| **HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 80 MG/0.8 ML** | T5 | PA; QL (1.6 ML per 28 days) |
| **HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML** | T5 | PA; QL (0.2 ML per 28 days) |
| **HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML** | T5 | PA; QL (0.4 ML per 28 days) |
| **HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML** | T5 | PA; QL (0.8 ML per 28 days) |
| *ibandronate oral* | T2 | |
| **JUBBONTI** | T3 | PA; QL (1 ML per 180 days) |
| **KEVZARA SUBCUTANEOUS PEN INJECTOR** | T5 | PA; QL (2.28 ML per 28 days) |
| **KEVZARA SUBCUTANEOUS SYRINGE 200 MG/1.14 ML** | T5 | PA; QL (2.28 ML per 28 days) |
| **KINERET** | T5 | PA; QL (18.76 ML per 28 days) |
| *leflunomide* | T2 | |
| **LEQSELVI** | T5 | PA; QL (62 EA per 31 days) |
| *milnacipran oral tablet* | T3 | PA |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **MITIGARE** | T4 | QL (62 EA per 31 days) |
| **OLUMIANT** | T5 | PA; QL (31 EA per 31 days) |
| **ORENCIA CLICKJECT** | T5 | PA; QL (4 ML per 28 days) |
| **ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML** | T5 | PA; QL (4 ML per 28 days) |
| **ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML** | T5 | PA; QL (1.6 ML per 28 days) |
| **ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML** | T5 | PA; QL (2.8 ML per 28 days) |
| **OSPOMYV** | T4 | PA; QL (1 ML per 180 days) |
| **OTEZLA** | T5 | PA; QL (62 EA per 31 days) |
| **OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)** | T5 | PA; QL (110 EA per 365 days) |
| **OTEZLA XR** | T5 | PA; QL (30 EA per 30 days) |
| **OTEZLA XR INITIATION** | T5 | PA; QL (82 EA per 365 days) |
| *penicillamine* | T5 | |
| *probenecid* | T2 | |
| *probenecid-colchicine* | T2 | |
| **PROLIA** | T3 | PA; QL (1 ML per 180 days) |
| *raloxifene* | T2 | |
| **RASUVO (PF)** | T4 | PA |
| **RIDAURA** | T5 | |
| **RINVOQ LQ** | T5 | PA; QL (372 ML per 31 days) |
| **RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG** | T5 | PA; QL (31 EA per 31 days) |
| **RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG** | T5 | PA; QL (168 EA per 365 days) |
| *risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg* | T4 | |
| *risedronate oral tablet,delayed release (dr/ec)* | T4 | |
| **SAVELLA ORAL TABLET** | T4 | PA |
| **SAVELLA ORAL TABLETS,DOSE PACK** | T3 | PA |
| **SIMLANDI(CF) AUTOINJECTOR** | T5 | PA; QL (2 EA per 28 days) |
| **SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML** | T5 | PA; QL (2 EA per 28 days) |
| **SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML** | T5 | PA; QL (1 ML per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML** | T5 | PA; QL (0.5 ML per 28 days) |
| **SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML** | T5 | PA; QL (1 ML per 28 days) |
| **SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML** | T5 | PA; QL (0.5 ML per 28 days) |
| **STOBOCLO** | T4 | PA; QL (1 ML per 180 days) |
| *teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)* | T5 | PA; QL (2.48 ML per 28 days) |
| *tofacitinib oral solution* | T5 | PA; QL (310 ML per 31 days) |
| *tofacitinib oral tablet* | T4 | PA; QL (62 EA per 31 days) |
| *tofacitinib oral tablet extended release 24 hr 11 mg* | T4 | PA; QL (31 EA per 31 days) |
| *tofacitinib oral tablet extended release 24 hr 22 mg* | T5 | PA; QL (31 EA per 31 days) |
| **TYENNE AUTOINJECTOR** | T5 | PA; QL (3.6 ML per 28 days) |
| **TYENNE SUBCUTANEOUS** | T5 | PA; QL (3.6 ML per 28 days) |
| **TYMLOS** | T5 | PA; QL (1.56 ML per 30 days) |
| **ULORIC** | T4 | PA |
| **XELJANZ ORAL SOLUTION** | T5 | PA; QL (310 ML per 31 days) |
| **XELJANZ ORAL TABLET** | T5 | PA; QL (62 EA per 31 days) |
| **XELJANZ XR** | T5 | PA; QL (31 EA per 31 days) |
| **YUFLYMA(CF) AI CROHN'S-UC-HS** | T5 | PA; QL (6 EA per 365 days) |
| **YUFLYMA(CF) AUTOINJECTOR** | T5 | PA; QL (2 EA per 28 days) |
| **YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML** | T5 | PA; QL (2 EA per 28 days) |
| **YUSIMRY(CF) PEN** | T5 | PA; QL (1.6 ML per 28 days) |
| **Obstetrics / Gynecology** | | |
| **ABIGALE** | T3 | |
| **ABIGALE LO** | T4 | |
| **ACTIVELLA** | T4 | |
| **ALTAVERA (28)** | T2 | |
| **ALYACEN 1/35 (28)** | T2 | |
| **ANGELIQ** | T4 | |
| **ANNOVERA** | T4 | |
| **APRI** | T2 | |
| **ARANELLE (28)** | T2 | |
| **ASHLYNA** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **AUBRA EQ** | T2 | |
| **AVIANE** | T2 | |
| **AZURETTE (28)** | T2 | |
| **BALCOLTRA** | T4 | |
| **BALZIVA (28)** | T4 | |
| **BEYAZ** | T4 | |
| **BIJUVA** | T4 | |
| **BLISOVI 24 FE** | T4 | |
| **BLISOVI FE 1.5/30 (28)** | T4 | |
| **BRIELLYN** | T4 | |
| **CAMILA** | T2 | |
| **CAMRESE LO** | T4 | |
| **CLEOCIN VAGINAL** | T4 | |
| **CLIMARA** | T4 | |
| **CLIMARA PRO** | T4 | |
| *clindamycin phosphate vaginal* | T2 | |
| **CLINDESSE** | T4 | |
| **COMBIPATCH** | T4 | |
| *conjugated estrogens* | T3 | |
| **CRINONE** | T4 | PA |
| **CRYSELLE (28)** | T2 | |
| **CYRED EQ** | T2 | |
| **DEBLITANE** | T2 | |
| **DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML** | T4 | |
| **DEPO-ESTRADIOL** | T4 | |
| **DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML** | T4 | |
| **DEPO-PROVERA INTRAMUSCULAR SYRINGE** | T4 | |
| **DEPO-SUBQ PROVERA 104** | T3 | |
| **DIVIGEL** | T4 | |
| **DOLISHALE** | T4 | |
| **DOTTI** | T3 | |
| *drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4)* | T4 | |
| *drospirenone-ethinyl estradiol* | T2 | |
| **DUAVEE** | T3 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ELESTRIN** | T4 | |
| **ELURYNG** | T4 | |
| **ENILLORING** | T4 | |
| **ENSKYCE** | T2 | |
| **ERRIN** | T2 | |
| **ESTARYLLA** | T2 | |
| **ESTRACE VAGINAL** | T4 | |
| *estradiol oral* | T4 | |
| *estradiol transdermal gel in metered-dose pump* | T4 | |
| *estradiol transdermal gel in packet* | T4 | |
| *estradiol transdermal patch semiweekly* | T3 | |
| *estradiol transdermal patch weekly* | T3 | |
| *estradiol vaginal cream* | T2 | |
| *estradiol vaginal tablet* | T4 | |
| *estradiol valerate* | T4 | |
| *estradiol-norethindrone acet* | T3 | |
| **ESTRING** | T4 | |
| *etonogestrel-ethinyl estradiol* | T3 | |
| **EVAMIST** | T4 | |
| **FALMINA (28)** | T2 | |
| **FEIRZA** | T2 | |
| **FEMLYV** | T4 | |
| **FEMRING** | T4 | |
| **FINZALA** | T4 | |
| **FYAVOLV** | T4 | |
| **GALBRIELA** | T4 | |
| **GALLIFREY** | T2 | |
| **GEMMILY** | T4 | |
| **GYNAZOLE-1** | T4 | |
| **HAILEY 24 FE** | T4 | |
| **HAILEY FE 1/20 (28)** | T2 | |
| **HEATHER** | T2 | |
| **ICLEVIA** | T2 | |
| **IMVEXXY MAINTENANCE PACK** | T3 | |
| **IMVEXXY STARTER PACK** | T3 | |
| **INCASSIA** | T2 | |
| **INTRAROSA** | T4 | PA; QL (28 EA per 28 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **INTROVALE** | T2 | |
| **ISIBLOOM** | T2 | |
| **JAIMIESS** | T2 | |
| **JASMIEL (28)** | T2 | |
| **JINTELI** | T4 | |
| **JOYEAUX** | T4 | |
| **JULEBER** | T2 | |
| **JUNEL 1.5/30 (21)** | T4 | |
| **JUNEL 1/20 (21)** | T4 | |
| **JUNEL FE 1.5/30 (28)** | T4 | |
| **JUNEL FE 1/20 (28)** | T4 | |
| **JUNEL FE 24** | T4 | |
| **KAITLIB FE** | T4 | |
| **KARIVA (28)** | T2 | |
| **KELNOR 1/35 (28)** | T2 | |
| **KURVELO (28)** | T2 | |
| **KYLEENA** | T4 | |
| *l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)* | T2 | |
| **LARIN 1.5/30 (21)** | T2 | |
| **LARIN 1/20 (21)** | T2 | |
| **LARIN FE 1.5/30 (28)** | T2 | |
| **LARIN FE 1/20 (28)** | T2 | |
| **LESSINA** | T2 | |
| **LEVONEST (28)** | T2 | |
| *levonorgest-eth.estradiol-iron* | T4 | |
| *levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg* | T2 | |
| *levonorgestrel-ethinyl estrad oral tablet 90-20 mcg (28)* | T4 | |
| *levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month* | T2 | |
| *levonorg-eth estrad triphasic* | T2 | |
| **LILETTA** | T3 | |
| **LO LOESTRIN FE** | T4 | |
| **LOESTRIN 1.5/30 (21)** | T4 | |
| **LOESTRIN 1/20 (21)** | T4 | |
| **LOESTRIN FE 1.5/30 (28-DAY)** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **LOESTRIN FE 1/20 (28-DAY)** | T4 | |
| **LOJAIMIESS** | T2 | |
| **LORYNA (28)** | T2 | |
| **LOW-OGESTREL (28)** | T2 | |
| **LUIZZA** | T2 | |
| **LYLEQ** | T2 | |
| **LYLLANA** | T3 | |
| **LYNKUET** | T4 | PA; QL (62 EA per 31 days) |
| **LYZA** | T2 | |
| **MARLISSA (28)** | T2 | |
| *medroxyprogesterone* | T2 | |
| **MELEYA** | T2 | |
| **MENOSTAR** | T4 | |
| *metronidazole vaginal gel 0.75 % (37.5mg/5 gram)* | T3 | |
| **MIBELAS 24 FE** | T4 | |
| **MICONAZOLE-3 VAGINAL SUPPOSITORY** | T4 | |
| **MICROGESTIN 1.5/30 (21)** | T2 | |
| **MICROGESTIN 1/20 (21)** | T2 | |
| **MICROGESTIN FE 1.5/30 (28)** | T2 | |
| **MICROGESTIN FE 1/20 (28)** | T2 | |
| **MILI** | T2 | |
| **MIMVEY** | T3 | |
| **MINIVELLE** | T4 | |
| **MINZOYA** | T4 | |
| **MIRENA** | T4 | |
| **MYFEMBREE** | T5 | PA; QL (31 EA per 31 days) |
| **NATAZIA** | T4 | |
| **NECON 0.5/35 (28)** | T4 | |
| **NEXPLANON** | T3 | |
| **NEXTSTELLIS** | T4 | |
| **NIKKI (28)** | T2 | |
| **NORA-BE** | T2 | |
| *norelgestromin-ethin.estradiol* | T2 | |
| *norethindrone (contraceptive)* | T2 | |
| *norethindrone acetate* | T2 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg* | T4 | |
| *norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg* | T2 | |
| *norethindrone-e.estradiol-iron oral capsule* | T4 | |
| *norethindrone-e.estradiol-iron oral tablet,chewable* | T4 | |
| *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** | T4 | |
| **NUVESSA** | T4 | |
| **NYLIA 1/35 (28)** | T4 | |
| **NYLIA 7/7/7 (28)** | T4 | |
| **ORIAHNN** | T5 | PA; QL (56 EA per 28 days) |
| **ORQUIDEA** | T2 | |
| **OSPHENA** | T4 | PA; QL (31 EA per 31 days) |
| **PHEXX** | T4 | |
| **PIMTREA (28)** | T2 | |
| **PORTIA 28** | T2 | |
| **PREMARIN ORAL** | T3 | |
| **PREMARIN VAGINAL** | T3 | |
| **PREMPHASE** | T3 | |
| **PREMPRO** | T3 | |
| *progesterone micronized oral* | T2 | |
| **PROMETRIUM** | T4 | |
| **PROVERA** | T4 | |
| **RECLIPSEN (28)** | T2 | |
| **RIVELSA** | T4 | |
| **ROSYRAH** | T4 | |
| **SAFYRAL** | T4 | |
| **SETLAKIN** | T2 | |
| **SHAROBEL** | T2 | |
| **SKYLA** | T4 | |
| **SLYND** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **SPRINTEC (28)** | T2 | |
| **SYEDA** | T2 | |
| **TARINA 24 FE** | T2 | |
| **TARINA FE 1-20 EQ (28)** | T2 | |
| *terconazole* | T3 | |
| **TILIA FE** | T2 | |
| *tranexamic acid oral* | T3 | |
| **TRI-ESTARYLLA** | T2 | |
| **TRI-LEGEST FE** | T2 | |
| **TRI-LO-ESTARYLLA** | T2 | |
| **TRI-LO-SPRINTEC** | T2 | |
| **TRI-MILI** | T4 | |
| **TRI-SPRINTEC (28)** | T2 | |
| **TRI-VYLIBRA** | T4 | |
| **TRI-VYLIBRA LO** | T4 | |
| **TURQOZ (28)** | T2 | |
| **TWIRLA** | T4 | |
| **TYBLUME** | T4 | |
| **TYDEMY** | T2 | |
| **VAGIFEM** | T4 | |
| **VALTYA** | T2 | |
| **VANDAZOLE** | T3 | |
| **VELIVET TRIPHASIC REGIMEN (28)** | T2 | |
| **VEOZAH** | T4 | PA; QL (31 EA per 31 days) |
| **VESTURA (28)** | T2 | |
| **VIENVA** | T2 | |
| **VIORELE (28)** | T2 | |
| **VIVELLE-DOT** | T4 | |
| **VYFEMLA (28)** | T4 | |
| **VYLIBRA** | T4 | |
| **WYMZYA FE** | T4 | |
| **XACIATO** | T4 | |
| **XARAH FE** | T2 | |
| **XELRIA FE** | T2 | |
| **XULANE** | T4 | |
| **YASMIN (28)** | T4 | |
| **YAZ (28)** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **YUVAFEM** | T4 | |
| **ZAFEMY** | T4 | |
| **ZOVIA 1-35 (28)** | T2 | |
| **Ophthalmology** | | |
| *acetazolamide* | T3 | |
| **ACULAR** | T4 | |
| **ACULAR LS** | T4 | |
| **ACUVAIL (PF)** | T4 | |
| **ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %** | T3 | |
| **ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.15 %** | T4 | |
| **ALREX** | T3 | |
| *apraclonidine* | T3 | |
| *atropine ophthalmic (eye) drops 1 %* | T2 | |
| **AZASITE** | T3 | |
| *azelastine ophthalmic (eye)* | T2 | |
| **AZOPT** | T4 | |
| *bacitracin-polymyxin b* | T2 | |
| *bepotastine besilate* | T4 | PA |
| **BEPREVE** | T4 | PA |
| *besifloxacin* | T4 | |
| **BESIVANCE** | T3 | |
| *betaxolol ophthalmic (eye)* | T3 | |
| **BETIMOL OPHTHALMIC (EYE) DROPS 0.5 %** | T4 | |
| *bimatoprost ophthalmic (eye) drops 0.01 %* | T4 | QL (5 ML per 31 days) |
| *bimatoprost ophthalmic (eye) drops 0.03 %* | T4 | |
| *brimonidine ophthalmic (eye) drops 0.1 %* | T3 | |
| *brimonidine ophthalmic (eye) drops 0.15 %, 0.2 %* | T2 | |
| *brimonidine-timolol* | T3 | |
| *brinzolamide* | T4 | |
| *bromfenac* | T3 | |
| **BROMSITE** | T4 | |
| *carteolol* | T2 | |
| **CEQUA** | T4 | ST; QL (60 EA per 30 days) |

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

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

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **LOTEMAX** | T4 | |
| **LOTEMAX SM** | T4 | |
| *loteprednol etabonate ophthalmic (eye) drops,gel* | T4 | |
| *loteprednol etabonate ophthalmic (eye) drops,suspension 0.2 %* | T3 | |
| *loteprednol etabonate ophthalmic (eye) drops,suspension 0.5 %* | T4 | |
| **LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %** | T3 | QL (5 ML per 31 days) |
| **MAXIDEX** | T4 | |
| **MAXITROL** | T4 | |
| *methazolamide* | T4 | |
| **MIEBO (PF)** | T4 | ST; QL (3 ML per 30 days) |
| *moxifloxacin ophthalmic (eye) drops* | T3 | |
| **NATACYN** | T4 | |
| *neomycin-bacitracin-poly-hc* | T2 | |
| *neomycin-bacitracin-polymyxin* | T2 | |
| *neomycin-polymyxin b-dexameth* | T2 | |
| *neomycin-polymyxin-gramicidin* | T2 | |
| *neomycin-polymyxin-hc ophthalmic (eye)* | T3 | |
| **NEVANAC** | T4 | |
| **OCUFLOX** | T4 | |
| *ofloxacin ophthalmic (eye)* | T2 | |
| **OXERVATE** | T5 | PA; QL (112 ML per 56 days) |
| **PHOSPHOLINE IODIDE** | T5 | PA; QL (5 ML per 25 days) |
| *pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %* | T2 | |
| *pilocarpine hcl ophthalmic (eye) drops 1.25 %* | T4 | PA; QL (5 ML per 25 days) |
| *polymyxin b sulf-trimethoprim* | T2 | |
| **PRED FORTE** | T4 | |
| **PRED MILD** | T4 | |
| *prednisolone acetate* | T2 | |
| *prednisolone sodium phosphate ophthalmic (eye)* | T2 | |
| **PROLENSA** | T3 | |
| **RESTASIS** | T3 | QL (60 EA per 30 days) |
| **RESTASIS MULTIDOSE** | T3 | QL (5.5 ML per 27 days) |
| **RHOPRESSA** | T3 | ST |
| **ROCKLATAN** | T3 | ST |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **SIMBRINZA** | T4 | |
| *sulfacetamide sodium ophthalmic (eye) drops* | T2 | |
| *sulfacetamide-prednisolone* | T2 | |
| *tafluprost (pf)* | T4 | |
| *timolol* | T4 | |
| *timolol maleate (pf)* | T4 | |
| *timolol maleate ophthalmic (eye) drops* | T1 | |
| *timolol maleate ophthalmic (eye) drops, once daily* | T3 | |
| *timolol maleate ophthalmic (eye) gel forming solution* | T3 | |
| **TIMOPTIC OCUDOSE (PF)** | T4 | |
| **TOBRADEX** | T3 | |
| **TOBRADEX ST** | T3 | |
| *tobramycin ophthalmic (eye)* | T2 | |
| *tobramycin-dexamethasone* | T3 | |
| *tobramycin-lotepred* | T4 | |
| **TOBREX OPHTHALMIC (EYE) OINTMENT** | T4 | |
| **TRAVATAN Z** | T4 | |
| *travoprost* | T3 | |
| *trifluridine* | T3 | |
| **TRYPTYR** | T4 | ST; QL (60 EA per 30 days) |
| **TYRVAYA** | T4 | ST; QL (8.4 ML per 30 days) |
| **VERKAZIA** | T5 | PA; QL (120 EA per 30 days) |
| **VEVYE** | T4 | ST; QL (2 ML per 30 days) |
| **VIGAMOX** | T4 | |
| **VYZULTA** | T4 | ST; QL (5 ML per 31 days) |
| **XALATAN** | T4 | |
| **XDEMVY** | T5 | PA; QL (10 ML per 42 days) |
| **XIIDRA** | T3 | QL (60 EA per 30 days) |
| **ZERVIATE** | T4 | PA |
| **ZIOPTAN (PF)** | T4 | ST |
| **ZIRGAN** | T4 | ST |
| **ZOLYMBUS** | T4 | ST; QL (30 EA per 30 days) |
| **ZYLET** | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **Respiratory And Allergy** | | |
| *acetylcysteine* | T3 | PA-BvD |
| **ADCIRCA** | T5 | PA; QL (62 EA per 31 days) |
| **ADEMPAS** | T5 | PA; QL (93 EA per 31 days) |
| **ADVAIR DISKUS** | T4 | ST; QL (60 EA per 30 days) |
| **ADVAIR HFA** | T3 | QL (12 GM per 30 days) |
| **AIRSUPRA** | T4 | PA; QL (32.1 GM per 30 days) |
| *albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation* | T2 | QL (17 GM per 30 days) |
| *albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)* | T2 | QL (13.4 GM per 30 days) |
| *albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)* | T4 | ST; QL (36 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 %), 2.5 mg/0.5 ml* | T2 | PA-BvD |
| *albuterol sulfate oral syrup* | T2 | |
| *albuterol sulfate oral tablet* | T4 | |
| **ALVESCO** | T4 | QL (12.2 GM per 30 days) |
| **ALYFTREK ORAL TABLET 10-50-125 MG** | T5 | PA; QL (56 EA per 28 days) |
| **ALYFTREK ORAL TABLET 4-20-50 MG** | T5 | PA; QL (84 EA per 28 days) |
| **ALYQ** | T5 | PA; QL (62 EA per 31 days) |
| *ambrisentan* | T5 | PA; QL (31 EA per 31 days) |
| **ANDEMBRY AUTOINJECTOR** | T5 | PA; QL (1.2 ML per 28 days) |
| **ANORO ELLIPTA** | T4 | QL (60 EA per 30 days) |
| *arformoterol* | T3 | PA-BvD |
| **ARNUITY ELLIPTA** | T4 | QL (30 EA per 30 days) |
| **ASMANEX HFA** | T3 | QL (13 GM per 30 days) |
| **ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)** | T3 | QL (1 EA per 30 days) |
| **ATROVENT HFA** | T3 | QL (25.8 GM per 30 days) |
| **AUVI-Q** | T4 | ST |
| *azelastine-fluticasone* | T4 | QL (23 GM per 30 days) |
| *beclomethasone dipropionate inhalation aerosol 40 mcg/actuation* | T4 | ST; QL (10.6 GM per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *beclomethasone dipropionate inhalation aerosol 80 mcg/actuation* | T4 | ST; QL (21.2 GM per 30 days) |
| **BERINERT INTRAVENOUS KIT** | T5 | PA |
| **BEVESPI AEROSPHERE** | T4 | QL (10.7 GM per 30 days) |
| *bosentan oral tablet* | T5 | PA; QL (62 EA per 31 days) |
| *bosentan oral tablet for suspension* | T5 | PA; QL (124 EA per 31 days) |
| **BREO ELLIPTA** | T3 | QL (60 EA per 30 days) |
| **BREYNA** | T3 | QL (10.3 GM per 30 days) |
| **BREZTRI AEROSPHERE** | T3 | QL (10.7 GM per 30 days) |
| **BRINSUPRI** | T5 | PA; QL (31 EA per 31 days) |
| *budesonide inhalation* | T4 | PA-BvD |
| *budesonide-formoterol* | T3 | QL (10.2 GM per 30 days) |
| *carbinoxamine maleate* | T4 | PA |
| **CARBZAH** | T4 | PA |
| *cetirizine oral solution 1 mg/ml* | T2 | QL (310 ML per 31 days) |
| **CINRYZE** | T5 | PA; QL (20 EA per 28 days) |
| **CLARINEX ORAL TABLET** | T4 | QL (31 EA per 31 days) |
| **CLARINEX-D 12 HOUR** | T4 | |
| *clemastine oral syrup* | T4 | PA |
| *clemastine oral tablet* | T2 | |
| **CLEMSZA** | T4 | |
| **COMBIVENT RESPIMAT** | T3 | QL (4 GM per 30 days) |
| **CORPHENA** | T5 | PA |
| *cromolyn inhalation* | T4 | PA-BvD |
| *cyproheptadine oral syrup* | T4 | PA |
| *cyproheptadine oral tablet* | T4 | PA |
| **DALIRESP** | T4 | QL (31 EA per 31 days) |
| **DAWNZERA** | T5 | PA; QL (0.8 ML per 28 days) |
| *desloratadine oral solution* | T5 | PA; QL (310 ML per 31 days) |
| *desloratadine oral tablet* | T4 | QL (31 EA per 31 days) |
| *desloratadine oral tablet,disintegrating* | T4 | QL (31 EA per 31 days) |
| **DUAKLIR PRESSAIR** | T4 | QL (1 EA per 30 days) |
| **DULERA** | T3 | QL (13 GM per 30 days) |
| **DYMISTA** | T4 | ST; QL (23 GM per 30 days) |
| **EKTERLY** | T5 | PA; QL (8 EA per 31 days) |
| *epinephrine injection auto-injector 0.15 mg/0.15 ml, 0.3 mg/0.3 ml* | T4 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml* | T3 | |
| **EPIPEN 2-PAK** | T4 | ST |
| **EPIPEN JR 2-PAK** | T4 | ST |
| **ESBRIET ORAL TABLET** | T5 | PA; QL (93 EA per 31 days) |
| **FASENRA PEN** | T5 | PA; QL (1 ML per 28 days) |
| **FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML** | T5 | PA; QL (0.5 ML per 56 days) |
| **FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML** | T5 | PA; QL (1 ML per 28 days) |
| **FIRAZYR** | T5 | PA; QL (18 ML per 30 days) |
| *flunisolide* | T2 | QL (50 ML per 25 days) |
| *fluticasone furoate* | T4 | QL (30 EA per 30 days) |
| *fluticasone furoate-vilanterol* | T3 | QL (60 EA per 30 days) |
| *fluticasone propionate inhalation blister with device 100 mcg/actuation, 50 mcg/actuation* | T4 | ST; QL (60 EA per 30 days) |
| *fluticasone propionate inhalation blister with device 250 mcg/actuation* | T4 | ST; QL (240 EA per 30 days) |
| *fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation* | T4 | ST; QL (12 GM per 30 days) |
| *fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation* | T4 | ST; QL (24 GM per 30 days) |
| *fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation* | T4 | ST; QL (10.6 GM per 30 days) |
| *fluticasone propionate nasal* | T2 | QL (16 GM per 30 days) |
| *fluticasone propion-salmeterol inhalation aerosol powdr breath activated* | T4 | ST; QL (1 EA per 30 days) |
| *fluticasone propion-salmeterol inhalation blister with device* | T3 | QL (60 EA per 30 days) |
| *fluticasone propion-salmeterol inhalation hfa aerosol inhaler* | T4 | QL (12 GM per 30 days) |
| *formoterol fumarate* | T4 | PA-BvD |
| **HAEGARDA** | T5 | PA |
| *hydroxyzine hcl oral solution 10 mg/5 ml* | T4 | PA |
| *hydroxyzine hcl oral tablet* | T2 | PA |
| *hydroxyzine pamoate* | T4 | PA |
| *icatibant* | T5 | PA; QL (18 ML per 30 days) |
| **INCRUSE ELLIPTA** | T4 | ST; QL (30 EA per 30 days) |
| *ipratropium bromide inhalation hfa aerosol inhaler* | T4 | QL (25.8 GM per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *ipratropium bromide inhalation solution* | T2 | PA-BvD |
| *ipratropium-albuterol* | T2 | PA-BvD |
| **JASCAYD** | T5 | PA; QL (62 EA per 31 days) |
| **KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 5.8 MG, 50 MG, 75 MG** | T5 | PA; QL (56 EA per 28 days) |
| **KALYDECO ORAL GRANULES IN PACKET 25 MG** | T5 | PA; QL (62 EA per 31 days) |
| **KALYDECO ORAL TABLET** | T5 | PA; QL (62 EA per 31 days) |
| **KARBINAL ER** | T4 | PA |
| **LETAIRIS** | T5 | PA; QL (31 EA per 31 days) |
| *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml* | T2 | PA-BvD |
| *levalbuterol hcl inhalation solution for nebulization 1.25 mg/0.5 ml* | T4 | PA-BvD |
| *levalbuterol hcl inhalation solution for nebulization 1.25 mg/3 ml* | T3 | PA-BvD |
| *levalbuterol tartrate* | T4 | QL (30 GM per 30 days) |
| *levocetirizine oral solution* | T4 | QL (310 ML per 31 days) |
| *levocetirizine oral tablet* | T2 | QL (31 EA per 31 days) |
| *macitentan* | T4 | PA; QL (31 EA per 31 days) |
| *mometasone nasal* | T2 | QL (34 GM per 30 days) |
| *montelukast* | T2 | QL (31 EA per 31 days) |
| **NEFFY** | T4 | ST |
| *nintedanib* | T5 | PA; QL (62 EA per 31 days) |
| **NUCALA SUBCUTANEOUS AUTO-INJECTOR** | T5 | PA; QL (3 ML per 28 days) |
| **NUCALA SUBCUTANEOUS RECON SOLN** | T5 | PA; QL (3 EA per 28 days) |
| **NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML** | T5 | PA; QL (3 ML per 28 days) |
| **NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML** | T5 | PA; QL (0.4 ML per 28 days) |
| **OFEV** | T5 | PA; QL (62 EA per 31 days) |
| **OHTUVAYRE** | T5 | PA; QL (150 ML per 30 days) |
| **OMNARIS** | T4 | QL (12.5 GM per 30 days) |
| **OPSUMIT** | T5 | PA; QL (31 EA per 31 days) |
| **OPSYNVI** | T5 | PA; QL (31 EA per 31 days) |
| **ORKAMBI ORAL GRANULES IN PACKET** | T5 | PA; QL (62 EA per 31 days) |
| **ORKAMBI ORAL TABLET** | T5 | PA; QL (124 EA per 31 days) |
| **ORLADEYO ORAL CAPSULE** | T5 | PA; QL (31 EA per 31 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **PERFOROMIST** | T4 | PA-BvD |
| *pirfenidone oral capsule* | T5 | PA; QL (279 EA per 31 days) |
| *pirfenidone oral tablet* | T5 | PA; QL (93 EA per 31 days) |
| **PROAIR RESPICLICK** | T4 | ST; QL (2 EA per 30 days) |
| *promethazine oral* | T4 | PA |
| *promethazine rectal* | T4 | |
| **PROMETHEGAN RECTAL SUPPOSITORY 25 MG, 50 MG** | T4 | |
| **PULMICORT** | T4 | PA-BvD |
| **PULMICORT FLEXHALER** | T4 | QL (1 EA per 30 days) |
| **PULMOZYME** | T5 | PA |
| **QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION** | T4 | QL (6.8 GM per 30 days) |
| **QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION** | T4 | QL (10.6 GM per 30 days) |
| **QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION** | T3 | QL (10.6 GM per 30 days) |
| **QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION** | T3 | QL (21.2 GM per 30 days) |
| **REVATIO ORAL TABLET** | T5 | PA; QL (372 EA per 31 days) |
| *roflumilast* | T4 | QL (31 EA per 31 days) |
| **RUCONEST** | T5 | PA |
| **RYALTRIS** | T4 | ST; QL (31 GM per 30 days) |
| **RYCLORA** | T4 | |
| **RYVENT** | T4 | PA |
| **SAJAZIR** | T5 | PA; QL (18 ML per 30 days) |
| **SEREVENT DISKUS** | T3 | QL (60 EA per 30 days) |
| *sildenafil (pulm.hypertension) oral suspension for reconstitution* | T5 | PA; QL (784 ML per 31 days) |
| *sildenafil (pulm.hypertension) oral tablet* | T3 | PA; QL (372 EA per 31 days) |
| **SINGULAIR ORAL TABLET** | T4 | QL (31 EA per 31 days) |
| **SINGULAIR ORAL TABLET,CHEWABLE** | T4 | QL (31 EA per 31 days) |
| **SPIRIVA RESPIMAT** | T3 | QL (4 GM per 30 days) |
| **SPIRIVA WITH HANDIHALER** | T4 | ST; QL (30 EA per 30 days) |
| **STIOLTO RESPIMAT** | T3 | QL (4 GM per 30 days) |
| **STRIVERDI RESPIMAT** | T3 | QL (4 GM per 30 days) |
| **SYMBICORT** | T4 | ST; QL (10.2 GM per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **SYMDEKO** | T5 | PA; QL (56 EA per 28 days) |
| *tadalafil (pulm. hypertension)* | T5 | PA; QL (62 EA per 31 days) |
| **TADLIQ** | T5 | PA; QL (310 ML per 31 days) |
| **TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML** | T5 | PA; QL (2 ML per 28 days) |
| **TAKHZYRO SUBCUTANEOUS SYRINGE 300 MG/2 ML (150 MG/ML)** | T5 | PA; QL (4 ML per 28 days) |
| *terbutaline oral* | T4 | |
| **TEZSPIRE SUBCUTANEOUS PEN INJECTOR** | T5 | PA; QL (1.91 ML per 28 days) |
| **THEO-24** | T3 | |
| *theophylline oral solution* | T2 | |
| *theophylline oral tablet extended release 12 hr* | T2 | |
| *theophylline oral tablet extended release 24 hr* | T2 | |
| *tiotropium bromide* | T4 | ST; QL (30 EA per 30 days) |
| **TRACLEER ORAL TABLET** | T5 | PA; QL (62 EA per 31 days) |
| **TRACLEER ORAL TABLET FOR SUSPENSION** | T5 | PA; QL (124 EA per 31 days) |
| **TRELEGY ELLIPTA** | T3 | QL (60 EA per 30 days) |
| **TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL** | T5 | PA; QL (56 EA per 28 days) |
| **TRIKAFTA ORAL TABLETS, SEQUENTIAL** | T5 | PA; QL (84 EA per 28 days) |
| **TUDORZA PRESSAIR** | T4 | ST; QL (1 EA per 30 days) |
| **TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 32 MCG, 32-64 MCG, 48 MCG, 48-64 MCG, 48-80 MCG, 64 MCG, 80 MCG** | T5 | PA |
| **TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16(112)-32(112) -48(28) MCG** | T5 | PA; QL (504 EA per 365 days) |
| *umeclidinium* | T4 | ST; QL (30 EA per 30 days) |
| *umeclidinium-vilanterol* | T4 | ST; QL (60 EA per 30 days) |
| **VENTOLIN HFA** | T3 | QL (36 GM per 30 days) |
| **WINREVAIR** | T5 | PA |
| **WIXELA INHUB** | T3 | QL (60 EA per 30 days) |
| **XHANCE** | T4 | PA; QL (32 ML per 30 days) |
| **XOLAIR** | T5 | PA |
| **XOPENEX HFA** | T4 | ST; QL (30 GM per 30 days) |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **YUPELRI** | T5 | PA-BvD |
| **YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 106 MCG** | T5 | PA; QL (224 EA per 28 days) |
| **YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 26.5 MCG, 53 MCG** | T5 | PA; QL (140 EA per 28 days) |
| **YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 79.5 MCG** | T5 | PA; QL (112 EA per 28 days) |
| *zafirlukast oral tablet 10 mg* | T2 | QL (93 EA per 31 days) |
| *zafirlukast oral tablet 20 mg* | T2 | QL (62 EA per 31 days) |
| *zileuton* | T5 | PA; QL (124 EA per 31 days) |
| **Urologicals** | | |
| *alfuzosin* | T2 | QL (31 EA per 31 days) |
| **AVODART** | T4 | QL (31 EA per 31 days) |
| *bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg* | T2 | |
| *bethanechol chloride oral tablet 50 mg* | T3 | |
| **CIALIS ORAL TABLET 5 MG** | T4 | PA; QL (31 EA per 31 days) |
| **CYSTAGON** | T4 | |
| *darifenacin* | T4 | QL (31 EA per 31 days) |
| *dutasteride* | T2 | QL (31 EA per 31 days) |
| *dutasteride-tamsulosin* | T4 | QL (31 EA per 31 days) |
| **ELMIRON** | T4 | |
| *fesoterodine* | T3 | QL (31 EA per 31 days) |
| *finasteride oral tablet 5 mg* | T2 | |
| *flavoxate* | T2 | |
| **GEMTESA** | T4 | QL (31 EA per 31 days) |
| **JALYN** | T5 | QL (31 EA per 31 days) |
| *mirabegron oral suspension,extended rel recon* | T4 | ST; QL (300 ML per 30 days) |
| *mirabegron oral tablet extended release 24 hr* | T4 | ST; QL (31 EA per 31 days) |
| **MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON** | T3 | QL (300 ML per 30 days) |
| **MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR** | T3 | QL (31 EA per 31 days) |
| *oxybutynin chloride oral syrup* | T3 | |
| *oxybutynin chloride oral tablet 2.5 mg* | T2 | |
| *oxybutynin chloride oral tablet 5 mg* | T3 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg* | T3 | QL (31 EA per 31 days) |
| *oxybutynin chloride oral tablet extended release 24hr 15 mg* | T3 | QL (62 EA per 31 days) |
| **OXYTROL** | T4 | QL (8 EA per 28 days) |
| *potassium citrate oral tablet extended release* | T2 | |
| **PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET** | T5 | PA |
| **PROSCAR** | T4 | |
| **RIVFLOZA SUBCUTANEOUS SOLUTION** | T5 | PA; QL (1 ML per 28 days) |
| **RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML** | T5 | PA; QL (0.8 ML per 28 days) |
| **RIVFLOZA SUBCUTANEOUS SYRINGE 160 MG/ML** | T5 | PA; QL (1 ML per 28 days) |
| *silodosin* | T4 | |
| *solifenacin* | T4 | QL (31 EA per 31 days) |
| *tadalafil oral tablet 2.5 mg* | T4 | PA; QL (62 EA per 31 days) |
| *tadalafil oral tablet 5 mg* | T4 | PA; QL (31 EA per 31 days) |
| *tamsulosin* | T1 | |
| *tolterodine oral capsule,extended release 24hr* | T3 | QL (31 EA per 31 days) |
| *tolterodine oral tablet* | T3 | QL (62 EA per 31 days) |
| **TOVIAZ** | T4 | QL (31 EA per 31 days) |
| *trospium oral capsule,extended release 24hr* | T4 | QL (31 EA per 31 days) |
| *trospium oral tablet* | T2 | QL (93 EA per 31 days) |
| **UROCIT-K 10** | T4 | |
| **UROCIT-K 15** | T4 | |
| **UROXATRAL** | T4 | QL (31 EA per 31 days) |
| **Vitamins, Hematinics / Electrolytes** | | |
| **AQNEURSA** | T5 | PA; QL (124 EA per 31 days) |
| *calcium acetate(phosphat bind)* | T2 | PA-BvD |
| **CLINIMIX 5%/D15W SULFITE FREE** | T4 | PA-BvD |
| **CLINIMIX 4.25%/D10W SULF FREE** | T4 | PA-BvD |
| **CLINIMIX 5%-D20W(SULFITE-FREE)** | T4 | PA-BvD |
| **CLINIMIX E 4.25%/D10W SUL FREE** | T4 | PA-BvD |
| **CLINIMIX E 4.25%/D5W SULF FREE** | T4 | PA-BvD |
| **CLINIMIX E 5%/D15W SULFIT FREE** | T4 | PA-BvD |
| **CLINIMIX E 5%/D20W SULFIT FREE** | T4 | PA-BvD |
| **CLINISOL SF 15 %** | T4 | PA-BvD |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **CLINOLIPID** | T4 | PA-BvD |
| **DOJOLVI** | T5 | PA |
| *electrolyte-a* | T4 | PA-BvD |
| *fluoride (sodium) oral tablet* | T2 | |
| **INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %** | T4 | PA-BvD |
| **ISOLYTE S PH 7.4** | T3 | PA-BvD |
| **ISOLYTE-P IN 5 % DEXTROSE** | T4 | PA-BvD |
| **KLOR-CON** | T4 | |
| **KLOR-CON 10** | T3 | |
| **KLOR-CON 8** | T3 | |
| **KLOR-CON M10** | T2 | |
| **KLOR-CON M15** | T2 | |
| **KLOR-CON M20** | T2 | |
| *magnesium sulfate injection* | T2 | |
| **NUTRILIPID** | T4 | PA-BvD |
| **PLASMA-LYTE A** | T4 | PA-BvD |
| **PLENAMINE** | T4 | PA-BvD |
| **POKONZA** | T5 | PA |
| *potassium chlorid-d5-0.45%nacl* | T2 | |
| *potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l* | T2 | |
| *potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l* | T2 | |
| *potassium chloride in lr-d5* | T2 | |
| *potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml* | T2 | |
| *potassium chloride intravenous* | T2 | |
| *potassium chloride oral capsule, extended release* | T2 | |
| *potassium chloride oral liquid* | T4 | |
| *potassium chloride oral packet 20 meq* | T4 | |
| *potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq* | T2 | |
| *potassium chloride oral tablet extended release 15 meq* | T4 | |
| *potassium chloride oral tablet,er particles/crystals* | T2 | |
| *potassium chloride-0.45 % nacl* | T2 | |

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

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *potassium chloride-d5-0.2%nacl* | T2 | |
| *potassium chloride-d5-0.9%nacl* | T2 | |
| **PREMASOL 10 %** | T4 | PA-BvD |
| **PRENATAL VITAMIN PLUS LOW IRON** | T2 | PA |
| **PROSOL 20 %** | T4 | PA-BvD |
| *sodium chloride 0.45 % intravenous* | T2 | |
| *sodium chloride 3 % hypertonic* | T2 | |
| *sodium chloride 5 % hypertonic* | T2 | |
| **TPN ELECTROLYTES** | T4 | |
| **TRAVASOL 10 %** | T4 | PA-BvD |
| **TROPHAMINE 10 %** | T4 | PA-BvD |

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

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# Section:
# Prior Authorization

# Acitretin

## Products Affected

- *acitretin*

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

# Acthar H.P.

## Products Affected

- **ACTHAR**

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

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

# Acthar SelfJect

## Products Affected

- **ACTHAR SELFJECT**

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

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

# Actimmune

## Products Affected

- **ACTIMMUNE**

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

# Adalimumab

## Products Affected

- **ABRILADA(CF)**
- **ABRILADA(CF) PEN**
- *adalimumab-aacf subcutaneous pen injector kit*
- *adalimumab-aacf subcutaneous syringe kit*
- **ADALIMUMAB-AACF(CF) PEN CROHNS**
- **ADALIMUMAB-AACF(CF) PEN PS-UV**
- *adalimumab-aaty*
- **ADALIMUMAB-AATY(CF) AI CROHNS**
- *adalimumab-adaz subcutaneous pen injector 40 mg/0.4 ml, 80 mg/0.8 ml*
- *adalimumab-adaz subcutaneous syringe 10 mg/0.1 ml, 20 mg/0.2 ml, 40 mg/0.4 ml*
- *adalimumab-adbm*
- *adalimumab-bwwd*
- *adalimumab-fkjp subcutaneous pen injector kit*
- *adalimumab-fkjp subcutaneous syringe kit*
- *adalimumab-ryvk*
- **AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML, 40 MG/0.8 ML, 80 MG/0.8 ML**
- **AMJEVITA(CF) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML, 20 MG/0.2 ML, 40 MG/0.4 ML, 40 MG/0.8 ML**
- **CYLTEZO(CF)**
- **CYLTEZO(CF) PEN**
- **HUMIRA PEN**
- **HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML**
- **HUMIRA(CF)**
- **HUMIRA(CF) PEN**
- **HUMIRA(CF) PEN CROHNS-UC-HS**
- **HUMIRA(CF) PEN PSOR-UV-ADOL HS**
- **HYRIMOZ PEN CROHN'S-UC STARTER**
- **HYRIMOZ PEN PSORIASIS STARTER**
- **HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML, 80 MG/0.8 ML**
- **HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML**
- **YUSIMRY(CF) PEN**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |

| PA Criteria | Criteria Details |
|---|---|
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For uveitis, inadequate response or intolerance to 1 immunosuppressant or corticosteroid, or all are contraindicated. |
| **Age Restrictions** | Deny if less than 18 years of age for Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, and Ankylosing Spondylitis or less than 12 years of age for Hidradenitis Suppurative or Less than 6 years of age for Crohn's disease or Less than 5 years of age for Ulcerative Colitis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Uveitis |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For adalimumab products except Hadlima, Simlandi, and Yuflyma, intolerance to 2 of the following preferred adalimumab products is required: Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis therapy without concomitant methotrexate, doses above plan quantity limit will be approved aligned with recommended weekly dosing regimen. For pediatric ulcerative colitis and hidradenitis suppurativa, doses above plan quantity limit will be approved to align with recommended dosing regimen. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Adbry

## Products Affected

- **ADBRY**

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

# ADHD Drugs

## Products Affected

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

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

# Afinitor

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | For everolimus only, documentation of advanced, hormone receptor-positive, HER2-negative breast cancer -AND- all of the following (1-3): 1) member is a postmenopausal woman 2) using in combination with exemestane 3) therapeutic failure or intolerance to prior treatment with letrozole or anastrozole. For everolimus only, documentation of non-functional neuroendocrine tumors -AND- all of the following (1-2): 1) disease is classified as progressive, well-differentiated, non-functional 2) disease is of gastrointestinal or lung origin that are unresectable, locally advanced or metastatic. For everolimus only, documentation of advanced renal cell carcinoma -AND- therapeutic failure or intolerance to prior treatment with sunitinib or sorafenib. For everolimus only, documentation of renal angiomyolipoma and tuberous sclerosis complex (TSC), member does not require immediate surgery. For everolimus and everolimus tablets for oral suspension, documentation of TSC with Subependymal Giant Cell Astrocytoma -AND- member is not a candidate for curative surgical resection. For everolimus only, documentation of progressive neuroendocrine tumors of pancreatic origin -AND- disease is unresectable, locally advanced or metastatic. For everolimus tablets for oral suspension only, documentation of use for adjunctive treatment of TSC-associated partial-onset seizures. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For brand Afinitor, intolerance to generic everolimus tablets is required. For brand Afinitor Disperz, all of the following are required (1 and 2): 1) intolerance to generic everolimus tablets or unable to swallow generic everolimus tablets, 2) intolerance to generic everolimus tablets for suspension. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Agamree

## Products Affected

- **AGAMREE**

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

# Aimovig

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, the following criteria will apply (1-2): 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of reduction in migraine frequency |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Airsupra

## Products Affected

- **AIRSUPRA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- all of the following: 1) therapeutic failure or intolerance to inhaled corticosteroid/formoterol combination product, 2) therapeutic failure or intolerance to inhaled corticosteroid used in combination with albuterol. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Ajovy

## Products Affected

- **AJOVY AUTOINJECTOR**
- **AJOVY SYRINGE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, the following criteria will apply (1-2). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of reduction in migraine frequency. If 18 years of age or older, therapeutic failure, intolerance, or contraindication to 2 of the following products: Aimovig, Emgality, and Qulipta |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Akeega

## Products Affected

- **AKEEGA**

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

# Alecensa

## Products Affected

- **ALECENSA**

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

# Alkindi

## Products Affected

- **ALKINDI SPRINKLE**

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

# Alpha1-Proteinase Inhibitors

## Products Affected

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

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

# Alunbrig

## Products Affected

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

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

# Alyftrek

## Products Affected

- **ALYFTREK ORAL TABLET 10-50-125 MG, 4-20-50 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of cystic fibrosis (CF) in patients who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to vanzacaftor/tezacaftor/deutivacaftor based on clinical and/or in vitro assay. An FDA-cleared CF genetic test will be used if genotype is unknown. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, documentation supporting improvement or stabilization of FEV1 compared to baseline FEV1 -or- increase in body mass index -or- decreased pulmonary exacerbations -or- improved quality of life as demonstrated by CF Questionnaire is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Amitiza

## Products Affected

- **AMITIZA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For chronic idiopathic constipation, therapeutic failure, contraindication or intolerance to Linzess and intolerance to lubiprostone. For irritable bowel syndrome with constipation in females, therapeutic failure, contraindication or intolerance to Linzess and intolerance to lubiprostone. For opioid-induced constipation, intolerance to lubiprostone. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Amlodipine Liquid

## Products Affected

- **KATERZIA**
- **NORLIQVA**
- **SDAMLO ORAL POWDER IN CONTAINER 5 MG**

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

# Ampyra

## Products Affected

- **AMPYRA**
- *dalfampridine*

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

# Anabolic Steroids

## Products Affected

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

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

# Ancobon

## Products Affected

- **ANCOBON**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of serious infection caused by susceptible strains of Candida or Cryptococcus. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months |
| **Other Criteria** | Intolerance to generic flucytosine is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Andembry

## Products Affected

- **ANDEMBRY AUTOINJECTOR**

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For initial and induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended initial and induction therapy dosing regimens per indication. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Anticholinergic Meds

## Products Affected

- *paroxetine hcl*
- **PAXIL CR**
- **PAXIL ORAL TABLET**

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

# Anzupgo

## Products Affected

- **ANZUPGO**

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

# Apokyn

## Products Affected

- **APOKYN**
- *apomorphine*

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

# Aqneursa

## Products Affected

- **AQNEURSA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Concurrent use of Aqneursa (levacetylleucine) -AND- Miplyffa (arimoclomal) |
| **Required Medical Information** | Documentation of diagnosis -AND- neurological symptoms of Niemann-Pick Disease Type C (e.g., ataxia, dysarthria, dysphagia, cognitive impairment, seizures) -AND- weight at least 15 kg |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of positive clinical response |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Aqvesme

## Products Affected

- **AQVESME**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of anemia with alpha- or beta-thalassemia, as supported by 1) DNA-analysis, or 2) hemoglobin-analysis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 24 weeks initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, improvement in laboratory results (e.g. increase in hemoglobin) -OR- improvement in clinical status (e.g. decrease in transfusion burden) -OR- there is another explanation for response failure (e.g. bleeding, surgery, other concomitant illnesses) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Arikayce

## Products Affected

- **ARIKAYCE**

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

# Atoncy

## Products Affected

- *atomoxetine oral solution*
- **ATONCY**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of ADHD -AND- trial/failure, intolerance or contraindication to a stimulant |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Intolerance to generic atomoxetine capsules OR Inability to swallow tablets or capsules is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# ATTR-CM drugs

## Products Affected

- **ATTRUBY**
- **VYNDAMAX**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Concomitantly with transthyretin-lowering agents |
| **Required Medical Information** | Documentation of cardiomyopathy of transthyretin-mediated amyloidosis (ATTR-CM) with amyloid deposits on cardiac biopsy or scintigraphy with heart contralateral greater than 1.5 (Grade III) or visual grade 2 to 3 - AND- Cardiac involvement supported by cardiac magnetic resonance, echocardiography or serum cardiac biomarker (e.g. B-type natriuretic peptide, cardiac troponin) -AND- For Attruby (acoramidis), ATTR-CM type is wild-type or variant -AND- For Vyndamax (tafamidis), ATTR-CM type is wild-type or hereditary. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For reauthorization, attestation of improvement or delayed disease progression from baseline demonstrated by 6-minute walk test, cardiac function (e.g. LVEF, NYHA class), Kansas City Cardiomyopathy Questionnaire-Overall Summary, number of cardiovascular-related hospitalizations or serum cardiac biomarkers (e.g. B-type natriuretic peptide, cardiac troponin) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | No |

# Atypical Antipsychotics

## Products Affected

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

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

# Aubagio

## Products Affected

- **AUBAGIO**
- *teriflunomide*

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

# Augtyro

## Products Affected

- **AUGTYRO ORAL CAPSULE 160 MG, 40 MG**

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

# Austedo

## Products Affected

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

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

# Auvelity

## Products Affected

- **AUVELITY ORAL TABLET, IR AND ER, BIPHASIC**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of major depressive disorder (MDD) -AND- Therapeutic failure or intolerance to generic bupropion hydrochloride tablets -AND- Therapeutic failure, intolerance or contraindication to one other generic antidepressant (e.g. SNRI, SSRI). Documentation of Alzheimer's disease (AD) -AND- Experiencing agitation associated with dementia due to AD. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Avmapki-Fakzynja

## Products Affected

- **AVMAPKI-FAKZYNJA**

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

# Ayvakit

## Products Affected

- **AYVAKIT**

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

# Baclofen Solution

## Products Affected

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

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

# Bafiertam

## Products Affected

- **BAFIERTAM**

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

# Balversa

## Products Affected

- **BALVERSA**

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

# Banzel

## Products Affected

- **BANZEL**
- *rufinamide*

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

# Baxfendy

## Products Affected

- **BAXFENDY**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Hypertension -AND- One of the following (1-2): 1) Inadequate blood pressure control despite concurrent use of maximally tolerated doses of at least two antihypertensive medications with different mechanisms of action, 2) Intolerance or contraindication to all first-line antihypertensive medication classes (i.e., ACEi/ARB, CCB, and thiazide diuretic). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of a reduction in blood pressure from baseline is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Benlysta

## Products Affected

- **BENLYSTA SUBCUTANEOUS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | For diagnosis of active systemic lupus erythematosus (SLE), both of the following (1-2): 1) Documentation of positive anti-nuclear antibody (ANA) titer (greater than or equal to 1:80) or anti-double-stranded DNA antibody (anti-dsDNA) greater than or equal to 30IU/mL, 2) member will continue to receive concomitant standard of care treatment with use of at least one of the following (alone or in combination) (a-c): a) corticosteroids (e.g. prednisone), b) antimalarials (e.g. hydroxychloroquine), c) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate). For diagnosis of active lupus nephritis (LN), one of the following (3 or 4): 3) Diagnosis confirmed by renal biopsy, 4) Contraindication to renal biopsy, laboratory findings specific to LN (e.g., elevated serum creatinine, abnormal urine analysis, decreased eGFR). -AND- Member will continue to receive concomitant standard of care treatment which includes corticosteroids (e.g. prednisone) with at least one of the following (d or e): d) mycophenolate for induction followed by mycophenolate for maintenance, e) cyclophosphamide for induction followed by azathioprine for maintenance. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For SLE reauthorization, attestation of disease stability or improvement -AND- attestation the member will continue to receive standard of care therapy with corticosteroids, antimalarials, or immunosuppressives. For active LN reauthorization, attestation of disease stability or improvement -AND- attestation the member will continue to receive standard of care therapy with mycophenolate or azathioprine. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Berinert

## Products Affected

- **BERINERT INTRAVENOUS KIT**

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For 18 years of age or older, therapeutic failure, intolerance or contraindication to icatibant. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Besremi

## Products Affected

- **BESREMI**
- **BESREMI PEN**

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

# Bimzelx

## Products Affected

- **BIMZELX AUTOINJECTOR 160 MG/ML, 320 MG/2 ML**
  **SUBCUTANEOUS AUTO-INJECTOR**
  **160 MG/ML, 320 MG/2 ML**
- **BIMZELX SUBCUTANEOUS SYRINGE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- documentation of member weight and prescribed dose. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 nonsteroidal anti-inflammatory drugs (NSAIDs) or all are contraindicated. For ankylosing spondylitis, inadequate response or intolerance to 1 NSAID or all are contraindicated. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | Must follow recommended dosing guidelines based upon weight. Induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For plaque psoriasis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, and Skyrizi SC. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For non-radiographic axial spondyloarthritis patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cimzia, Rinvoq, Cosentyx. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For hidradenitis suppurativa, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Bonjesta

## Products Affected

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

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

# Bosulif

## Products Affected

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

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

# Bosutinib

## Products Affected

- *bosutinib oral tablet 400 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For members 18 years of age and older, one of the following (1, 2): 1) newly diagnosed Philadelphia chromosome (PH) -positive CML in the chronic phase 2) diagnosis of Ph-positive CML in the chronic, accelerated, or blast phase and no longer responding to or intolerant to at least 1 prior therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Braftovi

## Products Affected

- **BRAFTOVI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Use in wild-type BRAF melanoma, wild-type BRAF CRC, or wild-type BRAF NSCLC. |
| **Required Medical Information** | Documentation of diagnosis. For metastatic colorectal cancer (mCRC) and using in combination with cetuximab, all of the following (1-3): 1) BRAF V600E mutation status as detected by an FDA-authorized test 2) using in combination with cetuximab 3) member has received prior therapy for CRC. For mCRC and using in combination with cetuximab and fluorouracil-based chemotherapy, all of the following (4-5): 4) BRAF V600E mutation status, as detected by an FDA-authorized test 5) using in combination with cetuximab and fluorouracil-based chemotherapy. For unresectable or metastatic melanoma, all of the following (6-7): 6) BRAF V600E or V600K mutation status, as detected by an FDA-authorized test 7) using in combination with binimetinib. For metastatic non-small cell lung cancer, all of the following (8-9): 8) BRAF V600E mutation status, as detected by an FDA-authorized test 9) using in combination with binimetinib. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
|---|---|
| **Prerequisite Therapy Required** | Yes |

# Brekiya

## Products Affected

- **BREKIYA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of cluster headache episodes, or migraine headaches with or without aura. All of the following (1-3): 1) non-oral route of administration is required, 2) therapeutic failure, intolerance, or contraindication to generic sumatriptan injection, 3) intolerance or contraindication to generic dihydroergotamine mesylate injection. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Brinsupri

## Products Affected

- **BRINSUPRI**

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

# Brukinsa

## Products Affected

- **BRUKINSA ORAL TABLET**

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

# Bucapsol

## Products Affected

- **BUCAPSOL ORAL CAPSULE 10 MG, 15 MG, 7.5 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of generalized anxiety disorder (GAD) and unable to swallow tablets. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Buphenyl

## Products Affected

- *sodium phenylbutyrate*

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

# Buspirone

## Products Affected

- *buspirone oral tablet 12.5 mg, 2.5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of generalized anxiety disorder -AND- unable to split generic buspirone tablets to obtain the required dose. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Bylvay

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of pruritis with progressive familial intrahepatic cholestasis or cholestatic pruritus with Alagille syndrome -AND- The member does not have history of hepatic decompensation. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of improvement in pruritis -AND- attestation that the member has not progressed to hepatic decompensation. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Cablivi

## Products Affected

- **CABLIVI INJECTION KIT**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of acquired thrombocytopenic purpura (aTTP) -AND- Used in conjunction with plasma exchange and immunosuppressive therapy (i.e. systemic corticosteroids or rituximab) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 75 days initial authorization, 60 days reauthorization |
| **Other Criteria** | For reauthorization, the request is for a new episode requiring the re-initiation of plasma exchange for the treatment of acquired thrombotic thrombocytopenic purpura (aTTP) -AND- no more than 2 recurrences of aTTP have occurred following initial course of therapy. Total treatment duration will be limited to 58 days beyond the last therapeutic plasma exchange. No more than three courses of Cablivi will be approved per lifetime. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Cabometyx

## Products Affected

- **CABOMETYX**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- one of the following (1-6): 1) diagnosis of advanced renal cell carcinoma (RCC), 2) diagnosis of advanced RCC and using as a first-line treatment in combination with nivolumab, 3) member has previously been treated with sorafenib for hepatocellular carcinoma, 4) member has experienced disease progression following prior VEGFR-targeted therapy and is either radioactive iodine-refractory or is ineligible for radioactive iodine therapy for locally advanced or metastatic differentiated thyroid cancer, 5) diagnosis of previously treated, unresectable, locally advanced or metastatic, well-differentiated pancreatic neuroendocrine tumors (pNET), 6) diagnosis of previously treated, unresectable, locally advanced or metastatic, well-differentiated extra-pancreatic neuroendocrine tumors (epNET) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Calquence

## Products Affected

- **CALQUENCE (ACALABRUTINIB MAL)**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For mantle cell lymphoma, member has received at least one prior therapy -OR- all of the following (1-3): 1) member has not received prior therapy for MCL, 2) member is ineligible for autologous hematopoietic stem cell transplantation (HSCT), and 3) using in combination with bendamustine and rituximab. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Camzyos

## Products Affected

- **CAMZYOS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy -AND- Left ventricular ejection fraction of greater than or equal to 55% -AND- Valsalva left ventricular outflow tract peak gradient of greater than or equal to 50 mmHg at rest or after provocation -AND- Therapeutic failure or intolerance to one of the following (1 or 2) or contraindication to all: 1) Non-vasodilating beta blocker (e.g. metoprolol) 2) non-dihydropyridine calcium channel blocker (e.g. diltiazem) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, 1 of the following is required (1-4): 1) prescriber attestation of no NYHA class worsening or reduction in symptom class 2) improvement or stabilization of baseline post-exercise left ventricular outflow tract (LVOT) peak gradients 3) stabilization of baseline peak oxygen consumption, or 4) prescriber attestation of slowed disease progression. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Caplyta

## Products Affected

- **CAPLYTA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | For schizophrenia, bipolar I disorder, and bipolar II disorder, therapeutic failure, intolerance, or contraindication to one other generic atypical antipsychotic (e.g. quetiapine). For major depressive disorder, documentation of adjunctive therapy and therapeutic failure, contraindication or intolerance to one other generic antidepressant in addition to the antidepressant currently being used for the treatment of MDD (e.g. SSRI, SNRI, NDRIs, TCA, MAOI). |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Caprelsa

## Products Affected

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

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

# Carac

## Products Affected

- *fluorouracil topical cream 0.5 %*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- Intolerance to generic topical fluorouracil solution or fluorouracil 5% cream. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Carbaglu

## Products Affected

- **CARBAGLU**
- *carglumic acid*

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

# Carbinoxamine

## Products Affected

- *carbinoxamine maleate*
- **CARBZAH**
- **KARBINAL ER**
- **RYVENT**

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

# Cardamyst

## Products Affected

- **CARDAMYST**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of paroxysmal supraventricular tachycardia (PSVT) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Cayston

## Products Affected

- **CAYSTON**

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

# Cerdelga

## Products Affected

- **CERDELGA**

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

# CF drugs

## Products Affected

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

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

# Cholbam

## Products Affected

- **CHOLBAM**

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

# Cialis

## Products Affected

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

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

# Cibinqo

## Products Affected

- **CIBINQO**

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

# Cimzia

## Products Affected

- **CIMZIA**
- **CIMZIA POWDER FOR RECONST**
- **CIMZIA STARTER KIT**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide) or all nonbiologic DMARDs are contraindicated. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) or all are contraindicated. For non-radiographic axial spondyloarthritis, inadequate response or intolerance to two nonsteroidal anti-inflammatory drugs (NSAIDs) or all are contraindicated. For moderate to severe psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- all nonbiologic DMARDs are contraindicated -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity, or at high risk of disabling joint damage. |
| **Age Restrictions** | Deny if less than 2 years of age for polyarticular juvenile idiopathic arthritis or less than 18 years of age for all other indications. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For initial and induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended initial and induction therapy dosing regimens per indication. For Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, and Rinvoq. For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq and Xeljanz/Xeljanz XR. For plaque psoriasis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, and Skyrizi SC. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq/Rinvoq LQ, and Xeljanx/Xeljanz solution. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Cinryze

## Products Affected

- **CINRYZE**

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

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

# Citalopram Capsule

## Products Affected

- *citalopram oral capsule*

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

# Clemastine Syrup

## Products Affected

- *clemastine oral syrup*

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

# Clotic

## Products Affected

- **CLOTIC**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Pending CMS Review |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 14 days |
| **Other Criteria** | Pending CMS Review |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Cobenfy

## Products Affected

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

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

# Cometriq

## Products Affected

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

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

# Copiktra

## Products Affected

- **COPIKTRA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- member is no longer responding or is intolerant to at least 2 prior therapies for chronic lymphocytic leukemia and small lymphocytic leukemia. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Corlanor

## Products Affected

- *ivabradine oral tablet 5 mg, 7.5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- All of the following: 1) Normal sinus rhythm, 2) Resting heart rate greater than or equal to 70 beats per minute, 3) For adults, left ventricular ejection fraction less than or equal to 35 percent, 4) For adults, concurrent use of 1 beta-blocker used for treatment of heart failure (i.e. bisoprolol, carvedilol, metoprolol succinate) or therapeutic failure, intolerance, or contraindication to the maximum tolerated dose of 2 beta-blockers used for treatment of heart failure. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Corphena

## Products Affected

- **CORPHENA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- Therapeutic failure, contraindication or intolerance to 2 generic antihistamine products |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Cosentyx

## Products Affected

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

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | No |

# Cotellic

## Products Affected

- **COTELLIC**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- all of the following for unresectable or metastatic melanoma (1-2): 1) BRAF V600E or V600K mutation status 2) Concomitant therapy with vemurafenib. For cobimetinib monotherapy, documentation of histiocytic neoplasms. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Crenessity

## Products Affected

- **CRENESSITY ORAL CAPSULE 100 MG, 50 MG**
- **CRENESSITY ORAL SOLUTION**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of classic congenital adrenal hyperplasia -AND- used as adjunct to glucocorticoid replacement -AND- one of the following (1-3): 1) member has supraphysiological glucocorticoid dosing, 2) high levels of androstenedione, or 3) high levels of 17-hydroxyprogesterone. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, one of the following is required (1-2): 1) reduction in daily glucocorticoid dose, 2) improvement or stabilization in androgen levels. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Crinone

## Products Affected

- **CRINONE**

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

# Ctexli

## Products Affected

- **CTEXLI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis of cerebrotendinous xanthomatosis (CTX) confirmed by genetic testing. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months for initial approval with an additional 12 months upon renewal |
| **Other Criteria** | For reauthorization, one of the following is required (1-2): 1) improvement in lab values, 2) improvement in neurologic and psychiatric symptoms. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Cuvrior

## Products Affected

- **CUVRIOR**

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

# Cysteamine Ophthalmic Drops

## Products Affected

- **CYSTADROPS**
- **CYSTARAN**

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

# Danziten

## Products Affected

- **DANZITEN**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For Ph+ chronic myeloid leukemia (CML), member's CML is in the chronic or accelerated phase and the member is no longer responding to or is intolerant to imatinib -OR- member is newly diagnosed in the chronic phase. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Daraprim

## Products Affected

- **DARAPRIM**
- *pyrimethamine*

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

# Daurismo

## Products Affected

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

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

# Dawnzera

## Products Affected

- **DAWNZERA**

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

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

# Daybue

## Products Affected

- **DAYBUE**
- **DAYBUE STIX ORAL POWDER IN PACKET 5,000 MG, 6,000 MG, 8,000 MG**

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

# Daytrana

## Products Affected

- **DAYTRANA**
- *methylphenidate transdermal*

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

# Deferasirox

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For chronic iron overload due to blood transfusions, transfusion history of greater than or equal to 100 mL/kg of packed red blood cells (i.e. at least 20 units of packed red blood cells for a 40 kg person or more in individuals weighing more than 40 kg) -And- history of serum ferritin consistently greater than 1,000 mcg/L or liver iron concentration (LIC) greater than or equal to 7 iron per gram of liver dry weight (mg Fe/g dw). For Chronic Iron Overload in Non-Transfusion-Dependent Thalassemia (NTDT) Syndrome, LIC of at least 5 mg Fe/g dw -AND- serum ferritin greater than 300 mcg/L. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Jadenu and brand Exjade, initial authorization requires intolerance to deferasirox (generic Exjade) and reauthorization requires intolerance to generic deferasirox (generic Exjade) if not previously trialed. For reauthorization of chronic iron overload due to blood transfusion, continued requirement for regular blood transfusions -AND- serum ferritin level greater than or equal to 500mcg/L or LIC greater than or equal to 3 mg Fe/g dw. For reauthorization of chronic iron overload in NTDT syndrome, LIC greater than or equal to 3 mg Fe/g dw. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
|---|---|
| **Prerequisite Therapy Required** | Yes |

# Denosumab (Onco)

## Products Affected

- **AUKELSO**
- **BILPREVDA**
- **BOMYNTRA**
- **OSENVELT**
- **WYOST**
- **XTRENBO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For hypercalcemia of malignancy, refractory to bisphosphonates. For giant cell tumor of bone, unresectable or surgical resection is likely to result in severe morbidity -AND- one of the following (1. or 2.)- 1.) the member is 18 years old or older -OR- 2.) the member is a skeletally mature adolescent (e.g. has at least one mature long bone) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For non-preferred denosumab products, intolerance to 1 of the following preferred products is required: Xgeva, Xtrenbo, or Wyost. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Denosumab (Osteo)

## Products Affected

- **BILDYOS**
- **BOSAYA**
- **CONEXXENCE**
- **ENOBY**
- **JUBBONTI**
- **OSPOMYV**
- **STOBOCLO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -And- For osteoporosis at high risk for fracture, meeting one of the following (1. thru 4.) 1) History of previous fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 (i.e. osteopenia) -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 40 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For osteoporosis and osteopenia, documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated -OR- very high risk for a fracture, defined by one of the following: fracture within past 12 months, fracture while on osteoporosis therapy, history of multiple fractures, fractures while on drugs causing skeletal harm, fall risk, history of injurious falls, T-score less than -3, FRAX 10 year major osteo fracture risk of greater than 30%, or FRAX 10 year hip fracture risk of greater than 4.5%. Covered under Part B for patients eligible for home health services when provider certifies that patient sustained bone fracture related to post-menopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug. For non-preferred denosumab products, intolerance to 1 of the following preferred products is required: Prolia, Jubbonti, or Enoby. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Desloratadine Solution

## Products Affected

- *desloratadine oral solution*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of seasonal allergic rhinitis, perennial allergic rhinitis, or chronic idiopathic urticaria. -AND- Intolerance to generic desloratadine tablets or desloratadine orally disintegrating tablets -AND- Therapeutic failure, contraindication, or intolerance to 1 other generic antihistamine product. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Desmoda

## Products Affected

- **DESMODA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Cr Cl less than 50ml/min, Hyponatremia |
| **Required Medical Information** | Diagnosis of Central Diabetes Insipidus -AND- Intolerance to generic desmopressin acetate tablets (crushable) -AND- Inability to swallow tablets |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, all of the following are required (1-3): 1) member has experienced a positive clinical response to therapy, 2) intolerance to generic desmopressin acetate tablets (crushable), 3) continued inability to swallow tablets. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Diacomit

## Products Affected

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

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

# Dicyclomine

## Products Affected

- *dicyclomine oral tablet 40 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of irritable bowel syndrome or functional bowel disorder -AND- Therapeutic failure to generic dicyclomine 20 mg tablet -AND- Member is unable to take a single administration of two 20 mg generic dicyclomine tablets to achieve a 40 mg dose. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Dificid

## Products Affected

- **DIFICID ORAL TABLET**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 10 days |
| **Other Criteria** | For brand Dificid, intolerance to generic fidaxomicin tablets is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Dihydroergotamine

## Products Affected

- *dihydroergotamine nasal*
- **TRUDHESA**

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

# Dojolvi

## Products Affected

- **DOJOLVI**

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

# Doptelet

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of thrombocytopenia and chronic liver disease -AND- Member has a scheduled procedure. -AND- Platelet count of less than 50x10*9/L. Diagnosis of persistent or chronic immune thrombocytopenia. -AND- One of the following (1-2): 1) Therapeutic failure, contraindication, or intolerance to corticosteroid therapy or immunoglobulin therapy, 2) Therapeutic failure after a splenectomy. -AND- One of the following (3-4): 3) Platelet count of less than or equal to 30x10*9/L, 4) Platelet count of less than 50x10*9/L and significant mucous membrane bleeding or a risk factor for bleeding (e.g. hypertension, peptic ulcer disease, vigorous lifestyle). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | For thrombocytopenia with chronic liver disease- 1 mo. For immune thrombocytopenia- 12 mo. |
| **Other Criteria** | Platelet count is provided for applicable dosing. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Doptelet Sprinkle

## Products Affected

- **DOPTELET SPRINKLE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of persistent or chronic immune thrombocytopenia. -AND- One of the following (1-2): 1) Therapeutic failure, contraindication, or intolerance to corticosteroid therapy or immunoglobulin therapy, 2) Therapeutic failure after a splenectomy. -AND- One of the following (3-4): 3) Platelet count of less than or equal to 30x10*9/L, 4) Platelet count of less than 50x10*9/L and significant mucous membrane bleeding or a risk factor for bleeding (e.g. hypertension, peptic ulcer disease, vigorous lifestyle). |
| **Age Restrictions** | Deny if less than 1 year of age or greater than 5 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Doxepin Cream

## Products Affected

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

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

# DPP4 Agents

## Products Affected

- *alogliptin*
- *alogliptin-metformin*
- *alogliptin-pioglitazone*
- **BRYNOVIN**
- *saxagliptin*
- *saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg, 5-1,000 mg, 5-500 mg*
- **ZITUVIMET**
- **ZITUVIMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-1,000 MG, 50-500 MG**
- **ZITUVIO ORAL TABLET 100 MG, 25 MG, 50 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of type 2 diabetes mellitus. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | One of the following (1-2) is required: 1) Therapeutic failure, intolerance, or contraindication to Janumet, Janumet XR, Tradjenta, Jentadueto, or Jentadueto XR is required, 2) For Brynovin, inability to swallow tablets. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# DPP4-SGLT2 Combo

## Products Affected

- *dapagliflozin-saxagliptin*
- **STEGLUJAN**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of type 2 diabetes mellitus. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Trial/failure, intolerance, or contraindication to Glyxambi and Trijardy XR are required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Drizalma

## Products Affected

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

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

# Duexis2

## Products Affected

- *ibuprofen-famotidine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- all of the following: 1) Intolerance to ibuprofen used in combination with famotidine. -AND- 2) Trial/failure of one additional generic formulary NSAID (other than ibuprofen) used in combination with another generic formulary H2-receptor blocker (other than famotidine). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Duobrii

## Products Affected

- **DUOBRII**

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

# Dupixent

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Mod/Sev atopic dermatitis (AD): failure/intolerance to 1 topical corticosteroid (TCS) or, if 2+ yrs, topical calcineurin inhibitor (e.g. tacrolimus, etc) OR, if sev AD, topical tx are precluded d/t body surface area involvement or severely damaged skin. TCS in combo w/Dupixent for mod/sev AD is permitted & allows coverage. Mod/sev asthma: hx of 2+ exacerbations req oral/inj corticosteroids in past 12mos or 1+ exacerbation req hospitalization in past 12mos AND blood eosinophils of at least 150cells/uL or current daily/alternate-day oral corticosteroid (OCS) AND inadequate control despite regular med/high-dose inhaled corticosteroids (ICS) & 1 or more add'l asthma controller (e.g. LABA, leukotriene receptor antagonist [LTRA], theophylline) +/- OCS, unless intolerant or contraindicated (c/i) to all AND will continue med/high dose ICS & 1 or more add'l asthma controller +/- OCS. Chronic rhinosinusitis w/ nasal polyposis (CRSwNP): failure, intolerance, or c/i to intranasal corticosteroid. Eosinophilic esophagitis: esophageal eosinophils of 15eos/hpf or higher on esophageal biopsy AND clinical esophageal dysfxn symptoms. Prurigo nodularis. COPD: blood eosinophils of at least 300cells/uL or current daily/alternate-day OCS AND inadequate control despite 3+ mos of regular LAMA, LABA, & ICS tx, unless intolerant or c/i to all. Chronic Spontaneous Urticaria: failure, intolerance, or c/i to 1 2nd-gen H1 antihistamine at max rec dose (e.g. cetirizine, etc). Bullous pemphigoid: failure, intolerance, or c/i on high/super high potency TCS or OCS. Allergic fungal rhinosinusitis: hx of sinonasal surgery AND diagnosis confirmed by at least 2 of the following: Type 1 hypersensitivity to fungus (history, in vitro IgE, or skin testing), positive fungal stain from surgical sinus contents, presence of eosinophilic mucin w/o sinus tissue invasion, presence of CRSwNP, or characteristic CT signs |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |

| PA Criteria | Criteria Details |
|---|---|
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For atopic dermatitis reauthorization, attestation of positive clinical response to therapy. For asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of severe asthma exacerbations, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For CRSwNP reauthorization, attestation of decrease in nasal polyp score or reduction in nasal congestion/obstruction severity score. For EoE reauthorization, attestation of histological remission (less than 15 eos/hpf) on esophageal biopsy or reduced severity or frequency of clinical symptoms of esophageal dysfunction. For prurigo nodularis reauthorization, attestation of reduction in itch or number of nodules or lesions from baseline. For COPD reauthorization, attestation of one of the following is required (1-4): 1) reduction in COPD symptoms, 2) improvement in exercise tolerance, 3) delayed disease progression, or 4) reduction in the number of COPD exacerbations. For CSU reauthorization, improved CSU symptoms. For BP reauthorization, 1 of the following is required (1-4): 1) attestation of disease control, 2) reduction in number of relapses, 3) improvement in BP symptoms, or 4) reduction in oral corticosteroid use. For allergic fungal rhinosinusitis reauthorization, attestation of decrease in nasal polyp score or reduction in nasal congestion/obstruction severity score. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Duvyzat

## Products Affected

- **DUVYZAT**

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

# Ebglyss

## Products Affected

- **EBGLYSS PEN**
- **EBGLYSS SYRINGE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe atopic dermatitis, documentation of one of the following (1 or 2): 1) trial & failure, or intolerance to at least one generic topical corticosteroid -OR- generic topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus) 2) The member has severe atopic dermatitis and is incapable of applying topical therapies due to the extent of body surface area involvement or topical therapies are contraindicated due to severely damaged skin. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Atopic Dermatitis, patients must have a trial/failure, intolerance, or contraindication to both preferred products: Dupixent and Rinvoq. For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen for 16 weeks and once for an additional 8 weeks if clinical response is not achieved by 16 weeks. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# EGFR Tyrosine Kinase Inhibitors

## Products Affected

- *erlotinib*
- **GILOTRIF**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Afatinib products:  tumors with resistant EGFR mutations. Erlotinib products: use in NSCLC tumors with mutations other than those in FDA-approved indications. Use in combination with platinum based chemotherapy. |
| **Required Medical Information** | For afatinib, documentation of metastatic non-small cell lung cancer (NSCLC) -AND- one of the following, as detected by an FDA-approved test (1-3): 1) disease harbors EGFR exon 19 deletions 2) disease harbors EGFR exon 21 (L858R) substitution mutation 3) disease harbors non-resistant EGFR mutation (i.e., S768I, L861Q, G719X) -OR- documentation of squamous metastatic NSCLC and member has experienced progression on platinum-based chemotherapy. For erlotinib, documentation of metastatic NSCLC -AND- one of the following, as detected by an FDA-approved test (1-2): 1) disease harbors EGFR exon 19 deletions 2) disease harbors EGFR exon 21 (L858R) substitution mutations -OR- documentation of locally advanced, unresectable or metastatic pancreatic cancer -AND- all of the following (1-2): 1) using erlotinib as first-line therapy 2) using in combination with gemcitabine. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Egrifta

## Products Affected

- **EGRIFTA SV**
- **EGRIFTA WR**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of HIV and lipodystrophy, member must actively be receiving antiretroviral therapy including protease inhibitors, nucleoside reverse transcriptase inhibitors, or non-nucleoside reverse transcriptase inhibitors |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, continued antiretroviral therapy for HIV infection - AND- reduction in visceral adipose tissue from baseline (e.g. reduction of minimum waist circumference, waist to hip ratio, or BMI) are required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Ekterly

## Products Affected

- **EKTERLY**

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For 18 years of age or older, one of the following (1-3): 1) therapeutic failure, intolerance or contraindication to icatibant, 2) unable to use a self-administered injection due to diagnosis of needle phobia confirmed by psychiatric evaluation, or 3) physical or cognitive impairment which places them at high risk of inappropriate administration with generic icatibant injection. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Elyxyb

## Products Affected

- **ELYXYB**

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

# Emflaza

## Products Affected

- *deflazacort*
- **EMFLAZA**
- **JAYTHARI**
- **KYMBEE**
- **PYQUVI**

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Emgality

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, the following criteria will apply (1-2). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). For episodic cluster headaches, characterized by severe or very severe unilateral orbital, supraorbital, and/or temporal pain lasting 15 to 180 minutes when left untreated -AND- Attack frequency of at least one attack every other day during the cluster period. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For reauthorization of episodic migraine prevention, attestation of reduction in migraine frequency is required. For reauthorization of cluster headache, attestation of reduction in the number of mean weekly cluster headaches from baseline is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Empaveli

## Products Affected

- **EMPAVELI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) -AND- 1 of the following (1-2): 1) PNH mutant clones confirmed by flow cytometry, or 2) glycosylphosphatidylinositol-anchored proteins (GPI-AP)-deficient polymorphonuclear cells (PMNs) confirmed by flow cytometry -AND- 1 of the following (3-6): 3) anemia secondary to PNH (e.g. hemoglobin less than 10.5 g/dL with symptoms of anemia), 4) elevated lactate dehydrogenase (LDH) greater than or equal to 1.5 times the upper limit of normal, 5) history of a thromboembolic event, or 6) clinical findings of systemic complications (e.g. fatigue, hemoglobinuria, abdominal pain, dyspnea, dysphagia, erectile dysfunction, history of blood cell transfusion due to PNH) -AND- will not be used in combination with another complement inhibitor for PNH (e.g. Soliris (eculizumab), Ultomiris (ravulizumab), Fabhalta (iptacopan)) unless initially cross-titrating. Diagnosis of Complement 3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN), -AND- all of the following (7-9): 7) diagnosis confirmed by biopsy, 8) UPCR greater than or equal to 1.0 g/g, 9) currently therapy of the member should be on the maximally tolerated dose of one of the following (a or b): a) ACE-inhibitor, b) ARB. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For PNH reauthorization, attestation of positive clinical response defined as one of the following (1-3): 1) hemoglobin stabilization or increase from baseline, 2) decrease in transfusions from baseline, or 3) decrease in LDH levels from baseline or reduction of hemolysis -AND- will not be used in combination with another complement inhibitor for PNH (e.g. Soliris (eculizumab), Ultomiris (ravulizumab), Fabhalta (iptacopan)). For reauthorization of C3G or IC-MPGN, reduction in UPCR from baseline. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Endari

## Products Affected

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

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

# Ensacove

## Products Affected

- **ENSACOVE**

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

# Enspryng

## Products Affected

- **ENSPRYNG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of neuromyelitis optica spectrum disorder (NMOSD) -AND- Attestation of anti-aquaporin-4 (AQP4) antibody positive -AND- Not used in combination with another monoclonal antibody used for the treatment of NMOSD -AND- One core clinical characteristic of NMOSD (1-6): 1) Optic neuritis 2) Acute myelitis 3) Area postrema syndrome 4) Acute brainstem syndrome 5) Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions 6) Symptomatic cerebral syndrome with NMOSD-typical brain lesions |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of decrease in number of NMOSD relapses. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Entresto Sprinkle

## Products Affected

- **ENTRESTO SPRINKLE**

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

# Entyvio

## Products Affected

- **ENTYVIO PEN**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- attestation of receiving or currently undergoing at least 2 doses of IV Entyvio within 6 weeks of initiating therapy with Entyvio SC. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For moderate to severe ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For moderate to severe active Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, and Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Eohilia

## Products Affected

- **EOHILIA**

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

# Epclusa

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Criteria will be applied consistent with current AASLD/IDSA guidance. For Brand Epclusa, the member has a contraindication to or is otherwise not a candidate for one of the following regimens recommended by the AASLD/IDSA guidelines containing the following agents: sofosbuvir/velpatasvir (i.e. Epclusa authorized generic), Mavyret. |
| **Age Restrictions** | Deny if less than 3 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Criteria/duration applied consistent with current AASLD-IDSA guidance |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Epidiolex

## Products Affected

- **EPIDIOLEX**

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

# Eprontia

## Products Affected

- **EPRONTIA**
- *topiramate oral solution*

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

# Ergotamine

## Products Affected

- **ERGOMAR**
- *ergotamine-caffeine*

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

# Ergotamine-Caffeine

## Products Affected

- **CAFERGOT**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of use to abort a vascular headache -AND- therapeutic failure, intolerance, or contraindication to a generic triptan -OR- documentation of use to prevent a vascular headache -AND- therapeutic failure, intolerance, or contraindication to generic prophylactic migraine medication (e.g., topiramate, propanolol, timolol). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Cafergot, intolerance to generic ergotamine-caffeine tablets is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Erivedge

## Products Affected

- **ERIVEDGE**

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

# Erleada

## Products Affected

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

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

# Escitalopram Capsule

## Products Affected

- *escitalopram oxalate oral capsule*

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

# Etanercept

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. |
| **Age Restrictions** | Deny if less than 18 years of age for Rheumatoid Arthritis and Ankylosing Spondylitis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Psoriatic Arthritis or Less than 4 years of age for Plaque Psoriasis |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Therapeutic failure or intolerance to 1 of the following preferred adalimumab products is required, when being utilized for the same medically accepted indication and age: Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. |
| **Indications** | All FDA-approved Indications. |

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Eucrisa

## Products Affected

- **EUCRISA**

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

# Evekeo

## Products Affected

- *amphetamine sulfate*
- **EVEKEO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For narcolepsy the following are required: Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B)Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than or equal to 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than or equal to 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For narcolepsy, trial and failure, intolerance to 2 of the following generic alternatives is required: immediate release amphetamine/dextroamphetamine, dextroamphetamine, and methylphenidate. For ADHD, trial/failure or intolerance to 2 unique generic stimulants (e.g. methylphenidate) is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Evenity

## Products Affected

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

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Evrysdi

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of spinal muscular atrophy (SMA) -AND- Baseline motor function test results (e.g. MFM, CHOP, HINE, RULM, HFMSE, 6MWT) -AND- Not using concomitantly with Spinraza (nusinersen) -AND- Molecular genetic testing of 5q SMA showing Homozygous gene deletion, Homozygous conversion mutation or Compound heterozygote. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months |
| **Other Criteria** | For reauthorization, attestation of slowed disease progression or stabilization of SMA associated symptoms (e.g. stabilization or decreased decline in motor function compared to the predicted natural history trajectory of the disease, or a reduction in the rate of decline in motor function as measured by validated scales such as MFM, CHOP, HINE, RULM, HFMSE, or 6MWT) -AND- Not using concomitantly with Spinraza (nusinersen) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Exxua

## Products Affected

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

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

# Fabhalta

## Products Affected

- **FABHALTA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For paroxysmal nocturnal hemoglobinuria (PNH), meets one of the following (1 or 2): 1) PNH mutant clones confirmed by flow cytometry, or 2) glycosylphosphatidylinositol-anchored proteins (GPI-AP)-deficient polymorphonuclear cells (PMNs) confirmed by flow cytometry -AND- meets one of the following (3-6): 3) anemia secondary to PNH (e.g. hemoglobin less than 10.5 g/dL with symptoms of anemia), 4) elevated lactate dehydrogenase (LDH) greater than or equal to 1.5 times the upper limit of normal, 5) history of a thromboembolic event, or 6) clinical findings of systemic complications (e.g. fatigue, hemoglobinuria, abdominal pain, dyspnea, dysphagia, erectile dysfunction, history of blood cell transfusion due to PNH) -AND- will not be used in combination with another complement inhibitor for PNH (e.g. Soliris (eculizumab), Ultomiris (ravulizumab), Empaveli (pegcetacoplan)) unless initially cross-titrating. For diagnosis of primary immunoglobulin A nephrology (IgAN) confirmed by biopsy, member is at risk for rapid disease progression evidenced by one of the following (7 or 8): 7) Urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g or 8) Proteinuria greater than or equal to 1 g/day -AND- has experienced therapeutic failure, contraindication, or intolerance to a maximally tolerated dose of one of the following (a or b): a) Angiotensin converting enzyme (ACE) inhibitor, b) Angiotensin receptor blocker (ARB) -AND- experienced therapeutic failure, contraindication, or intolerance to one of the following (c or d): c) Filspari (sparsentan) or d) Tarpeyo (budesonide). For Complement 3 Glomerulopathy (C3G) confirmed by biopsy, meets all of the following (13-14): 13) UPCR greater than or equal to 1.0 g/g, 14) currently therapy of the member should be on the maximally tolerated dose of one of the following (e or f): e) ACE-inhibitor, f) ARB. |
| **Age Restrictions** | |

| PA Criteria | Criteria Details |
|---|---|
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization of PNH, attestation of positive clinical response defined as one of the following (1-3): 1) hemoglobin stabilization or increase from baseline, 2) decrease in transfusions from baseline, or 3) decrease in LDH levels from baseline or reduction of hemolysis -AND- will not be used in combination with another complement inhibitor for PNH (e.g. Soliris (eculizumab), Ultomiris (ravulizumab), Empaveli (pegcetacoplan)). For reauthorization of IgAN, reduction in urine protein-to-creatinine ratio (UPCR) or proteinuria from baseline. For reauthorization of C3G, reduction in UPCR from baseline. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Fanapt

## Products Affected

- **FANAPT**
- **FANAPT TITRATION PACK A**
- **FANAPT TITRATION PACK B**
- **FANAPT TITRATION PACK C**

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

# Fasenra

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of severe asthma and all of the following (1-4): 1) history of at least 2 asthma exacerbations requiring oral or injectable corticosteroid treatment in past 12 mos or at least 1 asthma exacerbation requiring hospitalization in past 12 mos 2) blood eosinophils greater than or equal to 150cells/uL within the past 6 weeks or greater than or equal to 300cells/uL within the past 12 mos in without other potential causes of eosinophilia (e.g. hypereosinophilic syndromes, neoplastic disease, known suspected parasitic infection) 3) inadequate symptom control despite regular treatment with medium or high dose inhaled corticosteroid (ICS) and at least 1 add'l asthma controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline), with or without oral corticosteroids (OCS), unless intolerant or contraindicated to all 4) will continue treatment with medium or high dose ICS and at least 1 add'l asthma controller medication, with or without OCS -OR- Documentation of eosinophilic granulomatosis with polyangiitis (EGPA) and all of the following (5-6): 5) history of relapsing or refractory disease 6) will be receiving standard of care while on Fasenra therapy with glucocorticoid treatment (e.g. prednisone or prednisolone), with or without immunosuppressive therapy (e.g. cyclosporine, leflunomide, azathioprine). Documentation of Hypereosinophilic syndrome (HES) and all of the following (7-8): 7) no identifiable non-hematologic secondary cause, 8) Treatment with HES therapy (chronic or episodic OCS, immunosuppressive or cytotoxic therapy) for at least 4wks, unless therapeutic failure, intolerant, or contraindicated to all. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |

| PA Criteria | Criteria Details |
|---|---|
| **Coverage Duration** | 12 months |
| **Other Criteria** | For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For severe asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of severe asthma exacerbation, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For EPGA reauthorization, attestation of one of the following is required (5-8): 5) reduction in the frequency and/or severity of relapses, 6) reduction or discontinuation of doses of corticosteroids and/or immunosuppressant, 7) disease remission, or 8) reduction in severity or frequency of EGPA-related symptoms. For HES reauthorization, 1 of the following is required (9-11): 9) reduction in frequency of HES flares, 10) maintenance or reduction in background HES therapy requirements, 11) reduction in or stabilization of eosinophil-mediated organ damage (e.g., cardiac, pulmonary, gastrointestinal, or neurological manifestations). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Fecal Microbiota Products

## Products Affected

- **VOWST**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of a recent diagnosis of Clostridioides difficile infection (CDI) confirmed by a positive stool test -AND- Classified as recurrent (e.g., at least 2 CDI episodes) -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 month |
| **Other Criteria** | For reauthorization, attestation of recurrent CDI episodes after administration of the initial fecal microbiota product -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Ferriprox

## Products Affected

- *deferiprone*
- **FERRIPROX (2 TIMES A DAY)**
- **FERRIPROX ORAL SOLUTION**
- **FERRIPROX ORAL TABLET 1,000 MG**

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

# Fetzima

## Products Affected

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

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

# Filspari

## Products Affected

- **FILSPARI ORAL TABLET 200 MG, 400 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Concomitant use with angiotensin receptor blockers (ARBs), endothelin receptor antagonists (ERAs), or aliskiren. |
| **Required Medical Information** | Pending CMS Review |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For IgAN reauthorization, reduction in proteinuria from baseline is required. For FSGS reauthorization, reduction in UPCR from baseline is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Filsuvez

## Products Affected

- **FILSUVEZ**

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

# Fintepla

## Products Affected

- **FINTEPLA**

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

# Firazyr

## Products Affected

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For brand Firazyr, therapeutic failure, intolerance or contraindication to icatibant. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Firdapse

## Products Affected

- **FIRDAPSE**

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

# Firmagon

## Products Affected

- **FIRMAGON KIT W DILUENT SYRINGE**

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

# Flector

## Products Affected

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

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

# Forteo

## Products Affected

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

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Forzinity

## Products Affected

- **FORZINITY**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Barth Syndrome -AND- Pathogenic mutation in TAFAZZIN gene, as confirmed by genetic testing -AND- Weight greater than or equal to 30 kg -AND- Being used to increase muscle strength. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of improvement in muscle strength is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Fotivda

## Products Affected

- **FOTIVDA**

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

# Fruzaqla

## Products Affected

- **FRUZAQLA ORAL CAPSULE 1 MG, 5 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- member has received previous threatment with a fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy -AND- member has received previous treatment with an anti-VEGF therapy -AND- one of the following, if member is RAS wild-type (1-2): 1) member has received previous therapy with an anti-EGFR therapy 2) prescriber attests that treatment with an anti-EGFR therapy would not be medically appropriate. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Fulvicin PG

## Products Affected

- *griseofulvin ultramicrosize oral tablet 165 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | onychomycosis: 12mos, tinea capitis: 12wks, tinea pedis: 8wks, tinea barbae/corporis/cruris: 6wks |
| **Other Criteria** | Therapeutic failure or intolerance to one of the following generic griseofulvin products is required: griseofulvin suspension, griseofulvin microsize tablets, griseofulvin ultramicrosize 125mg tablets, or griseofulvin ultramicrosize 150mg tablets. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Furoscix

## Products Affected

- **ENBUMYST**
- **FUROSCIX**
- **LASIX ONYU**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- The member has been receiving an oral loop diuretic (e.g. furosemide, bumetanide, torsemide) as part of their medication regimen -AND- treatment will be replaced with oral diuretics as soon as practical. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Gabapentin

## Products Affected

- **NEURONTIN ORAL CAPSULE 100 MG, 800 MG 300 MG, 400 MG**
- **NEURONTIN ORAL SOLUTION**
- **NEURONTIN ORAL TABLET 600 MG,**

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

# Gabarone

## Products Affected

- **GABARONE ORAL TABLET 100 MG, 400 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Intolerance to generic immediate release gabapentin tablets or capsules is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Galafold

## Products Affected

- **GALAFOLD**

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

# Gattex

## Products Affected

- **GATTEX 30-VIAL**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of short bowel syndrome (SBS) having less than 200 cm of functional small bowel -AND- Dependence on parenteral/intravenous nutrition -AND- weight of at least 10 kg. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of increase in weight from baseline or decrease in intravenous parenteral nutrition requirements from baseline -AND- 1 of the following (1-2): 1) continued dependence on parenteral nutrition/intravenous nutritional support, 2) not receiving parenteral nutrition/intravenous support and experienced therapeutic failure upon trial of discontinuation of parenteral nutrition/intravenous support. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Gavreto

## Products Affected

- **GAVRETO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For metastatic non-small cell lung cancer, disease is RET fusion-positive as detected by an FDA approved test. For advanced or metastatic thyroid cancer, all of the following (1-2): 1) disease is RET fusion-positive 2) if radioactive iodine is appropriate, the member is radioactive iodine-refractory. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Gilenya

## Products Affected

- *fingolimod*
- **GILENYA**

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

# Gimoti

## Products Affected

- **GIMOTI**

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

# Glatiramer

## Products Affected

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

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

# Gleevec

## Products Affected

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Gleostine

## Products Affected

- **GLEOSTINE**
- *lomustine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of primary or metastatic brain tumor(s) -AND- member has previously received surgical and/or radiotherapeutic procedure(s). Documentation of Hodgkin's lymphoma -AND- all of the following (1-2): 1) using lomustine in combination with other chemotherapies 2) member has experienced disease progression with initial chemotherapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Gleostine, intolerance to generic lomustine is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# GLP1

## Products Affected

- *liraglutide*
- **MOUNJARO**
- **OZEMPIC SUBCUTANEOUS**
- **TRULICITY**
- **VICTOZA 3-PAK**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Obesity or use for weight loss |
| **Required Medical Information** | Documentation of diabetes mellitus type 2 |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | When used for the same age and indication, for Victoza, intolerance to liraglutide and 1 of the following: Mounjaro, Ozempic, or Trulicity. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Glycate

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- using as an adjunctive treatment for peptic ulcer disease -AND- Therapeutic failure or intolerance to both generic glycopyrrolate 1mg tablet AND 2 mg tablet |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Gocovri

## Products Affected

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

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

# Gomekli

## Products Affected

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

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

# Gralise

## Products Affected

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

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

# Grastek

## Products Affected

- **GRASTEK**

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

# Growth Hormone

## Products Affected

- **GENOTROPIN**
- **GENOTROPIN MINIQUICK**
- **HUMATROPE INJECTION CARTRIDGE**
- **NGENLA**
- **NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)**
- **OMNITROPE**
- **SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG**
- **ZOMACTON**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis, growth chart, member has open epiphyses, growth velocity, response to stimulation test, when applicable to meet standard diagnostic criteria. Additionally for growth failure due to chronic kidney disease, glomerular filtration rate is less than 89ml/min per 1.73m*2. For HIV wasting and cachexia, Concurrent use of antiretroviral therapy -AND- weight loss from baseline of at least 10% in the past 12 months or at least 5% in the past 6 months. For short bowel syndrome, receiving management for short bowel syndrome, including specialized nutritional support -AND- less than 200 cm of functional small bowel. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of growth velocity and member has open epiphyses, as applicable to meet standard continuation of therapy guidelines. For reauthorization of HIV wasting and cachexia, attestation of increase in weight from start of therapy. For reauthorization of short bowel syndrome, continued dependence on parenteral nutrition/intravenous nutritional support -AND- attestation of increase in weight from baseline or decrease in intravenous parenteral nutrition requirements from baseline. |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Haegarda

## Products Affected

- **HAEGARDA**

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Harliku

## Products Affected

- **HARLIKU**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of alkaptonuria (AKU) confirmed by 24-hour urine with elevated homogentisic acid (HGA) or mutations in the homogentisate 1,2-dioxygenase (HGD) gene -AND- used to reduce urine HGA. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Reauthorization requires reduction in urine HGA from baseline. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Harvoni

## Products Affected

- **HARVONI**
- *ledipasvir-sofosbuvir*

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

# Hemady

## Products Affected

- **HEMADY**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of multiple myeloma -AND- used in combination with other anti-myeloma agents -AND- Intolerance to generic dexamethasone. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Hemangeol

## Products Affected

- **HEMANGEOL**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of proliferating infantile hemangioma. |
| **Age Restrictions** | Deny if treatment initiation is at less than 5 weeks or more than 5 months of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Hepcludex

## Products Affected

- **HEPCLUDEX**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of chronic hepatitis delta virus (HDV) and all of the following (1-3): 1) diagnosis supported by detectable serum HDV RNA and positive serum anti-HDV antibodies, 2) attestation that HDV infection is classified as chronic, 3) liver status of no cirrhosis or compensated cirrhosis, 4) attestation that the chronic HBV infection will be managed as clinically appropriate per the FDA-approved labeling. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, all of the following are required (1-3): 1) liver status of no cirrhosis or compensated cirrhosis, 2) attestation that the chronic HBV infection continues to be managed as clinically appropriate per the FDA-approved labeling, 3) attestation that response to treatment warrants continued therapy. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Hernexeos

## Products Affected

- **HERNEXEOS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For non-squamous non-small cell lung cancer (NSCLC), all of the following (1-2): 1) disease is unresectable or metastatic, 2) disease harbors HER2 (ERBB2) tyrosine kinase domain activating mutations, as detected by an FDA-authorized test |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Hetlioz

## Products Affected

- **HETLIOZ**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of Non-24 Sleep-Wake disorder -AND- evidenced by all the following (1 through 4): 1) history of insomnia, excessive daytime sleepiness, or both alternating with asymptomatic episodes 2) symptoms persistent for at least 3 months 3) daily sleep logs for at least 14 days demonstrating a sleep/wake pattern that delays each day 4) sleep disturbances are not better explained by another current disorder or medication/substance use -OR- Documented diagnosis of Smith-Magenis Syndrome as confirmed by deletion of chromosome 17p11.2 or variant in the RAI1 gene-AND- patient is experiencing nighttime sleep disturbances (e.g. difficulty falling asleep, shortened sleep cycles, inability to enter REM sleep, or frequent awaking during the night and early in the morning) |
| **Age Restrictions** | Deny if less than 16 years of age for nighttime sleep disturbances in Smith-Magenis Syndrome or deny if less than 18 years of age for Non-24 Hour Sleep-Wake Disorder |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Hetlioz, documentation of intolerance to generic tasimelteon is required. For reauthorization, attestation of increased total nighttime sleep or decreased daytime nap duration for Non-24 Sleep-Wake disorder -OR- attestation of positive clinical response to therapy with minimal side effects for Smith-Magenis Syndrome |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Hetlioz LQ

## Products Affected

- **HETLIOZ LQ**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of Smith-Magenis Syndrome as confirmed by deletion of chromosome 17p11.2 or variant in the RAI1 gene -AND- patient is experiencing nighttime sleep disturbances (e.g. difficulty falling asleep, shortened sleep cycles, inability to enter REM sleep, or frequent awaking during the night and early in the morning) |
| **Age Restrictions** | Deny if less than 3 or greater than 15 years of age. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of positive clinical response to therapy with minimal side effects for Smith-Magenis Syndrome -AND- member is between 3 and 15 years of age |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# High-risk meds

## Products Affected

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# High-risk meds phenobarbital

## Products Affected

- *phenobarbital*

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

# Homozygous FH

## Products Affected

- **JUXTAPID ORAL CAPSULE 10 MG, 2 MG, 20 MG, 30 MG, 5 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of homozygous familial hypercholesterolemia (HoFH) supported by 1 of the following (a-d): a) bi-allelic causal mutations of FH by genetic testing, b) LDL-C over 560mg/dL, c) LDL-C over 400mg/dL w/ aortic valve disease or xanthomata at less than 20 yrs old, d) LDL-C over 400mg/dL and 1 or both parents w/ clinically diagnosed FH, positive genetic testing for a known LDL-C-raising (e.g., LDLR, Apo[b], PCSK9) gene defect, or autosomal-recessive FH -AND- current LDL-C over 115mg/dL (if 17 yrs or younger) or over 70mg/dL (18 yrs or older) or over 55mg/dL w/ ASCVD or major ASCVD risk factors (18 yrs or older) -AND- If the member is 6 years of age or older, therapeutic failure to a max tolerated statin or documented statin intolerance -AND- The member will continue to receive concurrent lipid-lowering therapies for the treatment of HoFH. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months |
| **Other Criteria** | For 10 years of age or older, trial/failure, intolerance, or contraindication to the preferred product Repatha is required. For reauthorization, documentation showing an LDL-C reduction on Juxtapid therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis. |

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Horizant

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of moderate to severe active primary restless leg syndrome (RLS) -AND- Attestation that exacerbating factors of RLS have been addressed (e.g. alcohol use, caffeine consumption, antihistaminergic, serotonergic and antidopaminergic medication use management, and untreated obstructive sleep apnea) -AND- One of the following (1-2): 1) Serum ferritin level greater than 75 ng/mL or transferrin saturation greater than or equal to 20%, 2) If attestation of member being treated with iron therapy is provided, serum ferritin level less than or equal to 75 ng/mL or transferrin saturation less than 20% -AND- Both of the following (3-4): 3) Therapeutic failure, intolerance, or contraindication to generic pregabalin, 4) intolerance to generic immediate-release gabapentin. Documentation of post herpetic neuralgia -AND- intolerance to generic gabapentin. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Hyftor

## Products Affected

- **HYFTOR**

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

# Hyrnuo

## Products Affected

- **HYRNUO**

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

# Ibrance

## Products Affected

- **IBRANCE ORAL CAPSULE 125 MG**
- **IBRANCE ORAL TABLET**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of HR-positive, HER2-negative advanced or metastatic breast cancer -AND- meets one of the following (1. or 2.): 1) documentation of use with an aromatase inhibitor as initial endocrine-based therapy -OR- 2) documentation of use with fulvestrant in patients with disease progression following endocrine therapy. Documentation of endocrine-resistant, locally advanced or metastatic breast cancer -AND- all of the following (3-6): 3) disease is HR-positive, HER2-negative 4) disease is PIK3CA-mutated, as detected by an FDA-authorized test 5) the member is using in combination with inavolisib and fulvestrant 6) the member has experienced recurrence on or after completing adjuvant endocrine therapy. Documentation of locally advanced or metastatic breast cancer -AND- all of the following (7-9): 7) disease is HR-positive, HER2-positive, 8) will be used following induction treatment, 9) will be used in combination with trastuzumab (with or without pertuzumab) and endocrine therapy as maintenance treatment. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Ibsrela

## Products Affected

- **IBSRELA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of irritable bowel syndrome with constipation (IBS-C) -AND- Therapeutic failure, contraindication, or intolerance to Linzess -AND- If member is female, therapeutic failure, contraindication, or intolerance to lubiprostone -AND- If the member is male, therapeutic failure, contraindication, or intolerance to Trulance. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Ibtrozi

## Products Affected

- **IBTROZI**

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

# Iclusig

## Products Affected

- **ICLUSIG**

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

# Icotyde

## Products Affected

- **ICOTYDE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy -AND- if the member is 12 years of age to less than 18 years, weight is greater than or equal to 40 kg. |
| **Age Restrictions** | Deny if less than 12 years of age for Plaque Psoriasis |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For psoriasis, patients must have therapeutic failure or intolerance to 2 preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, and Skyrizi SC. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqeyma with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Idhifa

## Products Affected

- **IDHIFA**

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

# IG

## Products Affected

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered under Part B when administered in the home to a member with a diagnosis of primary immunodeficiency disease. For non-preferred IG products, patients must have intolerance or contraindication to both preferred products: Gammagard and Privigen. |
| **Indications** | All FDA-approved Indications, Some Medically-accepted Indications. |
| **Off Label Uses** | Myasthenia Gravis syndrome, Multiple Sclerosis, Polymyositis, Bone Marrow Transplant, Pediatric HIV, Guillain-Barre syndrome, Autoimmune Mucocutaneous Blistering Diseases |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Ilumya

## Products Affected

- **ILUMYA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For psoriasis induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen. For psoriasis, patients must have therapeutic failure or intolerance to 2 preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, and Skyrizi SC. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Imbruvica

## Products Affected

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

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

# Imkeldi

## Products Affected

- **IMKELDI**

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Inbrija

## Products Affected

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

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

# Increlex

## Products Affected

- **INCRELEX**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis of severe primary IGF-1 deficiency and all of the following: 1) Normal or elevated response (greater than 10 ng/ml) to two (2) of the following standard growth hormone stimulation tests: arginine, clonidine, glucagon, insulin, levodopa, propranolol. 2) Serum IGF-1 concentration that is less than or equal to three (3) standard deviations below the normal value based on laboratory reference range. 3) Height less than or equal to three (3) standard deviations below normal (at or below the third percentile for gender and age). 4) Member has open epiphyses. -OR- Documentation of diagnosis of growth hormone deficiency caused by gene deletion and all of the following: 1) Growth velocity at least 2 standard deviations below the age-appropriate mean or height at least 2.25 standard deviations below the age-appropriate mean. 2) Subnormal response (less than 10 ng/mL) to two (2) of the following standard growth hormone stimulation tests: arginine, clonidine, glucagon, insulin, levodopa, propranolol. 3) Development of neutralizing antibodies to growth hormone product(s). 4) Member has open epiphyses. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For pediatric patients, reauthorization requires open epiphyses. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | No |

# Ingrezza

## Products Affected

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

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

# Inluriyo

## Products Affected

- **INLURIYO**

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

# Inlyta

## Products Affected

- **INLYTA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of advanced renal cell carcinoma -AND- one of the following (1-2): 1) if using axitinib as first line therapy, member is using axitinib in combination with avelumab or pembrolizumab 2) if using axitinib as a single-agent, member has been treated with at least one prior systemic therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Inqovi

## Products Affected

- **INQOVI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For myelodysplastic syndrome, one of the following is required (1-2): 1) French American-British MDS subtypes of refractory anemia, refractory anemia with ringed sideroblasts or refractory anemia with excess blasts, 2) International Prognostic Scoring System group of intermediate-1, intermediate-2 or high-risk. For newly-diagnosed acute myeloid leukemia, use in combination with venetoclax -AND- one of the following is required (3-4): 3) age greater than or equal to 75 years of age, 2) 1 or more comorbidity that precludes the use of intensive induction chemotherapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Inrebic

## Products Affected

- **INREBIC**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of intermediate-2 or high-risk myelofibrosis per an accepted risk stratification tool for myelofibrosis (e.g., International Prognostic Scoring System [IPSS]) -AND- If a new start, baseline platelet count of greater than or equal to 50x10*9/L |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Baseline platelet count to be provided. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Insulin Supplies

## Products Affected

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

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

# Interferon Alfa

## Products Affected

- **PEGASYS**

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

# Interferon Beta

## Products Affected

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

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

# Interleukin-1b Blockers

## Products Affected

- **ARCALYST**

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

# Intrarosa

## Products Affected

- **INTRAROSA**

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

# IPF Agents

## Products Affected

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Iqirvo

## Products Affected

- **IQIRVO**

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

# Iressa

## Products Affected

- *gefitinib*
- **IRESSA**

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

# Itovebi

## Products Affected

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

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

# Itraconazole

## Products Affected

- *itraconazole*

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

# Ivermectin Oral

## Products Affected

- *ivermectin oral*
- **STROMECTOL**

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

# Iwilfin

## Products Affected

- **IWILFIN**

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

# Jakafi

## Products Affected

- **JAKAFI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of intermediate or high-risk myelofibrosis per an accepted risk stratification tool for myelofibrosis (e.g., International Prognostic Scoring System [IPSS]) and if a new start, baseline platelet count of greater than or equal to 50x10*9/L -OR- documentation of polycythemia vera and inadequate response or intolerance to hydroxyurea -OR- Documentation of steroid refractory acute graft-versus-host disease and prior therapy with at least one systemic corticosteroid -OR- Documentation of chronic graft-versus-host disease with prior failure of at least one systemic therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Baseline platelet count to be provided. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Jakafi XR

## Products Affected

- **JAKAFI XR**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of intermediate or high-risk myelofibrosis per an accepted risk stratification tool for myelofibrosis (e.g., International Prognostic Scoring System [IPSS]) and if a new start, baseline platelet count of greater than or equal to 50x10*9/L -OR- documentation of polycythemia vera and inadequate response or intolerance to hydroxyurea -OR- Documentation of steroid refractory acute graft-versus-host disease and prior therapy with at least one systemic corticosteroid -OR- Documentation of chronic graft-versus-host disease with prior failure of at least one systemic therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Baseline platelet count to be provided. Documentation of intolerance to Jakafi (ruxolitinib immediate-release) is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Jascayd

## Products Affected

- **JASCAYD**

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Javadin

## Products Affected

- **JAVADIN**

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

# Jaypirca

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For relapsed or refractory mantle cell lymphoma, member has received at least two (2) previous lines of systemic therapy, at least one (1) of which was a BTK inhibitor. For relapsed or refractory Chronic Lymphocytic Leukemia/Small Lymphocytic Leukemia, member has previously been treated with a covalent BTK inhibitor. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Jideytro

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is ROS1-positive and member has received a prior ROS1 kinase inhibitor. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Joenja

## Products Affected

- **JOENJA ORAL TABLET 70 MG**

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

# Journavx

## Products Affected

- **JOURNAVX**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Treatment duration beyond 14 days for a single episode of acute pain |
| **Required Medical Information** | Documentation of moderate to severe acute pain -AND- The episode of acute pain is anticipated to last less than 1 month -AND- Attestation that alternative therapies have been explored (e.g. NSAIDs). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 14 days |
| **Other Criteria** | For reauthorization, all of the following are required (1-3): 1) treatment is for a new episode of moderate to severe pain, separate and distinct from the previous episode of moderate to severe pain, 2) the new episode of acute pain is anticipated to last less than 1 month, 3) Attestation that, for the new episode of acute pain alternative therapies have been explored (e.g. NSAIDs). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Jynarque

## Products Affected

- **JYNARQUE ORAL TABLET**
- **JYNARQUE ORAL TABLETS, SEQUENTIAL**
- *tolvaptan (polycys kidney dis) oral tablet*
- *tolvaptan (polycys kidney dis) oral tablets, sequential*

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

# Kalydeco

## Products Affected

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

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

# Kerendia

## Products Affected

- **KERENDIA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | eGFR less than 25 mL/min/1.73 m*2, serum potassium greater than 5.5 mEq/L |
| **Required Medical Information** | Documentation of type 2 diabetes mellitus with chronic kidney disease (T2DM+CKD) or heart failure (HF) with left ventricular ejection fraction (LVEF) of greater than or equal to 40% -AND- one of the following (1. 2. or 3.): 1) concomitant use of a sodium-glucose Cotransporter-2 (SGLT2) inhibitor 2) therapeutic failure to at least one SGLT2 inhibitor or 3) contraindication or intolerance to at least one SGLT2 inhibitor. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation that signs or symptoms of hyperkalemia are not present. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Kesimpta

## Products Affected

- **KESIMPTA PEN**

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

# Keveyis

## Products Affected

- *dichlorphenamide*
- **KEVEYIS**
- **ORMALVI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of one of the following: 1. Primary hyperkalemic periodic paralysis 2. Primary hypokalemic periodic paralysis 3. Related variants of primary periodic paralysis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 2 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For brand Keveyis and Ormalvi, intolerance to generic dichlorphenamide (other than Ormalvi) is required. For reauthorization, attestation the number of muscle weakness attacks has decreased |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Kevzara

## Products Affected

- **KEVZARA SUBCUTANEOUS PEN INJECTOR**
- **KEVZARA SUBCUTANEOUS SYRINGE 200 MG/1.14 ML**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For polymyalgia rheumatica (PMR), one of the following (1-3): 1) inadequate response to corticosteroids, 2) intolerance to corticosteroid taper, or 3) used in combination with corticosteroid tapering course. For polyarticular juvenile idiopathic arthritis, weight greater than or equal to 63 kg -AND- one of the following (4-5): 4) inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide), or 5) requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. |
| **Age Restrictions** | Deny if less than 18 years of age for rheumatoid arthritis and polymyalgia rheumatica. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq and Xeljanz/Xeljanz XR. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq/Rinvoq LQ, and Xeljanx/Xeljanz solution. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
| --- | --- |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Khindivi

## Products Affected

- **KHINDIVI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of adrenocortical insufficiency -AND- Attestation that the member is not experiencing a period of adrenal stress or acute events -AND- Intolerance to oral generic hydrocortisone tablets. |
| **Age Restrictions** | Deny if less than 5 years of age or greater than 17 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Kineret

## Products Affected

- **KINERET**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For Deficiency of Interleukin-1 Receptor Antagonist (DIRA), therapeutic failure or intolerance to at least one (1) corticosteroid, or all corticosteroids are contraindicated. |
| **Age Restrictions** | Deny if less than 18 years of age for Rheumatoid Arthritis |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq and Xeljanz/Xeljanz XR. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Kisqali

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- disease is classified as HR-positive, HER2-negative -AND- one of the following (1-3): 1) member is using ribociclib in combination with an aromatase inhibitor as initial endocrine-based therapy 2) member is using ribociclib in combination with fulvestrant and member is using fulvestrant as initial endocrine-based therapy or member has experienced disease progression on endocrine therapy. 3) disease is classified as stage II or stage III early breast cancer at high risk of recurrence, ribociclib is being used in combination with an aromatase inhibitor as adjuvant treatment. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Klisyri

## Products Affected

- **KLISYRI (250 MG)**

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

# Komzifti

## Products Affected

- **KOMZIFTI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For relapsed or refractory acute myeloid leukemia, the member has a susceptible NPM1 mutation -AND- the member has no satisfactory alternative treatment options. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Korlym

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of endogenous Cushing's syndrome -AND- Patient is not a candidate for surgery or where surgery has failed -AND- one of the following (1 or 2): 1) Diagnosis of diabetes, 2) Glucose intolerance |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Korlym, intolerance to generic mifepristone is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Koselugo

## Products Affected

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

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

# Krazati

## Products Affected

- **KRAZATI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of non-small cell lung cancer -AND- disease is KRAS G12C-mutated as determined by an FDA approved test -AND- member has received at least one prior systemic therapy -AND- using as a single agent. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Kuvan

## Products Affected

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

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

# Kygevvi

## Products Affected

- **KYGEVVI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Thymidine Kinase 2 Deficiency (TK2d) -AND- Pathogenic mutation in TK2 gene, as confirmed by genetic testing -AND- symptom onset on or before 12 years of age |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Latuda

## Products Affected

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

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

# Lazcluze

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of non-small cell lung cancer (NSCLC) -AND- all of the following (1-4): 1) disease harbors EGFR exon 19 deletions or EGFR exon 21 (L858R) substitution mutation, as detected by an FDA-approved test 2) disease is locally advanced or metastatic, 3) member is treatment naive for advanced disease, 4) using in combination with amivantinib. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Lenvima

## Products Affected

- **LENVIMA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of differentiated thyroid cancer -AND- meets all of the following (1-3): 1) disease is locally recurrent or metastatic 2) disease is progressive 3) disease is radioactive iodine refractory. Documentation of advanced renal cell carcinoma -AND- one of the following (4-5): 4) member is using lenvatinib in combination with pembrolizumab and is using lenvatinib and pembrolizumab as first-line treatment 5) member is using lenvatinib in combination with everolimus and has experienced therapeutic failure or intolerance to one prior anti-angiogenic therapy. Documentation of unresectable hepatocellular carcinoma -AND- member is using lenvatinib as first-line treatment. Documentation of endometrial cancer -AND- meets all of the following (6-10): 6) member is using lenvatinib in combination with pembrolizumab 7) disease is advanced 8) disease is not classified as microsatellite instability-high or disease is classified as mismatch repair proficient as determined by an FDA-approved test 9) member has experienced disease progression following prior systemic therapy 10) member is not a candidate for curative surgery or radiation. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Leqembi Iqlik

## Products Affected

- **LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 360 MG/1.8 ML**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Alzheimer's disease, classified as mild cognitive impairment or mild dementia prior to therapy initiation, and all of the following (1-2): 1) attestation of receiving or currently undergoing 18 months of Leqembi initiation therapy, 2) prescriber has ruled out other possible causes of cognitive impairment or dementia. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, documentation of diagnosis and 1 of the following are required (1-2): 1) reduction amyloid beta plaque levels from baseline confirmed by PET imaging, or 2) attestation of slowed decline in cognition. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Leqembi Iqlik Initiation

## Products Affected

- **LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 500 MG/2.5 ML ( 250MG/1.25MLX2)**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Alzheimer's disease, classified as mild cognitive impairment or mild dementia prior to therapy initiation, and all of the following (1-4): 1) confirmed prescence of amyloid beta pathology, 2) obtained a baseline brain MRI prior to treatment, 3) will obtain a brain MRI after 1, 2, 3 and 6 months of treatment, 4) prescriber has ruled out other possible causes of cognitive impairment or dementia. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | Pending CMS Review |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Leqselvi

## Products Affected

- **LEQSELVI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For severe alopecia areata, therapeutic failure/intolerance to an intralesional corticosteroid or high potency topical corticosteroid, or contraindication to all. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Lerochol

## Products Affected

- **LEROCHOL**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Concomitant use with another PCSK9 inhibitor or siRNA directed to PCSK9. |
| **Required Medical Information** | 1. HeFH supported by 1 of the following (a-d): a) causal mutation of FH by genetic testing, b) untreated LDL-C at least 190mg/dL with physical signs of FH (e.g. xanthomas, xanthelasma), c) untreated LDL-C at least 160mg/dL before 20 yrs old with physical signs of FH (e.g. xanthomas, xanthelasma), d) diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria w/score over 8 points, definite on Simon Broome register, or definite on the Make Early Diagnosis to Prevent Early Deaths tool AND LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% decrease in baseline LDL-C, or if very high risk, LDL-C at least 55mg/dL or non-HDL-C at least 85mg/dL. 2. Hypercholesterolemia w/ASCVD AND LDL-C at least 55mg/dL or non-HDL-C at least 85mg/dL or less than 50% decrease in baseline LDL-C. 3. Primary Hyperlipidemia/Hypercholesterolemia (w/o ASCVD, HeFH, or HoFH) AND LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% decrease in baseline LDL-C. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |

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

# Leukine

## Products Affected

- **LEUKINE INJECTION RECON SOLN**

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

# Leukotriene Modifiers

## Products Affected

- *zileuton*

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

# Lidoderm

## Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*
- **LIDOCAN III**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of postherpetic neuralgia (PHN) or diabetic peripheral neuropathy (DPN) -AND- One of the following (1-3): 1) trial and failure of 1 other agent used to treat diagnosis (e.g. gabapentin for PHN, duloxetine for DPN), 2) inability to swallow oral medication, 3) unable to take an oral medication due to potential adverse events (e.g. sedation). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications, Some Medically-accepted Indications. |
| **Off Label Uses** | Diabetic peripheral neuropathy |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Lifyorli

## Products Affected

- **LIFYORLI ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 125 MG/DAY(100 MG X1-25MG X3), 125 MG/DAY(100 MG X1-25MG X9), 150 MG/DAY(100 MG X1-25MG X2), 150 MG/DAY(100 MG X1-25MG X3), 150 MG/DAY(100 MG X1-25MG X9)**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For epithelial ovarian, fallopian tube, or primary peritoneal cancer, all of the following (1-3): 1) disease is platinum-resistant, 2) member has received 1-3 prior systemic treatment regimens, at least 1 of which included bevacizumab, 3) using in combination with nab-paclitaxel. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Lipfendra

## Products Affected

- **LIPFENDRA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Concomitant use with another PCSK9 inhibitor or siRNA directed to PCSK9. |
| **Required Medical Information** | Pending CMS Review |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | Patients must have a trial/failure or contraindication to the preferred product Repatha. For reauthorization, documentation showing an LDL-C reduction on therapy from baseline must be provided. Therapeutic failure to a max tolerated statin or documented statin intolerance is required. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Litfulo

## Products Affected

- **LITFULO**

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

# Livdelzi

## Products Affected

- **LIVDELZI**

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

# Livmarli

## Products Affected

- **LIVMARLI ORAL SOLUTION 19 MG/ML, 9.5 MG/ML**
- **LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG, 30 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of Cholestatic Pruritus -AND- Documentation of one of the following diagnoses (1-2): 1) Alagille syndrome (AGLS) confirmed by genetic testing demonstrating a JAGGED1 or NOTCH2 deletion or mutation, 2) progressive familial intrahepatic cholestasis (PFIC) confirmed by genetic testing that is not PFIC type 2 with a ABCB11 variant resulting in nonfunctional or absent bile salt export pump (BSEP) protein -AND- Documentation that the member does not have any of the following diagnoses (3-5): 3) decompensated cirrhosis, 4) portal hypertension, 5) history of a hepatic decompensation event. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial, 12 months reauthorization |
| **Other Criteria** | Livmarli 19mg/mL oral solution will not be approved for ALGS. Livmarli 9.5 mg/mL oral solution will not be approved for PFIC. For reauthorization, attestation of improvement in pruritus -AND- attestation that the member has not progressed to any of the following (1-3): 1) portal hypertension, 2) cirrhosis, or 3) experienced a hepatic decompensation event. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | No |

# Livtencity

## Products Affected

- **LIVTENCITY**

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

# Loargys

## Products Affected

- **LOARGYS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Arginase 1 Deficiency (ARG1-D) -AND- Used in conjunction with dietary protein restriction -AND- Diagnosis is confirmed by 1 of the following (1-3): 1) genetic testing, 2) newborn screening, or 3) elevated arginine levels in plasma. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Lodoco

## Products Affected

- **LODOCO**

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Lokelma

## Products Affected

- **LOKELMA**

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

# Lonsurf

## Products Affected

- **LONSURF**

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

# Lorbrena

## Products Affected

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

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

# Lotronex

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | For irritable bowel syndrome (IBS): Exclude if male gender |
| **Required Medical Information** | Documentation of chronic severe diarrhea-predominant IBS -AND- trial and failure or intolerance to one anti-diarrheal (e.g. loperamide), anti-spasmodic, or tricyclic antidepressant, or contraindication to all |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 weeks initial authorization, 12 months reauthorization |
| **Other Criteria** | For brand Lotronex, initial authorization requires intolerance to generic alosetron and reauthorization requires intolerance to generic alosetron if not previously trialed. For reauthorization, attestation that symptoms of IBS continue to persist AND positive clinical response. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Lovaza

## Products Affected

- **LOVAZA**

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

# Lumakras

## Products Affected

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

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

# Lumryz

## Products Affected

- **LUMRYZ**
- **LUMRYZ STARTER PACK**

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Lupkynis

## Products Affected

- **LUPKYNIS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of active lupus nephritis (LN) -AND- One of the following (1 or 2): 1) Diagnosis confirmed by renal biopsy, 2) Contraindication to renal biopsy, laboratory findings specific to LN (e.g., elevated serum creatinine, abnormal urine analysis, decreased eGFR) -AND- Member will continue to receive concomitant standard of care treatment with corticosteroids (e.g. prednisone) and mycophenolic acid analog (e.g. mycophenolate mofetil). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 24 weeks initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of disease stability or disease improvement -AND- Member will continue to receive concomitant standard of care treatment with corticosteroids (e.g. prednisone) and one of the following (1 or 2): 1) mycophenolic acid analog (e.g. mycophenolate mofetil), 2) azathioprine. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Lupron Depot Ped

## Products Affected

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

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

# Lybalvi

## Products Affected

- **LYBALVI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of schizophrenia or bipolar I disorder -AND- One of the following (1 or 2): 1) Therapeutic failure, intolerance or contraindication to generic risperidone and generic quetiapine, 2) Currently stable and responding to olanzapine but experiencing weight gain from the medication. If using for maintenance monotherapy treatment of bipolar 1 disorder, only criterion 2 is required. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Lynparza

## Products Affected

- **LYNPARZA**

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

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

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

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

# Lyrica CR

## Products Affected

- **LYRICA CR**
- *pregabalin oral tablet extended release 24 hr*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. When using pregabalin products concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Intolerance to generic pregabalin IR is required. For brand Lyrica CR, intolerance to generic pregabalin ER is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Lytgobi

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- all of the following (1-2): 1) disease harbors FGFR2 fusions or other rearrangements 2) member has experienced therapeutic failure or intolerance to at least one prior therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Mavenclad

## Products Affected

- *cladribine(multiple sclerosis) oral tablet 10 mg (10 pack), 10 mg (4 pack), 10 mg (5 pack), 10 mg (6 pack), 10 mg (7 pack), 10 mg (8 pack), 10 mg (9 pack)*
- **MAVENCLAD (10 TABLET PACK)**
- **MAVENCLAD (4 TABLET PACK)**
- **MAVENCLAD (5 TABLET PACK)**
- **MAVENCLAD (6 TABLET PACK)**
- **MAVENCLAD (7 TABLET PACK)**
- **MAVENCLAD (8 TABLET PACK)**
- **MAVENCLAD (9 TABLET PACK)**

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

# Mavyret

## Products Affected

- **MAVYRET ORAL PELLETS IN PACKET**
- **MAVYRET ORAL TABLET**

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

# Mayzent

## Products Affected

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

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

# Megace

## Products Affected

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

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

# Mekinist

## Products Affected

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

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Mektovi

## Products Affected

- **MEKTOVI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For unresectable or metastatic melanoma, all of the following (1-2): 1) BRAF V600E or V600K mutation status, as detected by an FDA-authorized test 2) using in combination with encorafenib. For metastatic non-small cell lung cancer, all of the following (1-2): 1) BRAF V600E mutation status, as detected by an FDA-authorized test 2) using in combination with encorafenib. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Mesalamine Active

## Products Affected

- **CANASA**
- *mesalamine oral tablet,delayed release (dr/ec) 800 mg*
- *mesalamine rectal suppository*
- **ROWASA RECTAL ENEMA KIT**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Ulcerative Colitis (UC) -AND- Intolerance to 1 of the following (1-4): 1) generic Mesalamine 4 g/60 mL enema, 2) generic Mesalamine 400 mg DR capsule, 3) generic Mesalamine 1.2 g DR tablet, 4) Pentasa 250 mg capsule |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 weeks initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of disease stability or beneficial response to therapy -AND- additional courses for UC treatment are necessary. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Mesalamine Remission

## Products Affected

- **APRISO**
- **LIALDA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Ulcerative Colitis (UC) -AND- Intolerance to 1 of the following (1-4): 1) generic Mesalamine 4 g/60 mL enema, 2) generic Mesalamine 400 mg DR capsule, 3) generic Mesalamine 1.2 g DR tablet, 4) Pentasa 250 mg capsule |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of disease stability or beneficial response to therapy -AND- additional courses for UC treatment are necessary. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Methamphetamine

## Products Affected

- *methamphetamine*

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

# Metronidazole

## Products Affected

- *metronidazole oral tablet 125 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- intolerance to either generic metronidazole 250mg tablet or generic metronidazole 500mg tablet. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months |
| **Other Criteria** | For reauthorization, the following attestations are required (1-2): 1) treatment is for a repeat episode of infection, 2) for recurrent trochomoniasis infection, first course of treatment completed at least 4 weeks prior to reauthorization. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Metyrosine

## Products Affected

- *metyrosine*

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

# Miplyffa

## Products Affected

- **MIPLYFFA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Concurrent use of Aqneursa (levacetylleucine) -AND- Miplyffa (arimoclomal) |
| **Required Medical Information** | Documentation of diagnosis -AND- neurological symptoms of Niemann-Pick Disease Type C (e.g., ataxia, dysarthria, dysphagia, cognitive impairment, seizures) -AND- concurrent use with miglustat. |
| **Age Restrictions** | Deny if less than 2 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of positive clinical response |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Modeyso

## Products Affected

- **MODEYSO**

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

# Motegrity

## Products Affected

- **MOTEGRITY**
- *prucalopride*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of chronic idiopathic constipation. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Therapeutic failure, contraindication or intolerance to Linzess and lubiprostone are required. For brand Motegrity, therapeutic failure or intolerance to generic prucalopride is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Motpoly XR

## Products Affected

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

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

# MTX Injection

## Products Affected

- **RASUVO (PF)**

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

# Mulpleta

## Products Affected

- **MULPLETA**

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

# Myalept

## Products Affected

- **MYALEPT**

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

# Myasthenia Gravis

## Products Affected

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

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

# Mycapssa

## Products Affected

- **MYCAPSSA**
- **PALSONIFY**

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

# Myfembree

## Products Affected

- **MYFEMBREE**

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Myqorzo

## Products Affected

- **MYQORZO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy -AND- Left ventricular ejection fraction of greater than or equal to 55% -AND- Valsalva left ventricular outflow tract peak gradient of greater than or equal to 50 mmHg at rest or after provocation -AND- Therapeutic failure or intolerance to one of the following (1 or 2) or contraindication to all: 1) Non-vasodilating beta blocker (e.g. metoprolol) 2) non-dihydropyridine calcium channel blocker (e.g. diltiazem) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, prescriber attestation of no NYHA class worsening or reduction in symptom class -OR- improvement or stabilization of baseline post-exercise left ventricular outflow tract (LVOT) peak gradients -OR- stabilization of baseline peak oxygen consumption |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Namzaric

## Products Affected

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

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

# Nayzilam

## Products Affected

- **NAYZILAM**

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

# Nemluvio

## Products Affected

- **NEMLUVIO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of prurigo nodularis -OR- Documentation of moderate to severe atopic dermatitis and one of the following (1-3): 1) trial and failure or intolerance to at least one topical corticosteroid or one topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus), 2) severe atopic dermatitis and the member is incapable of applying topical therapies due to the extent of body surface area involvement, or 3) severe atopic dermatitis and topical therapies are contraindicated due to severely damaged skin. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For prurigo nodularis, must follow recommended dosing guidelines based upon weight. For atopic dermatitis, must follow recommended dosing based on FDA approved dosing guidelines. For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For prurigo nodularis reauthorization, attestation of reduction in itch or number of nodules or lesions from baseline. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Nereus

## Products Affected

- **NEREUS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of prevention of vomiting induced by motion. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 month |
| **Other Criteria** | Therapeutic failure, contraindication, or intolerance to generic scopolamine patch and 1 generic first generation antihistamine (e.g., meclizine). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Nerlynx

## Products Affected

- **NERLYNX**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of early-stage, HER2-positive breast cancer -AND- meets all of the following: 1)member has received adjuvant trastuzumab-based therapy 2) member is using neratinib as a single agent. Documentation of advanced HER-2 positive, or metastatic HER2-positive breast cancer and meets all of the following 1) using neratinib in combination with capecitabine 2) member has received two or more prior anti-HER2 based regimens in the metastatic setting. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Nexavar

## Products Affected

- **NEXAVAR**
- *sorafenib*

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

# Nexletol

## Products Affected

- **NEXLETOL**
- **NEXLIZET**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | 1.HeFH supported by 1 of the following (a-d): a) causal mutation of FH by genetic testing, b) untreated LDL-C at least 190mg/dL w/physical signs of FH (e.g. xanthomas, xanthelasma), c) untreated LDL-C at least 160mg/dL before 20 yrs old w/physical signs of FH, d) diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria w/score over 8 points, definite on Simon Broome register, or definite on the Make Early Diagnosis to Prevent Early Deaths tool AND LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% decrease in baseline LDL-C, or if very high risk, LDL-C at least 55mg/dL or non-HDL-C at least 85mg/dL -AND- Attestation of combination use with other LDL-C lowering therapies or concomitant LDL-C lowering therapy is not possible. 2.ASCVD or attestation of high risk for CVD -AND- Therapeutic failure/intolerance/contraindication to ezetimibe. 3. Primary Hyperlipidemia/Hypercholesterolemia (w/o ASCVD or HeFH) AND LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% decrease in baseline LDL-C -AND- Attestation of combination use with other LDL-C lowering therapies or concomitant LDL-C lowering therapy is not possible. -AND- Therapeutic failure/intolerance/contraindication to ezetimibe. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |

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

# Nilotinib Tartrate

## Products Affected

- *nilotinib d-tartrate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For Ph+ CML, the member is an adult patient and meets one of the following (1-2): 1) the member's CML is in the chronic or accelerated phase or 2) the member is newly diagnosed in the chronic phase. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Documentation of intolerance to generic nilotinib hydrochloride is required. |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Ninlaro

## Products Affected

- **NINLARO**

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

# Nitisinone

## Products Affected

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

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

# Northera

## Products Affected

- *droxidopa oral capsule 100 mg, 200 mg, 300 mg*
- **NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of neurogenic orthostatic hypotension caused by primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency or non-diabetic autonomic neuropathy -AND- documentation of inadequate response, intolerance or contraindication to preferred generic alternative midodrine. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months |
| **Other Criteria** | For brand Northera, initial authorization requires documentation of trial and failure of generic droxidopa and reauthorization requires failure of generic droxidopa if not previously trialed. For reauthorization, attestation of increase from baseline of systolic or diastolic blood pressure upon standing -OR- attestation of decrease from baseline of neurogenic orthostatic hypotension symptoms upon standing (e.g., dizziness, feeling faint, etc.). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Nourianz

## Products Affected

- **NOURIANZ**

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

# Nubeqa

## Products Affected

- **NUBEQA**

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

# Nucala

## Products Affected

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Severe Asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of severe asthma exacerbation, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For EGPA reauthorization, attestation of one of the following is required (5-8): 5) reduction in frequency and/or severity of relapses, 6) reduction or discontinuation of corticosteroids and/or immunosuppressant, 7) disease remission, or 8) reduction in severity or frequency of EGPA-related symptoms. For HES reauthorization, attestation of one of the following is required (9-10): 9) reduction in frequency of HES flares, or 10) maintenance or reduction in background HES therapy requirements. For CRSwNP reauthorization, attestation of one of the following is required (11-12): 11) decrease in nasal polyp score, or 12) reduction in nasal congestion/obstruction severity score. For COPD reauthorization, attestation of one of the following is required (13-16): 13) reduction in COPD symptoms, 14) improvement in exercise tolerance, 15) delayed disease progression, or 16) reduction in the number of COPD exacerbations. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Nuedexta

## Products Affected

- *dextromethorphan-quinidine*
- **NUEDEXTA**

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

# Nuplazid

## Products Affected

- **NUPLAZID**

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

# Nurtec

## Products Affected

- **NURTEC ODT**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For Episodic Migraine Prevention, defined as 4-14 migraine days per month, the following criteria will apply (1-2). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). For acute treatment of migraine with or without aura, trial and failure of one generic triptan or all triptans are contraindicated. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization of episodic migraine prevention, attestation of reduction in migraine frequency. For reauthorization of acute treatment of migraine, attestation of reduction in migraine symptoms. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Nuvigil

## Products Affected

- *armodafinil*
- **NUVIGIL**

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

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

# Octreotide

## Products Affected

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

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

# Odactra

## Products Affected

- **ODACTRA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy |
| **Required Medical Information** | Documentation of allergic rhinitis due to house dust mites -AND- allergic rhinitis with or without conjunctivitis has been confirmed by skin testing for licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to D. pteronyssinus or D. Farina -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent |
| **Age Restrictions** | Deny if less than 5 years of age or greater than 65 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Member must also be prescribed an epinephrine auto injector. For reauthorization, attestation of improved allergy symptoms is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Odomzo

## Products Affected

- **ODOMZO**

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

# Ogsiveo

## Products Affected

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

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

# Ohtuvayre

## Products Affected

- **OHTUVAYRE**

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

# Ojemda

## Products Affected

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

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

# Ojjaara

## Products Affected

- **OJJAARA**

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

# Olpruva

## Products Affected

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

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

# Olumiant

## Products Affected

- **OLUMIANT**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Part A covered for Covid-19 in hospitalized patients |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severely active rheumatoid arthritis an inadequate response or intolerance to at least one non-biologic DMARD (e.g., methotrexate, leflunomide). For severe alopecia areata, inadequate response or intolerance to an intralesional corticosteroid or high potency topical corticosteroid, or contraindication to all. |
| **Age Restrictions** | Deny if less than 18 years of age for Rheumatoid Arthritis and Alopecia Areata |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq and Xeljanz/Xeljanz XR, with at least 1 being a tumor necrosis factor blocker. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Omvoh

## Products Affected

- **OMVOH PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML, 300MG/3ML(100MG /ML-200 MG/2ML)**
- **OMVOH SUBCUTANEOUS SYRINGE 200 MG/2 ML, 300MG/3ML(100MG /ML-200 MG/2ML)**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- attestation of receiving or currently undergoing 3 doses of IV Omvoh within 3 months of initiating therapy with Omvoh SC. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For moderate to severe ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For moderate to severe active Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, and Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Onapgo

## Products Affected

- **ONAPGO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of advanced Parkinson's disease -AND- being used to treat motor fluctuations -AND- experiencing motor fluctuations despite the use of oral carbidopa/levodopa -AND- Therapeutic failure, intolerance, or contraindication to one of the following generic products: pramipexole, ropinirole, entacapone, selegiline or rasagiline |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Onfi

## Products Affected

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

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

# Ongentys

## Products Affected

- **ONGENTYS**

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

# Ontralfy

## Products Affected

- **ONTRALFY**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of spasticity -AND- Inability to swallow tizanidine tablets and capsules. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months |
| **Other Criteria** | For reauthorization, both of the following are required (1, 2): 1) documentation of member experiencing a new episode of spasticity, 2) member still unable to swallow tizanidine tablets or capsules. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Onureg

## Products Affected

- **ONUREG**

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

# Onyda XR

## Products Affected

- **ONYDA XR**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of ADHD -AND- trial/failure, intolerance or contraindication to a stimulant |
| **Age Restrictions** | Deny if less than 6 years of age or greater than 17 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Inability to swallow tablets or capsules is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Ophthalmic Antihistamines

## Products Affected

- *bepotastine besilate*
- **BEPREVE**
- **ZERVIATE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of ocular itching associated with allergic conjunctivitis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Therapeutic failure, intolerance, or contraindication to generic azelastine ophthalmic drops is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Opioid Tapentadol

## Products Affected

- *tapentadol oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months |
| **Other Criteria** | |

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Opioid Tapentadol (LA)

## Products Affected

- *tapentadol oral tablet extended release 12 hr*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required. |
| **Age Restrictions** | |

| PA Criteria | Criteria Details |
|---|---|
| **Prescriber Restrictions** | |
| **Coverage Duration** | Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Opipza

## Products Affected

- **OPIPZA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- 1 of the following (1-2): 1) intolerance to generic aripiprazole tablets, 2) inability to swallow oral tablets. If medication is being used for major depressive disorder, documentation of adjunctive therapy and therapeutic failure, contraindication or intolerance to one other generic antidepressant in addition to the antidepressant currently being used for the treatment of MDD (e.g. SSRI, SNRI, NDRIs, TCA, MAOI). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Opzelura

## Products Affected

- **OPZELURA**

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Oral Rosacea

## Products Affected

- **EMROSI**
- **ORACEA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of rosacea with inflammatory lesions (papules and pustules) -AND- trial, contraindication or intolerance to metronidazole cream, lotion, or gel -AND- trial, contraindication or intolerance to generic doxycycline IR-DR 40 mg. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Orencia

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. |
| **Age Restrictions** | Deny if less than 18 years of age for Rheumatoid Arthritis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Psoriatic Arthritis |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients over 18 years of age must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq/Rinvoq LQ, and Xeljanx/Xeljanz solution. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Orgovyx

## Products Affected

- **ORGOVYX**

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

# Oriahnn

## Products Affected

- **ORIAHNN**

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

# Orilissa

## Products Affected

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

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

# Orkambi

## Products Affected

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

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

# Orladeyo

## Products Affected

- **ORLADEYO ORAL CAPSULE**

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

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

# Orserdu

## Products Affected

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

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

# Osphena

## Products Affected

- **OSPHENA**

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

# Otezla

## Products Affected

- **OTEZLA**
- **OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)**
- **OTEZLA XR**
- **OTEZLA XR INITIATION**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For plaque psoriasis, all of the following (1-2): 1) member is greater than or equal to 18 years of age with mild-to-severe disease -OR- if the member is greater than or equal to 6 years of age and less than 18 years, weight is greater than or equal to 20 kg for Otezla or 50 kg for Otelza XR, and member has moderate-to-severe disease -AND- 2) inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For oral ulcers associated with Behcet's Disease, inadequate response or intolerance to one systemic therapy for prevention of recurrent oral ulcers. For psoriatic arthritis, if the member is greater than or equal to 6 years of age and less than 18 years and weight is greater than or equal to 20 kg for Otezla or 50 kg for Otelza XR. |
| **Age Restrictions** | Deny if less than 6 years of age for plaque psoriasis or psoriatic arthritis. Deny if less than 18 years of age for Behcet's Disease. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Oxervate

## Products Affected

- **OXERVATE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Treatment duration greater than 8 weeks per eye |
| **Required Medical Information** | Documentation of diagnosis -AND- affected eye (e.g. right eye, both eyes). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 weeks |
| **Other Criteria** | Coverage beyond 8 weeks per eye will not be approved |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Ozempic Oral

## Products Affected

- **OZEMPIC ORAL**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Obesity or use for weight loss |
| **Required Medical Information** | Documentation of diabetes mellitus type 2 |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Palynziq

## Products Affected

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

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

# Panretin

## Products Affected

- **PANRETIN**

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

# Paroxetine Capsule

## Products Affected

- *paroxetine mesylate(menop.sym)*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- Attestation of counseling on risk-benefit profile and potential anticholinergic adverse effects |
| **Age Restrictions** | Automatic approval if less than 65 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Pemazyre

## Products Affected

- **PEMAZYRE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of unresectable locally advanced cholangiocarcinoma or metastatic cholangiocarcinoma -AND- all of the following (1-2): 1) disease harbors FGFR2 fusion or other rearrangement as detected by an FDA-approved test 2) member has experienced therapeutic failure or intolerance to at least on prior therapy. Documentation of relapsed or refractory myeloid/lymphoid neoplasms -AND- disease harbors an FGFR1 rearrangement. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Pen Needles

## Products Affected

- *pen needle, diabetic needle 29 gauge x 1/2"*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For non-preferred pen needle products, trial/failure or contraindication to preferred Embecta pen needles with NDC starting with 83017 is required. Embecta pen needles with NDC starting with 83017 will receive automatic approval. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Pentasa

## Products Affected

- *mesalamine oral capsule, extended release 500 mg*
- **PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Ulcerative Colitis (UC) -AND- Intolerance to 1 of the following (1-4): 1) generic Mesalamine 4 g/60 mL enema, 2) generic Mesalamine 400 mg DR capsule, 3) generic Mesalamine 1.2 g DR tablet, 4) Pentasa 250 mg capsule |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of disease stability or beneficial response to therapy -AND- additional courses for UC treatment are necessary. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Pheburane

## Products Affected

- **PHEBURANE**

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

# Phenoxybenzamine

## Products Affected

- *phenoxybenzamine*

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

# Phospholine Iodide

## Products Affected

- **PHOSPHOLINE IODIDE**

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

# Piqray

## Products Affected

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

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

# Pokonza

## Products Affected

- **POKONZA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of treatment or prophylaxis of hypokalemia -AND- Inability to swallow solid oral dosage forms -AND- For members 18 years of age and older, intolerance to potassium chloride oral tablets and potassium chloride oral capsules. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Pomalyst

## Products Affected

- *pomalidomide*
- **POMALYST**

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

# Ponvory

## Products Affected

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

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

# Posaconazole Powder Packet

## Products Affected

- **NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For aspergillus or candida infection prophylaxis, high risk of developing invasive Aspergillosis or Candidiasis infection due to being severely immunocompromised (e.g., hematopoietic stem cell transplant recipients with graft versus host disease, those with hematologic malignancies with prolonged neutropenia from chemotherapy) -AND- weight less than or equal to 40 kg. For invasive aspergillosis infection, trial/failure or contraindication to voriconazole -AND- inability to swallow tablets or capsules. |
| **Age Restrictions** | Deny if less than 2 years of age or greater than 17 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Posaconazole Suspension

## Products Affected

- *posaconazole oral*

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

# Posaconazole Tablet

## Products Affected

- *posaconazole oral*

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

# Praluent

## Products Affected

- **PRALUENT PEN**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Concomitant use with another PCSK9 inhibitor or siRNA directed to PCSK9. |
| **Required Medical Information** | 1.HoFH supported by 1 of the following (a-d): a) bi-allelic causal mutations of FH by genetic testing, b) LDL-C over 560mg/dL, c) LDL-C over 400mg/dL w/aortic valve disease or xanthomata at less than 20 yrs old, d) LDL-C over 400mg/dL and 1 or both parents w/clinically diagnosed FH, positive genetic testing for a known LDL-C-raising gene (e.g., LDLR, ApoB, PCSK9) defect, or autosomal-recessive FH AND current LDL-C over 115mg/dL (if 17yrs or younger) or over 70mg/dL (18yrs or older) or over 55mg/dL w/ASCVD or major ASCVD risk factors (18yrs or older). 2.HeFH supported by 1 of the following (a-d): a) causal mutation of FH by genetic testing, b) untreated LDL-C at least 190mg/dL or untreated LDL-C at least 160mg/dL before 20 yrs old, c) physical signs of FH (e.g. xanthomas, xanthelasma), d) diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria w/score over 8 points, definite on Simon Broome register, or definite on the Make Early Diagnosis to Prevent Early Deaths tool AND LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% decrease in baseline LDL-C, or if very high risk, LDL-C at least 55mg/dL or non-HDL-C at least 85mg/dL. 3.Hypercholesterolemia w/ASCVD or attestation of major CV risk AND LDL-C at least 55mg/dL or non-HDL-C at least 85mg/dL or Lp(a) at least 125nmol/L or, if ASCVD, less than 50% decrease in baseline LDL-C. 4.Primary Hyperlipidemia/Hypercholesterolemia (w/o ASCVD, HeFH, or HoFH) AND LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% decrease in baseline LDL-C. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |

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

# Preferred Adalimumab

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For uveitis, inadequate response or intolerance to 1 immunosuppressant or corticosteroid, or all are contraindicated. |
| **Age Restrictions** | Deny if less than 18 years of age for Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, and Ankylosing Spondylitis or less than 12 years of age for Hidradenitis Suppurative or Less than 6 years of age for Crohn's disease or Less than 5 years of age for Ulcerative Colitis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Uveitis |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis therapy without concomitant methotrexate, doses above plan quantity limit will be approved aligned with recommended weekly dosing regimen. For pediatric ulcerative colitis and hidradenitis suppurativa, doses above plan quantity limit will be approved to align with recommended dosing regimen. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit. These criteria are applicable to Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Preferred Ustekinumab

## Products Affected

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

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Prenatal Vitamins

## Products Affected

- **PRENATAL VITAMIN PLUS LOW IRON**

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

# 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*
- **AMBIEN**
- **AMBIEN CR**
- **ASCOMP WITH CODEINE**
- **ATIVAN ORAL TABLET 0.5 MG, 1 MG, 2 MG**
- **BELBUCA**
- *buprenorphine*
- *butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg*
- **BUTRANS**
- *chlordiazepoxide hcl*
- *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- *clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg*
- *codeine sulfate*
- *codeine-butalbital-asa-caff*
- **CONZIP**
- **DEMEROL (PF) INJECTION SYRINGE 25 MG/ML**
- **DEMEROL INJECTION**
- **DIAZEPAM INTENSOL**
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*
- *diazepam oral tablet*
- **DILAUDID ORAL LIQUID**
- **DILAUDID ORAL TABLET 2 MG, 4 MG, 8 MG**
- **EDLUAR**
- *estazolam*
- *eszopiclone*
- *fentanyl*
- *flurazepam*
- *hydrocodone bitartrate oral capsule, oral only, er 12hr*
- *hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr*
- *hydrocodone-acetaminophen oral solution 10-300 mg/15 ml, 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*
- *hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml*
- *hydromorphone oral liquid*
- *hydromorphone oral tablet 2 mg, 4 mg, 8 mg*
- *hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg*
- **HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG**
- **KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG**
- *levorphanol tartrate*
- **LORAZEPAM INTENSOL**
- *lorazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- **LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1 MG, 1.5 MG, 2 MG, 3 MG**
- **LUNESTA**
- *meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*
- *meperidine oral solution*
- *meperidine oral tablet 50 mg*
- *methadone oral solution 10 mg/5 ml, 5 mg/5 ml*
- *methadone oral tablet 10 mg, 5 mg*
- *morphine concentrate oral solution*
- *morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg*
- *morphine oral capsule,extend.release pellets 10 mg, 100 mg, 20 mg, 50 mg, 60 mg, 80 mg*
- *morphine oral solution 10 mg/5 ml (2 mg/ml), 20 mg/5 ml (4 mg/ml)*
- *morphine oral tablet*

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |

| PA Criteria | Criteria Details |
|---|---|
| **Required Medical Information** | For concomitant use of opiate agonist and substance abuse therapy, documentation of acute pain condition (eg, acute traumatic injury) in which treatment with other agents would cause insufficient pain control or treatment for terminal illness related pain. For concomitant use of an opiate agonist, benzodiazepine, and centrally acting skeletal muscle relaxant, trial/failure of at least 2 other skeletal muscle relaxants (eg, methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, attestations that non-opiate (eg, NSAIDs) and non-benzodiazepine therapies (eg, SSRI, SNRI) have been considered, and attestation of intent to monitor & address concomitant drug-drug interaction adverse events. For concomitant use of opiate agonist and other opiate potentiators (eg, gabapentinoids, sedative-hypnotics), attestation of intent to monitor & address concomitant drug-drug interaction adverse events. For long acting opioid medications, the following apply (1-3): 1)Severe pain requiring daily, around-the-clock, long-term opioid treatment. 2)Not opioid naive. 3)Attestations that non-opiate alternative therapies have been explored (eg, NSAIDs), controlled substance history was reviewed in the state Prescription Drug Monitoring Program (PDMP), counseling on potential adverse effects of opioid analgesics, including risk of misuse, abuse, addiction. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Opiate tx for pain+subs. abuse, approve opiate x 1mo. All other combos and dx approve x 12mo. |
| **Other Criteria** | Opiate agonists will receive automatic approval if no recent claims for a substance abuse therapy (e.g. buprenorphine-naloxone) OR a benzodiazepine with a centrally acting skeletal muscle relaxant (e.g., carisoprodol) OR a gabapentinoid OR a sedative-hypnotic. Benzodiazepines (e.g. triazolam, alprazolam) will receive automatic approval if no recent claims for an opiate agonist with a centrally acting skeletal muscle relaxant (e.g. carisoprodol). Sedative-hypnotics (e.g. zolpidem) will receive automatic approval if no recent claims for an opiate agonist. Infusible opiate agonists will be covered under Part B when administered via infusion pump. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Pretomanid

## Products Affected

- *pretomanid*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. Criteria will be applied consistent with the current ATS/CDC/ERS/IDSA Clinical Practice Guideline for the Treatment of Drug-Susceptible and Drug-Resistant Tuberculosis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of disease improvement -AND- member requires additional antimicrobial therapy. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Prevymis Oral Pellets

## Products Affected

- **PREVYMIS ORAL PELLETS IN PACKET**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. |
| **Age Restrictions** | Deny if less than 6 months of age with HSCT. Deny if less than 12 years of age with kidney transplant. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 7 months |
| **Other Criteria** | One of the following is required (1-2): 1) inability to swallow tablets, 2) unable to use Prevymis (letermovir) tablets due to body weight dosing limitations. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Procysbi

## Products Affected

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

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

# Prolia

## Products Affected

- **PROLIA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -And- For osteoporosis at high risk for fracture, meeting one of the following (1. thru 4.) 1) History of previous fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 (i.e. osteopenia) -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 40 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For osteoporosis and osteopenia, documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated -OR- very high risk for a fracture, defined by one of the following: fracture within past 12 months, fracture while on osteoporosis therapy, history of multiple fractures, fractures while on drugs causing skeletal harm, fall risk, history of injurious falls, T-score less than -3, FRAX 10 year major osteo fracture risk of greater than 30%, or FRAX 10 year hip fracture risk of greater than 4.5%. Covered under Part B for patients eligible for home health services when provider certifies that patient sustained bone fracture related to post-menopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug. |

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Provigil

## Products Affected

- *modafinil*
- **PROVIGIL**

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

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

# Pulmonary Arterial Hypertension

## Products Affected

- **ADCIRCA**
- **ADEMPAS**
- **ALYQ**
- *ambrisentan*
- *bosentan oral tablet*
- *bosentan oral tablet for suspension*
- **LETAIRIS**
- *macitentan*
- **OPSUMIT**
- **OPSYNVI**
- **ORENITRAM MONTH 1 TITRATION KT**
- **ORENITRAM MONTH 2 TITRATION KT**
- **ORENITRAM MONTH 3 TITRATION KT**
- **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG**
- **REVATIO ORAL TABLET**
- *sildenafil (pulm.hypertension) oral suspension for reconstitution*
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*
- **TADLIQ**
- **TRACLEER ORAL TABLET**
- **TRACLEER ORAL TABLET FOR SUSPENSION**
- **TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 32-64 MCG, 48 MCG, 48-64 MCG, 48-80 MCG, 64 MCG, 80 MCG**
- **YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis substantiated by results from right heart catheterization (RHC), defined as a mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than or equal to 3 Wood units -AND- WHO Group. For Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD), an exception to RHC will be allowed when the risk of RHC outweighs the benefit (e.g., risk of pneumothorax, fragile lung parenchyma) -AND- results of a non-invasive test demonstrate the diagnosis of PH-ILD. For bosentan and sildenafil (i.e. Revatio) in pediatric individuals, an exception to RHC will be allowed when the risk of RHC outweighs the benefit -AND- prescriber attests alternative studies have been completed (i.e. CT, MRI or specified test ruling out other causes of pulmonary hypertension). For Adempas, additional diagnosis of CTEPH as documented by right heart catheterization and V/Q scan substantiating mPAP greater than 20 mmHg at rest and PWP less than or equal to 15 mmHg and documented presence of occlusive thrombi within the pulmonary arteries will be approved. |

| PA Criteria | Criteria Details |
|---|---|
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Adcirca, intolerance to generic tadalafil or Alyq is required. For brand Letairis, intolerance to generic ambrisentan is required. For brand Revatio, intolerance to generic sildenafil is required. For brand Tracleer, intolerance to generic bosentan of the same dosage form is required. For brand Tadliq, intolerance to generic tadalafil or Alyq -OR- Inability to swallow tablets is required. For brand Opsumit, intolerance to generic macitentan is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Pulmozyme

## Products Affected

- **PULMOZYME**

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

# Purified Cortrophin Gel

## Products Affected

- **CORTROPHIN GEL**

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

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

# Pyrukynd

## Products Affected

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

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

# Qelbree

## Products Affected

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

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

# Qinlock

## Products Affected

- **QINLOCK**

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

# Quinine

## Products Affected

- *quinine sulfate*

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

# Qulipta

## Products Affected

- **QULIPTA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis of Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, of which 8 or more are migraine days. The following criteria will apply (1-2). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of reduction in migraine frequency |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Radicava ORS

## Products Affected

- **RADICAVA ORS STARTER KIT SUSP**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of amyotrophic lateral sclerosis (ALS) -AND- Therapeutic failure, intolerance, or contraindication to riluzole. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of experiencing stability or improvement of symptoms. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Ravicti

## Products Affected

- *glycerol phenylbutyrate*
- **RAVICTI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Urea cycle disorders due to N-acetylglutamate synthetase deficiency, Treatment of acute hyperammonemia in urea cycle disorders |
| **Required Medical Information** | Documentation of chronic management of a urea cycle disorders (UCDs) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Ravicti, intolerance to generic glycerol phenylbutyrate is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Relgaabi

## Products Affected

- *gabapentin oral capsule 200 mg*
- **RELGAABI ORAL CAPSULE 200 MG, 300 MG, 400 MG**

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

# Relistor

## Products Affected

- **RELISTOR ORAL**

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

# Relistor SC

## Products Affected

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

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

# Repatha

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Concomitant use with another PCSK9 inhibitor or siRNA directed to PCSK9. |
| **Required Medical Information** | 1.HoFH supported by 1 of the following (a-d): a) bi-allelic causal mutations of FH by genetic testing, b) LDL-C over 560mg/dL, c) LDL-C over 400mg/dL w/aortic valve disease or xanthomata at less than 20 yrs old, d) LDL-C over 400mg/dL and 1 or both parents w/clinically diagnosed FH, positive genetic testing for a known LDL-C-raising gene (e.g., LDLR, ApoB, PCSK9) defect, or autosomal-recessive FH AND current LDL-C over 115mg/dL (if 17yrs or younger) or over 70mg/dL (18yrs or older) or over 55mg/dL w/ASCVD or major ASCVD risk factors (18yrs or older). 2.HeFH supported by 1 of the following (a-d): a) causal mutation of FH by genetic testing, b) untreated LDL-C at least 190mg/dL or untreated LDL-C at least 160mg/dL before 20 yrs old, c) physical signs of FH (e.g. xanthomas, xanthelasma), d) diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria w/score over 8 points, definite on Simon Broome register, or definite on the Make Early Diagnosis to Prevent Early Deaths tool AND LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% decrease in baseline LDL-C, or if very high risk, LDL-C at least 55mg/dL or non-HDL-C at least 85mg/dL. 3.Hypercholesterolemia w/ASCVD or attestation of major CV risk AND LDL-C at least 55mg/dL or non-HDL-C at least 85mg/dL or Lp(a) at least 125nmol/L or, if ASCVD, less than 50% decrease in baseline LDL-C. 4.Primary Hyperlipidemia/Hypercholesterolemia (w/o ASCVD, HeFH, or HoFH) AND LDL-C at least 70mg/dL or non-HDL-C at least 100mg/dL or less than 50% decrease in baseline LDL-C. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For reauthorization associated with Major Cardiovascular Risk, attestation of need for continued Repatha therapy is required. For reauthorization associated with all other diagnoses, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. Therapeutic failure to a max tolerated statin or documented statin intolerance is required. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Retevmo

## Products Affected

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

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Revlimid

## Products Affected

- *lenalidomide*
- **REVLIMID**

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

# Revuforj

## Products Affected

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

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

# Rexulti

## Products Affected

- **REXULTI ORAL TABLET**

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

# Rezdiffra

## Products Affected

- **REZDIFFRA**

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Rezlidhia

## Products Affected

- **REZLIDHIA**

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

# Rezurock

## Products Affected

- **REZUROCK**

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

# Rhapsido

## Products Affected

- **RHAPSIDO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Chronic Spontaneous Urticaria (CSU) -AND- all of the following (1-4): 1) the member has experienced symptoms of CSU for at least 6 weeks, 2) prescriber has ruled out other potential causes of urticaria, 3) therapeutic failure, contraindication, or intolerance to 1 second-generation non-sedating H1 antihistamine at the maximum recommended dose (e.g. cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine), 4) the member will not be receiving Rhapsido in combination with Xolair or Dupixent. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | The member has experienced therapeutic failure, intolerance, or contraindication to Xolair and Dupixent. Reauthorization requiring reduction in itch severity, reduction in number or severity of hives, or reduction in number or severity of swelling episodes. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Riluzole

## Products Affected

- **TIGLUTIK**

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

# Rinvoq

## Products Affected

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For diagnoses in which tumor necrosis factor (TNF) blockers are also indicated (e.g., Rheumatoid Arthritis, Psoriatic Arthritis), the member has experienced therapeutic failure or intolerance to at least 1 TNF blocker. For ulcerative colitis or Crohns disease, the member has experienced therapeutic failure or intolerance to at least 1 systemic therapy if TNF blockers are not advisable. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Rinvoq LQ

## Products Affected

- **RINVOQ LQ**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or all non-biologic DMARDs are contraindicated or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. |
| **Age Restrictions** | For PsA, deny if 18 years of age or older |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | The member has experienced therapeutic failure or intolerance to at least 1 tumor necrosis factor (TNF) blocker. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Rivfloza

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of all of the following (1-4): 1) diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by one of the following (a or b): a) Genetic testing (i.e., AGXT gene mutation), b) Liver biopsy (i.e., absence or significantly reduced AGT activity), 2) relatively preserved kidney function (e.g., eGFR greater than or equal to 30 mL/min/1.73 m2), 3) at least two elevated urinary oxalate levels greater than 1.5 times the upper reference limit, and 4) The member has not received a liver transplant. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, continued preserved kidney function (e.g., eGFR greater than or equal to 30 mL/min/1.73 m2) -AND- reduction in urinary oxalate levels from baseline -AND- has not received a liver transplant. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Romvimza

## Products Affected

- **ROMVIMZA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of symptomatic tenosynovial giant cell tumor -AND- attestation that surgical resection may cause one of the following (1-2): 1) worsening functional limitation, 2) severe morbidity |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 24 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Rozlytrek

## Products Affected

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

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

# Rubraca

## Products Affected

- **RUBRACA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, all of the following (1-2): 1) Disease harbors a deleterious BRCA mutation (germline or somatic) 2) member is in complete or partial response to platinum-based chemotherapy. For metastatic castration-resistant prostate cancer, all of the following (1-3): 1) disease harbors a deleterious BRCA mutation (germline and/or somatic) 2) member has been treated with androgen receptor-directed therapy 3) member is concurrently receiving a gonadotropin-releasing hormone (GnRH) analog or member has had a bilateral orchiectomy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Ruconest

## Products Affected

- **RUCONEST**

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For 18 years of age or older, therapeutic failure, intolerance or contraindication to icatibant. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Rydapt

## Products Affected

- **RYDAPT**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Use as single agent induction therapy for AML |
| **Required Medical Information** | Documentation of diagnosis. For a new diagnosis of acute myeloid leukemia, member is using in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy regimens and member is FLT3 mutation positive as detected by an FDA-approved test. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Sabril

## Products Affected

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

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

# Safety Pen Needles

## Products Affected

- **ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For non-preferred safety pen needle products, trial/failure or contraindication to preferred Embecta safety pen needles with NDC starting with 83017 is required. Embecta safety pen needles with NDC starting with 83017 will receive automatic approval. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Samsca

## Products Affected

- **SAMSCA**
- *tolvaptan*

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

# Saphnelo

## Products Affected

- **SAPHNELO PEN**
- **SAPHNELO SUBCUTANEOUS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of active systemic lupus erythematosus (SLE) -AND- both of the following (1-2): 1) Documentation of positive anti-nuclear antibody (ANA) titer (greater than or equal to 1:80) or positive anti-double-stranded DNA antibody (anti-dsDNA) per the laboratory reference range (e.g., greater than or equal to 30IU/mL), 2) member will continue to receive concomitant standard of care treatment with use of at least one of the following (alone or in combination) (a-c): a) corticosteroids (e.g. prednisone), b) antimalarials (e.g. hydroxychloroquine), c) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of disease stability or disease improvement -AND- member will continue to receive standard of care therapy with corticosteroids, antimalarials, or immunosuppressives. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Saphris

## Products Affected

- *asenapine maleate*
- **SAPHRIS**

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

# Savella

## Products Affected

- *milnacipran oral tablet*
- **SAVELLA**

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

# Scemblix

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- one of the following (1-3): 1) the member is newly-diagnosed, 2) member has been previously treated for Ph+ CML in chronic phase, 3) disease is positive for the T3151 mutation. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Secuado

## Products Affected

- **SECUADO**

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

# Sephience

## Products Affected

- **SEPHIENCE ORAL POWDER IN PACKET 1,000 MG, 250 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of PKU -AND- documented baseline Phe level greater than 6 mg/dL -AND- clinical documentation of current weight -AND- sepiapterin dose does not exceed 60 mg/kg/day. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, initial therapy has resulted in decrease in phenylalanine levels from baseline or current phenylalanine levels within the range of 120-360 micromol/L -AND- clinical documentation of current weight is required -AND- sepiapterin dose does not exceed 60 mg/kg/day. For brand Sephience, therapeutic failure or intolerance to generic sapropterin dihydrochloride is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Sertraline Capsule

## Products Affected

- *sertraline oral capsule*

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

# Seysara

## Products Affected

- **SEYSARA**

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

# Siliq

## Products Affected

- **SILIQ**

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Simponi

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. Simponi 50mg: For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide) and Simponi will be used in combination with methotrexate. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). Diagnosis of psoriatic arthritis. Simponi 50mg and 100mg: Diagnosis of moderate to severe ulcerative colitis and if the member is less than 18 years of age, weight is greater than or equal to 15kg. |
| **Age Restrictions** | Deny if less than 18 years of age for rheumatoid arthritis, ankylosing spondylitis and psoriatic arthritis. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For ulcerative colitis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For ulcerative colitis patients 18 years of age and older must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For ulcerative colitis patients 5 years of age to less than 18 years of age must have therapeutic failure or intolerance to a preferred adalimumab product. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Sirturo

## Products Affected

- **SIRTURO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. Criteria will be applied consistent with the current ATS/CDC/ERS/IDSA Clinical Practice Guideline for the Treatment of Drug-Susceptible and Drug-Resistant Tuberculosis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of disease improvement -AND- member requires additional antimicrobial therapy. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Skyclarys

## Products Affected

- **SKYCLARYS**

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

# Skyrizi

## Products Affected

- **SKYRIZI SUBCUTANEOUS PEN INJECTOR**
- **SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML, 55 MG/0.37 ML**
- **SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For Crohns disease, attestation of receiving or currently undergoing IV administration of Skyrizi within 3 months of initiating therapy with Skyrizi SC. For moderate to severe ulcerative colitis, attestation of receiving or currently undergoing IV administration of Skyrizi within 3 months of initiating therapy with Skyrizi SC. |
| **Age Restrictions** | Deny if less than 18 years of age for Crohn's disease and ulcerative colitis. Deny if less than 6 years of age for plaque psoriasis and psoriatic arthritis. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Skytrofa

## Products Affected

- **SKYTROFA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For pediatric patients with Growth Hormone Deficiency and open epiphyses, all of the following are required when applicable to meet standard diagnostic criteria (1-3): 1) growth chart, 2) growth velocity, 3) response to stimulation test. For patients with Growth Hormone Deficiency and closed epiphyses, all of the following are required when applicable to meet standard diagnostic criteria (1-2): 1) member has not used growth hormone for at least 1 month, 2) deficient response to both of the following growth hormone stimulation test categories (A and B): A) Arginine (serum GH less than or equal to 4.1ng/mL) or Macimorelin (serum GH less than or equal to 2.8 ng/mL), B) Insulin (serum GH less than or equal to 5 ng/mL) or Glucagon (serum GH less than or equal to 3 ng/mL (if BMI less than or equal to 25) or less than or equal to 1 ng/mL (if BMI is greater than 25). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For pediatric patients, reauthorization requires open epiphyses. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
|---|---|
| **Prerequisite Therapy Required** | No |

# Sogroya

## Products Affected

- **SOGROYA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis, growth chart, member has open epiphyses, growth velocity, response to stimulation test, when applicable to meet standard diagnostic criteria. For patients with Growth Hormone Deficiency and closed epiphyses, all of the following are required when applicable to meet standard diagnostic criteria (1-2): 1) member has not used growth hormone for at least 1 month, 2) deficient response to both of the following growth hormone stimulation test categories (A and B): A) Arginine (serum GH less than or equal to 4.1ng/mL) or Macimorelin (serum GH less than or equal to 2.8 ng/mL), B) Insulin (serum GH less than or equal to 5 ng/mL) or Glucagon (serum GH less than or equal to 3 ng/mL (if BMI less than or equal to 25) or less than or equal to 1 ng/mL (if BMI is greater than 25). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For pediatric patients, reauthorization requires open epiphyses. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Sohonos

## Products Affected

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

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

# Solaraze

## Products Affected

- *diclofenac sodium topical gel 3 %*

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

# Somavert

## Products Affected

- **SOMAVERT**

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

# Sotyktu

## Products Affected

- **SOTYKTU**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. Documentation of moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For psoriasis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, and Skyrizi. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Sovaldi

## Products Affected

- **SOVALDI**

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

# Spevigo SC

## Products Affected

- **SPEVIGO SUBCUTANEOUS**

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

# Sprycel

## Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*
- **PHYRAGO ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG**
- **SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For Ph+ chronic myeloid leukemia, the member meets one of the following (1-3): 1) the member is a newly diagnosed adult in the chronic phase, 2) the member is a pediatric patient in the chronic phase, or 3) the member is in chronic, accelerated, or myeloid or lymphoid blast phase. For adults with Ph+ acute lymphocytic leukemia, member has had resistance or intolerance to prior therapy. For pediatric patients with Ph+ CML, the member is in the chronic phase. For pediatric patients with Ph+ acute lymphoblastic leukemia, the member is newly diagnosed and will be using in combination with chemotherapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brands Sprycel and Phyrago, intolerance to generic dasatinib is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Statin Liquid

## Products Affected

- **ATORVALIQ**
- **FLOLIPID**

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

# Steroidogenesis Inhibitors

## Products Affected

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

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

# Stivarga

## Products Affected

- **STIVARGA**

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

# Sucraid

## Products Affected

- **SUCRAID**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of congenital-sucrase-isomaltase deficiency (CSID) supported by one of the following (1, 2, or 3): 1) small bowel biopsy with disaccharidase assay showing absent or reduced sucrase activity, reduced or normal isomaltase activity, reduced maltase activity, and reduced or normal lactase activity. 2) genetic testing indicates a mutation in the sucrase-isomaltase gene. 3) sucrase deficiency evidenced by sucrose breath hydrogen test or carbon-sucrose breath test. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Sunosi

## Products Affected

- **SUNOSI**

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Sutent

## Products Affected

- *sunitinib malate*
- **SUTENT**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For gastrointestinal stromal tumor (GIST), the member has experienced therapeutic failure, intolerance, or contraindication to imatinib. For a high risk of recurrent renal cell carcinoma, member has had a nephrectomy and sunitinib is to be used as adjuvant treatment. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Sutent, documentation of trial and failure of generic sunitinib is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Symdeko

## Products Affected

- **SYMDEKO**

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

# Sympazan

## Products Affected

- **SYMPAZAN**

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

# Symproic

## Products Affected

- **SYMPROIC**

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

# Synarel

## Products Affected

- **SYNAREL**

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

# Tabrecta

## Products Affected

- **TABRECTA**

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

# Tafinlar

## Products Affected

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

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | No |

# Tagrisso

## Products Affected

- **TAGRISSO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of non-small cell lung cancer (NSCLC) and one of the following (1-5): 1) Adjuvant therapy after tumor resection -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test 2) Locally advanced disease -AND- using as first-line therapy -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test -AND- used in combination with pemetrexed and platinum-based chemotherapy, 3) Metastatic disease -AND- using as first-line therapy -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test -AND- used with or without combination therapy of pemetrexed and platinum-based chemotherapy, 4) Metastatic disease -AND- disease harbors EGFR T790M mutations, as detected by an FDA-approved test -AND- has progressed on or after EGFR TKI therapy, 5) Locally advanced, unresectable (stage III) disease -AND- disease has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy -AND- disease harbors EGFR exon 19 deletions or EGFR exon 21 L858R mutations, as detected by an FDA-approved test. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Takhzyro

## Products Affected

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

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

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

# Talicia

## Products Affected

- **TALICIA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of H. Pylori infection confirmed by invasive techniques (e.g. endoscopic) or non-invasive techniques (e.g. urea breath test, stool antigen) -AND- One of the following (1-2): 1) previous treatment using all the components of a first line therapy (e.g. Pylera and a proton pump inhibitor) failed to eradicate the H. Pylori infection, 2) allergy, intolerance, or contraindication to any component of Pylera. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 14 days |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Taltz

## Products Affected

- **TALTZ AUTOINJECTOR**
- **TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML, 40 MG/0.5 ML, 80 MG/ML**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs. |
| **Age Restrictions** | Deny if less than 18 years of age for Psoriatic Arthritis, Ankylosing Spondylitis and non-radiographic axial spondyloarthritis or less than 6 years of age for Plaque Psoriasis |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For plaque psoriasis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, and Skyrizi SC. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For non-radiographic axial spondyloarthritis patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cimzia, Rinvoq, Cosentyx. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Talzenna

## Products Affected

- **TALZENNA**

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

# Targretin

## Products Affected

- *bexarotene oral*
- **TARGRETIN ORAL**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of cutaneous manifestations of cutaneous T-cell lymphoma in patients who are refractory to at least one prior systemic therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Targretin, intolerance to generic bexarotene is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Targretin Gel

## Products Affected

- *bexarotene topical*
- **TARGRETIN TOPICAL**

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

# Tarpeyo

## Products Affected

- **TARPEYO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy -AND- At risk of disease progression as evidenced by proteinuria greater than or equal to 0.5 g/day -AND- One of the following (1 or 2): 1) Used in combination with an angiotensin-converting enzyme inhibitor (ACE-I), an angiotensin II receptor blocker (ARB), Filspari (sparsentan), or a sodium-glucose cotransporter-2 inhibitor (SGLT2i), or 2) Intolerance to at least one ACE-I and at least one ARB or contraindication all. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 10 months |
| **Other Criteria** | For reauthorizations, documentation of primary immunoglobulin A nephropathy (IgAN) -AND- member requires re-continuation of therapy with Tarpeyo -AND- One of the following (1 or 2): 1) Used in combination with ACE-I, ARB, Filspari (sparsentan), or SGLT2i, or 2) Intolerance to at least one ACE-I and at least one ARB or contraindication all. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Tascenso ODT

## Products Affected

- **TASCENSO ODT**

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

# Tasigna

## Products Affected

- *nilotinib hcl*
- **TASIGNA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For adult patients with Ph+ chronic myeloid leukemia (CML), member's CML is in the chronic or accelerated phase and the member is no longer responding to or is intolerant to imatinib -OR- member is newly diagnosed in the chronic phase. For pediatric patients, one of the following (1-2): 1) member has chronic phase or accelerated phase Ph+ CML and is is resistant or intolerant to prior tyrosine kinase inhibitor therapy 2) member is newly diagnosed with Ph+ CML in the chronic phase. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Tasigna, documentation of intolerance to generic nilotinib is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tasimelteon

## Products Affected

- *tasimelteon*

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

# Tavalisse

## Products Affected

- **TAVALISSE**

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

# Tavneos

## Products Affected

- **TAVNEOS**

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

# Tazarotene

## Products Affected

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

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

# Tazorac

## Products Affected

- *tazarotene topical cream*
- *tazarotene topical gel*
- **TAZORAC TOPICAL CREAM**
- **TAZORAC TOPICAL GEL**
- **TRILITAS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of 1 of the following (A or B). A) Documentation of plaque psoriasis -AND- trial and failure or intolerance to at least one topical corticosteroid (e.g. fluocinonide, mometasone, triamcinolone, betamethasone). B) Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two topical acne medications (e.g. adapalene, clindamycin, sulfacetamide, erythromycin) one of which must be generic topical tretinoin |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Tazorac cream, intolerance to generic tazarotene cream is required. For brand Tazorac gel, intolerance to generic tazarotene gel or Trilitas gel is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tecfidera

## Products Affected

- *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg* **CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG**
- **TECFIDERA ORAL**

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

# Tepmetko

## Products Affected

- **TEPMETKO**

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

# Testosterone (androgens)

## Products Affected

- **AVEED**
- **DEPO-TESTOSTERONE**
- **JATENZO ORAL CAPSULE 158 MG, 198 MG, 237 MG**
- **KYZATREX ORAL CAPSULE 150 MG, 200 MG**
- **TESTIM**
- *testosterone cypionate*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet*
- *testosterone transdermal solution in metered pump w/app*
- **TLANDO**
- **VOGELXO TRANSDERMAL GEL**
- **VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP**
- **XYOSTED**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of primary or secondary hypogonadism in males -OR- documentation of chronic steroid treatment in men. In all previously noted indications, members must also have documented low total testosterone level below the normal range for the laboratory -OR- a total testosterone level near the lower limit of the normal range with a low free testosterone level which is less than normal based upon the laboratory reference range -OR- the member is not producing any testosterone. Additional approvable indications include female patients with metastatic breast cancer (testosterone enanthate only), primary or secondary hypogonadism in males with testicular failure due to double orchidectomy, and delayed puberty in males (testosterone enanthate only). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications, Some Medically-accepted Indications. |
| **Off Label Uses** | Gender Dysphoria, Gender Identity Disorder |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | No |

# Tezspire

## Products Affected

- **TEZSPIRE SUBCUTANEOUS PEN INJECTOR**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of severe asthma AND all of the following (1-3): 1) one of the following (a. or b.): a) history of at least two asthma exacerbations requiring oral or injectable corticosteroid treatment in the past 12 months, b) history of at least one asthma exacerbation requiring hospitalization in the past 12 months, 2) inadequate symptom control despite regular treatment with medium or high dose inhaled corticosteroid (ICS) and at least one additional asthma controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline) with or without oral corticosteroids (OCS), 3) member will continue treatment with medium or high dose ICS and at least one additional asthma controller medication, with or without OCS. Diagnosis of chronic rhinosinusitis with nasal polyposis (CRwNP) and therapeutic failure, contraindication, or intolerance to 1 generic intra-nasal corticosteroid. |
| **Age Restrictions** | Deny if less than 12 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For asthma, therapeutic failure, intolerance, or contraindication to 1 of the following: Cinqair, Dupixent, Fasenra, Nucala, or Xolair. For CRwNP, therapeutic failure, intolerance, or contraindication to 1 of the following: Dupixent, Nucala, or Xolair. For asthma reauthorization, attestation of 1 of the following (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of severe asthma exacerbations, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For CRwNP reauthorization, 1 of the following (5-6): 5) decrease in nasal polyp score, or 6) reduction in nasal congestion/obstruction severity score. |

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Thalomid

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Use as monotherapy for ENL treatment in the presence of moderate to severe neuritis |
| **Required Medical Information** | Documentation of multiple myeloma in combination with dexamethasone -OR- documentation for use in the treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) -OR- documentation of therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Thiola

## Products Affected

- **THIOLA**
- **THIOLA EC**
- *tiopronin*
- **VENXXIVA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- Confirmation of cystinuria by at least one 24-hour urine collection with measurement of urinary cysteine levels greater than 400 mg/day -AND- Attestation of failure of urine alkalization with potassium citrate (to achieve pH of 7.0). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For brand Thiola, brand Thiola EC, or Venxxiva, intolerance to generic tiopronin. For reauthorization, attestation of urine cystine concentration decreased from baseline -OR- decrease in production of cystine stones is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Thrombopoiesis Stimulating Agents

## Products Affected

- **ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG**
- *eltrombopag olamine oral powder in packet 12.5 mg, 25 mg*
- *eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg*
- **PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG**
- **PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis of persistent or chronic immune idiopathic thrombocytopenia purpura and trial and failure of corticosteroid or immunoglobulin therapy or splenectomy -OR- documentation of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy -OR- severe aplastic anemia who have had an insufficient response to immunosuppressive therapy -OR- For eltrombopag olamine only, documentation of first line treatment for severe aplastic anemia and used in combination with at least two immunosuppressive therapies. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Platelet count to be provided. For Alvaiz (eltrombopag choline), therapeutic failure, contraindication, or intolerance to Promacta (eltrombopag olamine) is required. For brand Promacta, intolerance to generic eltrombopag olamine is required. |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tibsovo

## Products Affected

- **TIBSOVO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- disease is IDH1 mutation positive as detected by an FDA-approved test. For newly-diagnosed acute myeloid leukemia, member is using as monotherapy or in combination with azacitidine -AND- member meets one of the following (1-5): 1) age is greater than or equal to 75 years of age 2) severe cardiac or pulmonary comorbidity 3) reduced renal function 4) hepatic impairment 5) or prescriber attestation that member is not a candidate for intensive induction therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Tigan

## Products Affected

- *trimethobenzamide oral*

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

# Tizanidine

## Products Affected

- *tizanidine oral capsule 8 mg*
- **ZANAFLEX ORAL CAPSULE 8 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of spasticity -AND- Intolerance to generic tizanidine tablets (2mg or 4mg) -AND- Intolerance to generic tizanidine capsules (2mg, 4mg, or 6mg) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months |
| **Other Criteria** | For reauthorization, documentation of member experiencing a new episode of spasticity is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tocilizumab

## Products Affected

- **ACTEMRA ACTPEN**
- **ACTEMRA SUBCUTANEOUS**
- **AVTOZMA AUTOINJECTOR**
- **AVTOZMA SUBCUTANEOUS**
- **TYENNE AUTOINJECTOR**
- **TYENNE SUBCUTANEOUS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Part A covered for Covid-19 in hospitalized patients |
| **Required Medical Information** | Documentation of diagnosis. For rheumatoid arthritis, patients must have an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide). For polyarticular juvenile idiopathic arthritis, patients must have an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For systemic sclerosis-associated interstitial lung disease (SSc-ILD), patients must have therapeutic failure or intolerance to one immunosuppressant (e.g., mycophenolate mofetil, corticosteroids, cyclophosphamide). Documentation of systemic juvenile idiopathic arthritis. |
| **Age Restrictions** | Deny if less than 18 years of age for systemic sclerosis-associated interstitial lung disease (SSc-ILD), Rheumatoid Arthritis, and Giant Cell Arteritis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Systemic Juvenile Idiopathic Arthritis |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq and Xeljanz/Xeljanz XR. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq/Rinvoq LQ, and Xeljanz/Xeljanz solution. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. |

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tolsura

## Products Affected

- **TOLSURA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- Unable to tolerate generic itraconazole capsules |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation the member is still unable to tolerate generic itraconazole capsules |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Tonmya

## Products Affected

- **TONMYA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | For diagnosis of fibromyalgia, all of the following are required (1-3): 1) Attestation of widespread bilateral pain above and below the waist for more than 3 months duration, 2) Attestation of presence of fibromyalgia-related symptoms (e.g., cognitive impairment, fatigue, sleep disturbance, neurologic symptoms, exercise intolerance). 3) therapeutic failure, contraindication, or intolerance to duloxetine and pregabalin. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Topical Lidocaine

## Products Affected

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

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

# Torpenz

## Products Affected

- **TORPENZ**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of advanced, hormone receptor-positive, HER2-negative breast cancer -AND- member is a postmenopausal woman -AND- member is using Torpenz in combination with exemestane -AND- member has experienced therapeutic failure or intolerance to prior treatment with letrozole or anastrozole. Documentation of renal angiomyolipoma and tuberous sclerosis complex (TSC) -AND- the member does not require immediate surgery. Documentation of TSC with subependymal giant cell astrocytoma -AND- the member is not a candidate for curative surgical resection. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Torpenz, documentation of failure on generic everolimus tablets is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tremfya

## Products Affected

- **TREMFYA ONE-PRESS**
- **TREMFYA PEN INDUCTION PK(2PEN)**
- **TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML**
- **TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML, 200 MG/2 ML**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy -AND- if the member is 6 years of age to less than 18 years, weight is greater than or equal to 40 kg. For psoriatic arthritis, if the member is 6 years of age to less than 18 years, weight is greater than or equal to 40 kg. For moderate to severe ulcerative colitis or moderate to severe Crohn's disease, attestation of receiving or currently undergoing 3 doses of IV Tremfya within 3 to 4 months of initiating maintenance therapy with Tremfya SC or Tremfya SC is used for induction dosing. |
| **Age Restrictions** | Deny if less than 18 years of age for Ulcerative colitis and Crohn's disease. Deny if less than 6 years of age for psoriatic arthritis and plaque psoriasis. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For psoriasis, patients must have therapeutic failure or intolerance to 2 preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, and Skyrizi SC. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For ulcerative colitis (UC), patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For moderate to severe active Crohn's disease (CD), patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, and Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tretinoin

## Products Affected

- *adapalene topical cream*
- *adapalene topical gel 0.3 %*
- *adapalene topical swab*
- *adapalene-benzoyl peroxide*
- **AKLIEF**
- **ALTRENO**
- **ATRALIN**
- **CABTREO**
- *clindamycin-tretinoin*
- **DIFFERIN TOPICAL GEL WITH PUMP**
- **EPIDUO FORTE**
- **RETIN-A**
- **RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %**
- *tretinoin*
- *tretinoin microspheres topical gel*
- *tretinoin microspheres topical gel with pump 0.08 %*
- **TWYNEO**
- **WINLEVI**
- **ZIANA**

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

# Trientine

## Products Affected

- *trientine oral capsule 500 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of Wilson's Disease -AND- intolerant of penicillamine (e.g., generic penicillamine capsule or tablet). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Intolerance to generic trientine hydrochloride 250mg capsules is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Trikafta

## Products Affected

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

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

# Trintellix

## Products Affected

- **TRINTELLIX**

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

# Trulance

## Products Affected

- **TRULANCE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For chronic idiopathic constipation, therapeutic failure, contraindication or intolerance to Linzess and lubiprostone. For irritable bowel syndrome with constipation, therapeutic failure, contraindication or intolerance to Linzess -AND- if member is female, therapeutic failure, contraindication or intolerance to lubiprostone. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Truqap

## Products Affected

- **TRUQAP**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For locally advanced or metastatic breast cancer, all of the following (1-3): 1) HR mutation status, HER2 mutation status, and PIK3CA/AKT1/PTEN status as detected by an FDA-authorized test 2) concomitant therapy with fulvestrant 3) disease progression on at least one endocrine-based regimen in the metastatic setting -OR- recurrence on or within 12 months of completing adjuvant therapy. For metastatic prostate cancer, all of of the following (5-8): 5) disease is androgen pathway modulation-naive or -sensitive 6) disease is PTEN-deficient, as detected by an FDA-authorized test, 7) will be used in combination with abiraterone and prednisone, 8) concurrently receiving a gonadotropin-releasing hormone analog or has had bilateral orchiectomy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Trutakna

## Products Affected

- **TRUTAKNA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy -AND- At risk of rapid disease progression as evidenced by proteinuria greater than or equal to 0.5 g/day -AND- One of the following (1 or 2): 1) Used in combination with an angiotensin-converting enzyme inhibitor (ACE-I), an angiotensin receptor blocker (ARB), or a sodium-glucose cotransporter-2 inhibitor (SGLT2i), or 2) Contraindication or intolerance to a maximally tolerated dose of ACE-I, ARB, or SGLT2i. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, reduction in proteinuria from baseline is required -AND- Used in combination with, contraindication to, or intolerance to ACE-I, ARB, or SGLT2i. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tryngolza

## Products Affected

- **REDEMPLO**
- **TRYNGOLZA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of familial chylomicronemia syndrome (FCS) confirmed by the following A. or B. A) genetic test demonstrating biallelic pathogenic variants in at least one gene causing FCS (e.g., LPL, GPIHBP1, APOA5, APOC2, LMF1), or B) genetic test results are inconclusive and one of the following (1-5): 1) FCS score greater than or equal to 10, 2) NAFCS score greater than or equal to 45, 3) history of pancreatitis, 4) history of eruptive xanthomas, 5) history of lipemia retinalis -AND- fasting triglyceride level greater than or equal to 750 mg/dL, which do not respond to standard lipid-lowering therapy -AND- will be used in combination with diet. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, the member has experienced improvement in triglycerides from baseline. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tryvio

## Products Affected

- **TRYVIO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Resistant Hypertension -AND- Therapeutic failure, intolerance, or contraindication to maximally tolerated doses of all of the following (1-3): 1) thiazide diuretic, 2) ACE-I or ARB, 3) mineralocorticoid receptor antagonist. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of a reduction in blood pressure from baseline is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tukysa

## Products Affected

- **TUKYSA ORAL TABLET 150 MG, 50 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For advanced unresectable HER2-positive breast cancer or metastatic HER2-positive breast cancer, member will be using in combination with trastuzumab and capecitabine -AND- member has received one or more prior anti-HER2 based regimens in the metastatic setting. For RAS wild-type HER2-positive unresectable or metastatic colorectal cancer, member will be using in combination with trastuzumab -AND- member has experienced disease progression following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Turalio

## Products Affected

- **TURALIO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of symptomatic tenosynovial giant cell tumor associated with severe morbidity and functional limitations -AND- patient is not amenable to improvement with surgery or not a candidate for surgery |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 24 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Tykerb

## Products Affected

- *lapatinib*
- **TYKERB**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For advanced HER2-positive, or metastatic HER2-positive breast cancer, the member has received prior therapy with an anthracycline, a taxane, and trastuzumab -AND- will be using in combination with capecitabine. For HR+, metastatic breast cancer, the member is post-menopausal -AND- the member's cancer over expresses the HER2 receptor -AND- the member will be using lapatinib in combination with letrozole. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Tykerb, trial and failure of generic lapatinib is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Tymlos

## Products Affected

- **TYMLOS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Treatment duration greater than 24 months. |
| **Required Medical Information** | Documentation of diagnosis -AND- at high risk for fracture, meeting one of the following (1. thru 3.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 24 months |
| **Other Criteria** | Documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Additional documentation of trial/failure, intolerance or contraindication to preferred parathyroid hormone analog teriparatide. Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Tymlos will be limited to a coverage duration of 24 months. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Ubrelvy

## Products Affected

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

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

# Uloric

## Products Affected

- *febuxostat*
- **ULORIC**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of chronic management of hyperuricemia due to gout -And- trial/failure, intolerance or contraindication to allopurinol. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Uptravi

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization (RHC), defined as a mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than or equal to 3 Wood units -AND- WHO Group. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Trial and failure of Opsumit is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Ustekinumab

## Products Affected

- **IMULDOSA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **OTULFI SUBCUTANEOUS SOLUTION**
- **OTULFI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **PYZCHIVA AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 45 MG/0.5 ML, 90 MG/ML**
- **PYZCHIVA SUBCUTANEOUS SOLUTION**
- **PYZCHIVA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **SELARSDI SUBCUTANEOUS SOLUTION**
- **SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **STARJEMZA SUBCUTANEOUS SOLUTION**
- **STARJEMZA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **STELARA SUBCUTANEOUS SOLUTION**
- **STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- *ustekinumab subcutaneous solution*
- *ustekinumab subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml*
- *ustekinumab-aauz subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml*
- *ustekinumab-aekn subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml*
- *ustekinumab-ttwe subcutaneous solution*
- *ustekinumab-ttwe subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml*
- **WEZLANA SUBCUTANEOUS SOLUTION**
- **WEZLANA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- documentation of member weight and prescribed dose. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For Crohn's Disease or Ulcerative Colitis, attestation of receiving or currently undergoing a single induction dose of IV ustekinumab within 2 months of initiating therapy with ustekinumab SC. |
| **Age Restrictions** | Deny if less than 18 years of age for Ulcerative Colitis. Deny if less than 6 years of age for Plaque Psoriasis and Psoriatic Arthritis. Deny if less then 2 years of age for Crohn's Disease. |
| **Prescriber Restrictions** | |

| PA Criteria | Criteria Details |
|---|---|
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For ustekinumab products except Steqeyma and Yesintek, intolerance to both preferred ustekinumab products is required: Steqeyma with NDC starting with 72606 and Yesintek with NDC starting with 83257. Must follow recommended dosing guidelines based upon weight. Subcutaneous induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For pediatric Crohn's disease, doses above plan quantity limit will be approved to align with recommended dosing regimen. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Valchlor

## Products Affected

- **VALCHLOR**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received at least one prior skin-directed therapy (e.g. topical corticosteroids, topical chemotherapy, local radiation and topical retinoids). |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Valtoco

## Products Affected

- **VALTOCO**

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

# Vanflyta

## Products Affected

- **VANFLYTA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- disease is FLT3-ITD-positive as detected by an FDA-approved test -AND- one of the following (1-3): 1) member is receiving induction therapy and is using Vanflyta in combination with standard cytarabine and anthracycline induction therapy 2) member is receiving consolidation therapy and is using Vanflyta in combination with standard cytarabine consolidation therapy 3) member is receiving maintenance therapy and is using Vanflyta as monotherapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Vanrafia

## Products Affected

- **VANRAFIA**
- **VOYXACT**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy -AND- At risk of disease progression as evidenced by proteinuria greater than or equal to 0.5 g/day -AND- One of the following (1 or 2): 1) Used in combination with an angiotensin-converting enzyme inhibitor (ACE-I), an angiotensin II receptor blocker (ARB), or a sodium-glucose cotransporter-2 inhibitor (SGLT2i), or 2) Contraindication or intolerance to a maximally tolerated dose of ACE-I, ARB, or SGLT2i. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, reduction in proteinuria from baseline is required -AND- One of the following (1 or 2): 1) Used in combination with ACE-I, ARB, or SGLT2i, or 2) Contraindication or intolerance to ACE-I, ARB, or SGLT2i. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Velsipity

## Products Affected

- **VELSIPITY**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Veltassa

## Products Affected

- **VELTASSA ORAL POWDER IN PACKET 1 GRAM, 16.8 GRAM, 25.2 GRAM, 8.4 GRAM**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of hyperkalemia as defined by serum potassium level between 5.1 and 6.4 mmol/L on at least two (2) screenings -AND- Modification of medications to reduce serum potassium levels were not successful, when applicable. |
| **Age Restrictions** | Deny if less than 12 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of reduction in serum potassium levels following Veltassa administration and continued treatment for hyperkalemia is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Venbysi XR

## Products Affected

- *venlafaxine besylate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- venlafaxine extended-release product at a total daily dose greater than or equal to 75 mg has been received for greater than or equal to 4 days. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Venclexta

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For newly-diagnosed AML, member is using in combination with azacitidine, decitabine, or cytarabine -AND- age greater than or equal to 75 years or presence of at least one comorbidity that precludes use of intensive induction chemotherapy (i.e. severe cardiac or pulmonary comorbidity, reduced renal function, hepatic impairment, or physician attestation) is required. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Veozah

## Products Affected

- **LYNKUET**
- **VEOZAH**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documenation of moderate to severe vasomotor symptoms due to menopause -AND- one of the following (1 or 2): 1) therapeutic failure, contraindication, or intolerance to a generic hormone therapy product, or 2) attestation that hormone therapy is not clinically appropriate |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Verkazia

## Products Affected

- **VERKAZIA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- therapeutic failure or intolerance to 2 of the following medication classes or all are contraindicated: 1) generic ophthalmic antihistamines (e.g., olopatadine), 2) generic ophthalmic mast cell stabilizers (e.g., cromolyn sodium), 3) Generic ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Verquvo

## Products Affected

- **VERQUVO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of heart failure (NYHA Class II to IV) -AND- Left ventricular ejection fraction less than 45% -AND- Hospitalization for heart failure or received outpatient IV diuretics for heart failure -AND- Used in combination with a angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker or Entresto -AND- Used in combination with bisoprolol, carvedilol IR/ER or metoprolol succinate ER. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Verzenio

## Products Affected

- **VERZENIO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- disease is classified as HR-positive, HER2-negative. For early breast cancer that is at high risk of recurrence and is node-positive, all of the following (1-2): 1) used in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) 2) used as adjuvant treatment. For advanced or metastatic breast cancer, used as initial endocrine-based therapy and used in combination with an aromatase inhibitor -OR- used after documented disease progression following endocrine therapy and used in combination with fulvestrant -OR- used after documented disease progression and used following endocrine therapy and prior chemotherapy in the metastatic setting and will be used as monotherapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Viberzi

## Products Affected

- **VIBERZI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Severe (Child-Pugh C) hepatic impairment |
| **Required Medical Information** | Documentation of diarrhea predominant, irritable bowel syndrome (IBS-D) -AND- trial/failure or intolerance to one of the following medications for IBS-D or documentation of contraindication to all: antidiarrheal (e.g., loperamide), antispasmodic (e.g., dicyclomine, hyoscyamine), tricyclic antidepressant (e.g., amitriptyline, nortriptyline). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Vigafyde

## Products Affected

- **VIGAFYDE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of use as monotherapy in treatment of infantile spasms |
| **Age Restrictions** | Deny if less than 1 month old and greater than 2 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Intolerance to generic vigabatrin packets for oral solution is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Viibryd

## Products Affected

- **VIIBRYD ORAL TABLET**
- *vilazodone*

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

# Vijoice

## Products Affected

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

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

# Vimovo2

## Products Affected

- *naproxen-esomeprazole*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- all of the following: 1) Intolerance to naproxen used in combination with omeprazole. -AND- 2) Trial/failure of one additional generic formulary NSAID (other than naproxen) used in combination with another generic formulary PPI (other than omeprazole). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Vitrakvi

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation -AND- Tumors are metastatic or surgical resection is likely to result in severe morbidity -AND- There are no satisfactory alternative treatments or tumors have progressed following treatment. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Vivjoa

## Products Affected

- **VIVJOA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of recurrent vulvovaginal candidiasis defined as at least 3 episodes of vulvovaginal candidiasis in less than one year -AND Documentation the member is NOT of reproductive potential defined as postmenopausal or another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy) -AND- the member has experienced therapeutic failure, contraindication, or intolerance to a six-month maintenance course of oral fluconazole. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 14 weeks |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Vivlodex

## Products Affected

- *meloxicam submicronized*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- Intolerance to generic meloxicam tablets -AND- trial and failure or intolerance to one additional generic NSAID |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Vonjo

## Products Affected

- **VONJO**

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

# Voquezna

## Products Affected

- **VOQUEZNA ORAL TABLET 10 MG, 20 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For healing of erosive esophagitis (EE) and relief of heartburn associated with EE, therapeutic failure, contraindication, or intolerance to omeprazole and pantoprazole. For relief of heartburn associated with non-erosive gasteroesophageal reflux disease (GERD), therapeutic failure, contraindication, or intolerance to omeprazole and pantoprazole. For treatment of H. pylori infection, used in combination with amoxicillin -OR- amoxicillin and clarithromycin. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | H.pylori tx: 14days. EE Initial-8wks, Reauth-6mo. Non-erosive GERD Initial-4wks, Reauth-20wks |
| **Other Criteria** | For Erosive Esophagitis (EE) reauthorization, all of the following are required (1-3): 1) using for maintenance of EE healing and relief of heartburn associated with EE, 2) positive clinical response to an initial treatment course, 3) EE continues to require treatment for maintenance. For Non-erosive GERD reauthorization, all of the following are required (4-5): 4) non-erosive GERD requires additional therapy, 5) experienced symptom improvement or control during the initial 4-week treatment course. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Voquezna Combo Pak

## Products Affected

- **VOQUEZNA DUAL PAK**
- **VOQUEZNA TRIPLE PAK**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 14 days |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Voranigo

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- all of the following (1-3): 1) grade 2 astrocytoma or grade 2 oligodendroglioma, 2) disease harbors a susceptible isocitrate dehydrogenase (IDH)-1 or IDH-2 mutation, as detected by an FDA-approved test, 3) will be used following surgery including biopsy, sub-total resection, or gross total resection. |
| **Age Restrictions** | Deny if less than 12 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Voriconazole

## Products Affected

- **VFEND IV**
- *voriconazole intravenous recon soln*

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

# Vosevi

## Products Affected

- **VOSEVI**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member has a contraindication to or is otherwise not a candidate for one of the following regimens recommended by the AASLD/IDSA guidelines containing the following agents: sofosbuvir/velpatasvir (i.e. Epclusa authorized generic), Mavyret. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Criteria/duration applied consistent with current AASLD-IDSA guidance |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Votrient

## Products Affected

- *pazopanib oral tablet 200 mg*
- **VOTRIENT**

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

# Voxzogo

## Products Affected

- **VOXZOGO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of achondroplasia as evidenced by an FGFR3 gene mutation detected by genetic testing -AND- all of the following (1-2): 1) baseline annualized growth velocity (AGV), 2) attestation that the member's epiphyses have not closed. |
| **Age Restrictions** | Deny if greater than 17 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of increase in annualized growth velocity (AGV) from baseline and attestation that the member's epiphyses have not closed are required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Voydeya

## Products Affected

- **VOYDEYA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) -AND- all of the following (1-3): 1) clinically significant extravascular hemolysis supported by hemoglobin less than or equal to 9.5gm/dL or absolute reticulocyte count (ARC) greater than or equal to 120x10*9/L, 2) attestation of history of ravulizumab or eculizumab use for the treatment of PNH, 3) attestation of concomitant use with ravulizumab or eculizumab. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, continued concomitant use with ravulizumab or eculizumab -AND- attestation of positive clinical response defined as one of the following (1-5): 1) increased or stabilized hemoglobin levels, 2) reduction in transfusions, 3) improvement in hemolysis, 4) decrease in LDH levels, or 5) decreased reticulocyte levels. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Vraylar

## Products Affected

- **VRAYLAR**

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

# Vtama

## Products Affected

- **VTAMA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of all of the following (1-3). 1) Documentation of plaque psoriasis -AND- 2) trial and failure or intolerance to at least one generic, formulary medium, high, or ultrahigh potency topical corticosteroid (e.g. fluocinonide, triamcinolone, betamethasone) -OR- psoriasis on facial or intertriginous areas -AND- 3) trial and failure, contraindication, or intolerance to one generic, formulary vitamin D analog (e.g., calcipotriene, calcitriol) -OR- the member has psoriasis on the face -OR- Documentation of all of the following (4-6). 4) Atopic dermatitis, 5) trial and failure, intolerance, or contraindication to at least one generic formulary topical corticosteroid or documentation of facial or anogenital involvement, 6) trial and failure, intolerance, or contraindication to topical generic tacrolimus or topical generic pimecrolimus |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Vuity

## Products Affected

- *pilocarpine hcl ophthalmic (eye) drops 1.25 %*

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

# Vumerity

## Products Affected

- **VUMERITY**

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

# Vykat XR

## Products Affected

- **VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 25 MG, 75 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Prader-Willi Syndrome (PWS) confirmed by documentation of genetic analysis with identification of abnormal DNA methylation of chromosome 15q11.2-q13 -AND- Experiencing hyperphagia due to PWS diagnosis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of a decrease in hyperphagic and food-related behaviors is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Vyvgart Hytrulo

## Products Affected

- **VYVGART HYTRULO SUBCUTANEOUS SYRINGE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For generalized myasthenia gravis (gMG), therapeutic failure, contraindication, or intolerance to generic pyridostigmine. For chronic inflammatory demyelinating polyneuropathy (CIDP), 1 of the following (1-7): 1) motor distal latency prolongation in at least 2 nerves, 2) reduction of motor conduction velocity in at least 2 nerves, 3) prolongation of F-wave latency in at least 2 nerves, 4) absence of F-waves in at least 2 nerves, 5) motor conduction block in at least 1 nerve, 6) abnormal temporal dispersion in at least 2 nerves or, 7) distal CMAP duration prolongation in at least 1 nerve -AND- all of the following (8-12): 8) progressive symptoms occurring for at least 2 months, 9) progressive or relapsing motor sensory dysfunction of more than 1 limb or a peripheral nerve nature, developing over at least 2 months, 10) hypo- or areflexia, 11) nerve conduction studies strongly supportive of demyelination, 12) therapeutic failure or intolerance to 1 of the following or contraindication to all (a or b): a) systemic corticosteroids, b) an immune globulin (i.e., IVIG or subcutaneous immunoglobulin). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | gMG: 6 months initial, 12 months reauth. CIPD: 12 months |
| **Other Criteria** | For gMG reauthorization, improvement of gMG signs/symptoms (e.g., speech, swallowing, mobility, and/or respiratory function) -OR- decreased gMG exacerbations. For CIDP reauthorization, improvement of functional ability or strength from baseline. |
| **Indications** | All FDA-approved Indications. |

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Wainua

## Products Affected

- **WAINUA SUBCUTANEOUS AUTO-INJECTOR**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Concomitantly with transthyretin-lowering agents |
| **Required Medical Information** | Documentation of polyneuropathy associated with hereditary TTR (hATTR) amyloidosis with mutation in TTR gene confirmed by genetic testing -AND- Neurologic examination shows clinical signs and symptoms of the disease (e.g. peripheral/autonomic neuropathy, motor disability, carpel tunnel, etc.) -AND- Attestation of peripheral neuropathy impairment score (NIS) of 5 or greater |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For reauthorization, attestation of improvement of polyneuropathy from baseline. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Wakix

## Products Affected

- **WAKIX**

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Wayrilz

## Products Affected

- **WAYRILZ**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of persistent or chronic immune thrombocytopenia (ITP) -AND- Insufficient response to 1 of the following (1-3): 1) Corticosteroid therapy, 2) Immunoglobulin therapy, 3) Splenectomy -AND- One of the following (4-5): 4) Platelet count of less than or equal to 30x10*9/L, 5) Platelet count of less than or equal to 50x10*9/L and significant mucous membrane bleeding or a risk factor for bleeding (e.g. hypertension, peptic ulcer disease, vigorous lifestyle). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Reauthorization requires attestation of increase in platelet count. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Wegovy

## Products Affected

- **WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Treatment to reduce body weight and maintain weight reduction |
| **Required Medical Information** | Diagnosis of use in combination with reduced calorie diet and increased physical activity to reduce the risk of major adverse cardiovascular in adults with established cardiovascular disease and either obesity or overweight, and all of the following (1-4): 1) Baseline BMI is greater than or equal to 27 kg/m2, 2) If diagnosis of atherosclerotic cardiovascular disease, attestation of use as part of a plan to manage cardiovascular risk factors, 3) Attestation of use in combination with reduced calorie diet and increased physical activity, 4) Will not be used in combination with GLP1 RA or GLP1 RA combinations. Diagnosis of use in combination with reduced calorie diet and increased physical activity for the treatment of noncirrhotic metabolic dysfunction associated steatohepatitis (MASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults, and all of the following (5-8): 5) Diagnosis and fibrosis staging (F2 to F3) supported by either liver biopsy or non-invasive testing (NIT), 6) Attestation of use in conjunction with reduced calorie diet and increased physical activity, 7) Attestation that member does not have evidence of cirrhosis, or hepatic decompensation, 8) Will not be used in combination with GLP1 RA or GLP1 RA combinations. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For cardiovascular risk reduction reauthorization, attestation of continued use is required of Wegovy therapy in combination with reduced calorie diet and increased physical activity for reduction of major adverse cardiovascular event risk -AND- If diagnosis of atherosclerotic cardiovascular disease, attestation of use as part of a plan to manage cardiovascular risk factors -AND- one of the following (1-3): 1) use of the 1.7mg or 2.4mg weekly dose, 2) attestation of ongoing titration towards those doses, 3) attestation that the member cannot tolerate those doses. For MASH reauthorization, attestation of continued use in conjunction with diet and exercise -AND- member has not progressed to stage F4 fibrosis -AND- attestation that member does not have evidence of cirrhosis or hepatic decompensation. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Wegovy Oral

## Products Affected

- **WEGOVY ORAL**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Treatment to reduce body weight and maintain weight reduction |
| **Required Medical Information** | Diagnosis of use in combination with reduced calorie diet and increased physical activity to reduce the risk of major adverse cardiovascular in adults with established cardiovascular disease and either obesity or overweight, and all of the following (1-4): 1) Baseline BMI is greater than or equal to 27 kg/m2, 2) If diagnosis of atherosclerotic cardiovascular disease, attestation of use as part of a plan to manage cardiovascular risk factors, 3) Attestation of use in combination with reduced calorie diet and increased physical activity, 4) Will not be used in combination with GLP1 RA or GLP1 RA combinations. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For cardiovascular risk reduction reauthorization, attestation of continued use is required of Wegovy therapy in combination with reduced calorie diet and increased physical activity for reduction of major adverse cardiovascular event risk -AND- If diagnosis of atherosclerotic cardiovascular disease, attestation of use as part of a plan to manage cardiovascular risk factors -AND- one of the following (1-3): 1) use of the 1.7mg or 2.4mg weekly dose, 2) attestation of ongoing titration towards those doses, 3) attestation that the member cannot tolerate those doses. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | No |

# Welireg

## Products Affected

- **WELIREG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For von Hippel Lindau (VHL) syndrome, one of the following diagnoses not requiring immediate surgery (1, 2, or 3): 1) Renal cell carcinoma (RCC) 2) CNS hemangioblastoma 3) Pancreatic neuroendocrine tumor. For advanced RCC with a clear cell component, all of the following are required (4-6): 4) prior treatment with a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI), 5) prior treatment with a programmed death receptor-1 (PD-1) or a programmed death-ligand (PD-L1) inhibitor, 6) will be used as monotherapy. For RCC with a clear cell component, all of the following are required (7-8): 7) at intermediate-high or high risk of recurrence following nephrectomy -OR- has undergone nephrectomy and resection of metastatic lesions, 8) will be used as adjuvant treatment in combination with pembrolizumab or pembrolizumab berahyaluronidase alfa-pmph. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | No |

# Winrevair

## Products Affected

- **WINREVAIR**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization (RHC), defined as a mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than or equal to 3 Wood units -AND- WHO Group -AND- Concomitant use of at least one of the following (1-4): 1) generic endothelin-1 receptor antagonist, 2) phosphodiesterase type 5 inhibitor, 3) soluble guanylate cyclase stimulator, 4) generic prostacyclin agent -AND- Background therapy with PAH-specific therapies will be continued while being treated with Winrevair. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Xalkori

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For metastatic non-small cell lung cancer (NSCLC), disease is ALK-positive as detected by an FDA-approved test or ROS1-positive as detected by an FDA-approved test. For relapsed or refractory anaplastic large cell lymphoma (ALCL), disease is ALK-positive. For unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT), disease is ALK-positive. |
| **Age Restrictions** | Deny if less than 1 year of age or greater than 21 years of age for ALCL. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For crizotinib oral pellets and NSCLC, inability to swallow capsules is required. For crizotinib oral pellets and ALCL / IMT, inability to swallow oral capsules -OR- body surface area less than 1.34 m2 is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Xcopri

## Products Affected

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

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

# Xdemvy

## Products Affected

- **XDEMVY**

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

# Xeljanz

## Products Affected

- *tofacitinib oral tablet*
- *tofacitinib oral tablet extended release 24 hr*
- **XELJANZ ORAL TABLET**
- **XELJANZ XR**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For moderate to severe active rheumatoid arthritis, an inadequate response or intolerance to at least one non-biologic DMARD (e.g., leflunomide, methotrexate). For immediate release formulation for polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID). |
| **Age Restrictions** | Deny if less than 18 years of age for rheumatoid arthritis, ulcerative colitis, ankylosing spondylitis. For extended release, deny if less than 18 years of age for psoriatic arthritis. For immediate release, deny if less than 2 years of age for polyarticular juvenile idiopathic arthritis and psoriatic arthritis. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | The member has experienced inadequate response or intolerance to at least 1 tumor necrosis factor (TNF) blocker. For brand Xeljanz or Xeljanz XR, intolerance to generic tofacitinib is required. Doses greater than 10 mg per day (immediate release) and 11 mg per day (extended release) will not be approved for rheumatoid arthritis and psoriatic arthritis. Doses greater than 20mg per day (immediate release) and 22 mg per day (extended release) will not be approved for ulcerative colitis. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Xeljanz Solution

## Products Affected

- *tofacitinib oral solution*
- **XELJANZ ORAL SOLUTION**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. Documentation of polyarticular juvenile idiopathic arthritis -AND- Inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. |
| **Age Restrictions** | Deny if less than 2 years of age for polyarticular juvenile idiopathic arthritis and psoriatic arthritis. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | The member has experienced therapeutic failure or intolerance to at least 1 tumor necrosis factor (TNF) blocker. For brand Xeljanz, intolerance to generic tofacitinib is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Xenazine

## Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*
- **XENAZINE ORAL TABLET 12.5 MG, 25 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- attestation that the beneficiary is not actively suicidal |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Xenazine, trial and failure of generic tetrabenazine is required. In patients with comorbid depression, attestation of adequate treatment for depression is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Xermelo

## Products Affected

- **XERMELO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of carcinoid syndrome diarrhea AND used in combination with a somatostatin analog AND trial and failure of somatostatin analog monotherapy |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of reduction in average number of daily bowel movements -AND- the member will continue to use in combination with a somatostatin analog. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Xgeva

## Products Affected

- **XGEVA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For hypercalcemia of malignancy, refractory to bisphosphonates. For giant cell tumor of bone, unresectable or surgical resection is likely to result in severe morbidity -AND- one of the following (1. or 2.)- 1.) the member is 18 years old or older -OR- 2.) the member is a skeletally mature adolescent (e.g. has at least one mature long bone) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Xhance

## Products Affected

- **XHANCE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of chronic rhinosinusitis with nasal polyps or chronic rhinosinusitis without nasal polyps -AND- Therapeutic failure, intolerance or contraindication 1 corticosteroid nasal sprays. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Xifaxan

## Products Affected

- **XIFAXAN ORAL TABLET 550 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of 1 or 2. 1) Diagnosis of hepatic encephalopathy AND trial/failure, intolerance, or contraindication to lactulose. 2) Diagnosis of Irritable Bowel Syndrome with Diarrhea (IBS-D) AND trial/failure, intolerance to one of the following medications for IBS-D or documentation of contraindication to all: antidiarrheal (e.g., loperamide), antispasmodic (e.g., dicyclomine, hyoscyamine), tricyclic antidepressant (e.g., amitriptyline, nortriptyline). |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Hepatic encephalopathy: 1 year. IBS-D: 14 days. |
| **Other Criteria** | No more than three courses of rifaximin for the treatment of IBS-D will be approved per lifetime. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Xolair

## Products Affected

- **XOLAIR**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of the following (1-2): 1) Chronic Spontaneous Urticaria, 2) trial/failure or intolerance of a second-generation non-sedating H1 antihistamine at the maximum recommended doses (e.g. cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine). -OR- Documentation of the following (3-9): 3) moderate to severe persistent asthma, 4) a positive skin test or in vitro reactivity to a perennial aeroallergen, 5) Baseline IgE titer greater than or equal to 30 IU/mL, 6) documented pretreatment FEV1 less than 80% predicted in adults or less than 90% predicted in children and adolescents or FEV1 reversibility of at least 12% and 200mL after albuterol administration, 7) history of at least 2 asthma exacerbations requiring oral or injectable corticosteroid treatment in past 12mos or at least 1 asthma exacerbation requiring hospitalization in past 12mos, 8) inadequate symptom control despite regular treatment w/ medium- or high-dose inhaled corticosteroids (ICS) and at least 1 add'l asthma controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline) w/ or w/o OCS, unless intolerant or contraindicated to all, 9) will continue treatment with a medium- or high-dose ICS and at least 1 add'l asthma controller medication w/ or w/o OCS -OR- Documentation of the following (10-11): 10) chronic rhinosinusitis with nasal polyps (CRSwNP), 11) will use concomitantly with nasal corticosteroid maintenance treatment, -OR- Documentation of the following (12-17): 12) IgE mediated food allergy, 13) diagnosis confirmed by skin prick test or food-specific antibodies, 14) previous allergic reaction to food, 15) using for the reduction of allergic reactions (type 1), including anaphylaxis, 16) will be used in conjunction with food allergen avoidance, 17) member has a documented prescription for epinephrine. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |

| PA Criteria | Criteria Details |
|---|---|
| **Coverage Duration** | 12 months |
| **Other Criteria** | For asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of asthma exacerbations, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For CSU reauthorization, improved CSU symptoms. For CRSwNP reauthorization, attestation of decrease in nasal polyp score or reduction in nasal congestion/obstruction severity score. For IgE-mediated food allergy reauthorization, member requires continuation of therapy and will continue food allergen avoidance. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Xolremdi

## Products Affected

- **XOLREMDI**

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

# Xospata

## Products Affected

- **XOSPATA**

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

# Xpovio

## Products Affected

- **XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK)**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of use in combination with dexamethasone for relapse or refractory multiple myeloma with failure, intolerance or contraindication to 5 therapies (e.g. bortezomib, carfilzomib, lenalidomide, pomalidomide and daratumumab) -OR- Documentation of use in combination with both bortezomib and dexamethasone for multiple myeloma after receiving 1 prior multiple myeloma therapy -OR- Documentation of relapsing or refractory diffuse large B-cell lymphoma with failure, intolerance or contraindication to at least 2 lines of systemic therapy |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Xtandi

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For castration-resistant prostate cancer and metastatic castration sensitive-prostate cancer, the member is using in combination with a GnRH analog or the member has had a bilateral orchiectomy. For non-metastatic castration-sensitive prostate cancer, the member has biochemical recurrence at high risk for metastasis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Xyrem

## Products Affected

- *sodium oxybate*
- **XYREM**

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

| PA Criteria | Criteria Details |
| --- | --- |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Xywav

## Products Affected

- **XYWAV**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) - AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP -AND- Sensitivity to sodium intake due to heart failure, hypertension or impaired renal function. If the member has a diagnosis of cataplexy, provision of baseline number of cataplexy episodes is required. -OR- (II) Diagnosis of idiopathic hypersomnia - AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- documentation the member does not have cataplexy -AND- documentation of less than 2 SOREMPs -AND- documentation of the following (1, 2, or 3): 1) MSLT documenting MSL less than or equal to 8 minutes -OR- 2) polysomnography demonstrating total sleep time greater than or equal to 660 minutes per 24 hours -OR- 3) wrist actigraphy demonstrating total sleep time greater than or equal to 660 minutes per 24 hours. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | If 18 years or older and diagnosis of narcolepsy without cataplexy, trial and failure, intolerance, or contraindication to generic modafinil -AND- a generic CNS stimulant indicated for use in narcolepsy (e.g. methylphenidate, amphetamine salts) is required. For reauthorization, attestation supporting improvement in symptoms of narcolepsy, idiopathic hypersomnia and cataplexy (if applicable) is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Yonsa

## Products Affected

- **YONSA**

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

# Yorvipath

## Products Affected

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

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

# Yuviwel

## Products Affected

- **YUVIWEL SUBCUTANEOUS RECON SOLN 1.3 MG, 2.8 MG, 5.5 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of achondroplasia as evidenced by an FGFR3 gene mutation detected by genetic testing -AND- all of the following (1-2): 1) baseline annualized growth velocity (AGV), 2) attestation that the member's epiphyses have not closed. |
| **Age Restrictions** | Deny if greater than 17 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For reauthorization, attestation of increase in annualized growth velocity (AGV) from baseline and attestation that the member's epiphyses have not closed are required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Zavesca

## Products Affected

- *miglustat*
- **YARGESA**
- **ZAVESCA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of mild to moderate type 1 Gaucher disease confirmed by the following (A. or B.) A. (1, 2, 3, 4, or 5): 1)Hepatomegaly. 2)Splenomegaly. 3)Bone disease (i.e. osteonecrosis, osteopenia, secondary pathologic fractures, bone infarct). 4)Bone marrow complications as defined by anemia with hemoglobin less than or equal to 11.5 g/dL for females or 12.5 g/dL for males or thrombocytopenia with platelet count less than or equal to 120,000/mm*3. or 5)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). -OR- B. Attestation of deficiency in glucocerebrosidase activity in peripheral leukocytes or genetic testing confirms mutant alleles. -OR- Documentation of Niemann-Pick Disease Type C (NPC) and all of the following (6-8): 6) diagnosis is molecularly confirmed, 7) neurological symptoms of NPC (e.g., ataxia, dysarthria, dysphagia, cognitive impairment, seizures), 8) will be given in combination with arimoclomal. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Attestation enzyme replacement therapy (e.g. Cerezyme, Elelyso, or VPRIV) is not a therapeutic option. For brand Zavesca, intolerance to generic miglustat is required. |
| **Indications** | All FDA-approved Indications, Some Medically-accepted Indications. |
| **Off Label Uses** | Niemann-Pick Disease, type C |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Zavzpret

## Products Affected

- **ZAVZPRET**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of acute migraine headaches with or without aura -AND- Therapeutic failure, contraindication or intolerance to one generic triptan -AND- Inability to swallow capsules/tablets |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |
| **Other Criteria** | For reauthorization, attestation of reduction in migraine symptoms. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Zejula

## Products Affected

- **ZEJULA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis. For advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer, member is in complete or partial response to first-line platinum-based therapy -AND- disease is associated with homologous recombination deficiency-positive status, defined by at least one of the following (1 or 2): 1) a deleterious or suspected deleterious BRCA mutation or 2) genomic instability. For recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer, all of the following (1-2): 1) disease harbors a deleterious or suspected deleterious germline BRCA mutation 2) member is in a complete or partial response to platinum-based chemotherapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Zelboraf

## Products Affected

- **ZELBORAF**

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

# Zelsuvmi

## Products Affected

- **ZELSUVMI**

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

# Zenbexus

## Products Affected

- **ZENBEXUS**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of multiple myeloma -AND- combination use with daratumumab/hyaluronidase-fihj and dexamethasone -AND- received at least 1 prior line of therapy that included a proteasome inhibitor and an immunomodulatory agent. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Zepbound

## Products Affected

- **ZEPBOUND SUBCUTANEOUS PEN INJECTOR**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Treatment to reduce body weight and maintain weight reduction |
| **Required Medical Information** | Diagnosis of moderate to severe obstructive sleep apnea/hypopnea syndrome (OSAHS) -AND- Baseline polysomnography or recording time (without use of positive airway pressure (PAP) or oral appliance during testing) demonstrating an apnea/hypoapnea index (AHI) of greater than or equal to 15 events per hour -AND- A baseline AHI after optimization of guideline directed care -AND- Baseline BMI is greater than or equal to 30 kg/m2 -AND- Attestation of use in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity -AND- Attestation of use in combination with sleep hygiene modifications (e.g., sleep positioning to avoid a supine position, avoidance of alcohol and sedatives before bed) -AND- Will not be used in combination with GLP1 RA or GLP1 RA combinations |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For reauthorization, all of the following are required (1-9): 1) Diagnosis of moderate to severe obstructive sleep apnea/hypopnea syndrome (OSAHS) prior to initiation of Zepbound therapy, 2) Baseline polysomnography or recording time (without use of PAP or oral appliance during testing) prior to initiation of Zepbound therapy demonstrating an AHI of greater than or equal to 15 events per hour, 3) Attestation of a pre-Zepbound therapy baseline AHI from a polysomnography or recording time (without use of PAP or oral appliance during testing), 4) Attestation of decrease in baseline post-optimization of guideline directed care AHI after Zepbound initiation, 5) Attestation that additional Zepbound therapy is required to maintain the AHI decrease, 6) Attestation that baseline BMI was greater than or equal to 30 kg/m2 prior to initiation of Zepbound therapy, 7) Attestation of use in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity, 8) Attestation of use in combination with sleep hygiene modifications (e.g., sleep positioning to avoid a supine position, avoidance of alcohol and sedatives before bed), 9) the requested dose is 5mg, 10mg, 12.5mg, or 15mg once weekly, or attestation that the member is titrating to a dose of 5mg once weekly. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Zepbound Kwikpen

## Products Affected

- **ZEPBOUND KWIKPEN**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Treatment to reduce body weight and maintain weight reduction |
| **Required Medical Information** | Diagnosis of moderate to severe obstructive sleep apnea/hypopnea syndrome (OSAHS) -AND- Baseline polysomnography/recording time/home sleep apnea test (without use of positive airway pressure (PAP) or oral appliance during testing) demonstrating an apnea/hypoapnea index (AHI) or respiratory distress index (RDI) or respiratory event index (REI) of greater than or equal to 15 events per hour -AND- A baseline AHI or RDI or REI at the time of request -AND- Baseline BMI is greater than or equal to 30 kg/m2 -AND- Attestation of use in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity -AND- Attestation of use in combination with sleep hygiene modifications (e.g., sleep positioning to avoid a supine position, avoidance of alcohol and sedatives before bed) -AND- Will not be used in combination with GLP1 RA or GLP1 RA combinations. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months initial authorization, 12 months reauthorization |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For reauthorization, all of the following are required (1-9): 1) Diagnosis of moderate to severe obstructive sleep apnea/hypopnea syndrome (OSAHS) prior to initiation of Zepbound therapy, 2) Baseline polysomnography/recording time/home sleep apnea test (without use of PAP or oral appliance during testing) prior to initiation of Zepbound therapy demonstrating an AHI or RDI or REI of greater than or equal to 15 events per hour, 3) Attestation of a pre-Zepbound therapy baseline AHI or RDI or REI from a polysomnography/recording time/home sleep apnea test (without use of PAP or oral appliance during testing), 4) Attestation of decrease in baseline (i.e., at the time of the initial request) AHI or RDI or REI after Zepbound initiation, or if AHI/RDI/REI was zero it remained at zero, 5) Attestation that additional Zepbound therapy is required to maintain the AHI or RDI or REI decrease, 6) Attestation that baseline BMI was greater than or equal to 30 kg/m2 prior to initiation of Zepbound therapy, 7) Attestation of use in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity, 8) Attestation of use in combination with sleep hygiene modifications (e.g., sleep positioning to avoid a supine position, avoidance of alcohol and sedatives before bed), 9) the requested dose is 5mg, 7.5mg, 10mg, 12.5mg, or 15mg once weekly, or attestation that the member is titrating to a dose of 5mg once weekly. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# Zeposia

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Concomitant use of Zeposia and other disease modifying agents such as interferons, Copaxone, Tysabri. |
| **Required Medical Information** | Documentation of diagnosis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Ulcerative Colitis: Plan Year, Multiple Sclerosis: 24 months |
| **Other Criteria** | For moderate to severe active ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Zokinvy

## Products Affected

- **ZOKINVY**

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

# Zolinza

## Products Affected

- **ZOLINZA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following 2 systemic therapies. Systemic therapies include bexarotene, interferon alpha, extracorporeal photochemotherapy, PUVA, single agent or combination chemotherapies (e.g. cyclophosphamide, vinblastine, romidepsin) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Zolpidem Capsule

## Products Affected

- *zolpidem*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of insomnia characterized by difficulties with sleep onset -AND- therapeutic failure or intolerance to 2 of the following (1-3): 1) eszopiclone, 2) zaleplon, 3) generic zolpidem tablets/zolpidem ER tablets. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators. |
| **Age Restrictions** | Deny if greater than 64 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Zonisade

## Products Affected

- **ZONISADE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of partial-onset seizures -AND- Documentation of adjunctive therapy -AND- Inability to swallow capsules -AND- Therapeutic failure/intolerance to 2 or contraindication to all of the following (1-6): 1) generic carbamazepine suspension/chewable tablet/extended-release capsule, 2) generic gabapentin capsules/solution, 3) generic lacosamide solution, 4) generic levetiracetam solution, 5) generic oxcarbazepine suspension, 6) generic pregabalin capsules/solution. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Zoryve 0.05 Cream

## Products Affected

- **ZORYVE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of all of the following (1-3). 1) Documentation of mild to moderate atopic dermatitis -AND- 2) therapeutic failure, contraindication or intolerance to one generic formulary topical corticosteroid -OR- documentation of facial or anogenital involvement -AND- 3) therapeutic failure, contraindication or intolerance to topical generic tacrolimus or topical generic pimecrolimus. |
| **Age Restrictions** | Deny if less than 2 years of age or greater than 5 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Zoryve 0.15 Cream

## Products Affected

- **ZORYVE**

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

# Zoryve Cream

## Products Affected

- **ZORYVE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of all of the following (1-3). 1) Documentation of plaque psoriasis -AND- 2) trial and failure or intolerance to at least one generic, formulary medium, high, or ultrahigh potency topical corticosteroid (e.g. fluocinonide, triamcinolone, betamethasone) -OR- psoriasis on facial or intertriginous areas -AND- 3) trial and failure, contraindication, or intolerance to one generic, formulary vitamin D analog (e.g., calcipotriene, calcitriol) -OR- the member has psoriasis on the face. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Zoryve Foam

## Products Affected

- **ZORYVE**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of all of the following (1-3). 1) Documentation of seborrheic dermatitis -AND- 2) trial and failure or intolerance to at least one generic, formulary topical corticosteroid or seborrheic dermatitis on facial or intertriginous areas -AND- 3) if the member is 12 years of age or older, trial and failure, contraindication, or intolerance to one generic, topical antifungal agent for seborrheic dermatitis (e.g., ketoconazole, ciclopirox). -OR- Documentation of all of the following (4-6). 4) Documentation of plaque psoriasis -AND- 5) trial and failure or intolerance to at least one generic, formulary medium, high, or ultrahigh potency topical corticosteroid (e.g. fluocinonide, triamcinolone, betamethasone) or psoriasis on facial or intertriginous areas -AND- 6) trial and failure, contraindication, or intolerance to one generic, formulary vitamin D analog (e.g., calcipotriene, calcitriol) or the member has psoriasis on the face. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Ztalmy

## Products Affected

- **ZTALMY**

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

# ZTLido

## Products Affected

- **ZTLIDO**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of postherpetic neuralgia (PHN) -AND- One of the following (1, 2 or 3): 1) trial and failure of 1 other agent used to treat PHN (e.g. gabapentin) 2) Inability to swallow oral medication 3) Unable to take an oral medication due to potential adverse events (e.g. sedation) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Therapeutic failure, contraindication, or intolerance to generic lidocaine patch 5% is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# Zunveyl

## Products Affected

- **ZUNVEYL**

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

# Zurzuvae

## Products Affected

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

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

# Zykadia

## Products Affected

- **ZYKADIA**

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

# Zymfentra

## Products Affected

- **ZYMFENTRA**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- attestation of receiving or currently undergoing at least 3 doses of IV infliximab within 10 weeks of initiating therapy with Zymfentra. |
| **Age Restrictions** | Deny if less than 18 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For moderate to severe active ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq, and Xeljanz/Xeljanz XR. For moderate to severe active Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, and Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206, Simlandi with NDC starting with 51759, and Yuflyma with NDC starting 72606. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# Zytiga

## Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*
- **ABIRTEGA**
- **ZYTIGA ORAL TABLET 250 MG, 500 MG**

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of diagnosis -AND- using in combination with prednisone. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For brand Zytiga, intolerance of generic abiraterone or Abirtega is required. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

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**TEZSPIRE SUBCUTANEOUS PEN INJECTOR**..... 562
**THALOMID ORAL CAPSULE 100 MG, 50 MG**..... 564
**THIOLA**.....565
**THIOLA EC**.....565
**TIBSOVO**.....567
**TIGLUTIK**.....485
*tiopronin*..... 565
*tizanidine oral capsule 8 mg*.....569
**TLANDO**.....560
**TOBI**..... 84
**TOBI PODHALER**..... 84
*tobramycin in 0.225 % nacl*.....84
*tobramycin inhalation*..... 84
*tofacitinib oral solution*..... 649
*tofacitinib oral tablet*.....647
*tofacitinib oral tablet extended release 24 hr*.....647
**TOLSURA**.....572
*tolvaptan*.....498
*tolvaptan (polycys kidney dis) oral tablet*...282
*tolvaptan (polycys kidney dis) oral tablets, sequential*.....282
**TONMYA**.....573
*topiramate oral solution*..... 160
**TORPENZ**.....575
**TRACLEER ORAL TABLET**..... 458
**TRACLEER ORAL TABLET FOR SUSPENSION**.....458
*tramadol oral capsule,er biphase 24 hr 17-83*.....447
*tramadol oral capsule,er biphase 24 hr 25-75 100 mg, 200 mg*..... 447
*tramadol oral tablet 100 mg, 25 mg, 50 mg, 75 mg*..... 447
*tramadol oral tablet extended release 24 hr* ..... 447
*tramadol-acetaminophen*.....447
**TREMFYA ONE-PRESS**..... 576
**TREMFYA PEN INDUCTION PK(2PEN)**.....576
**TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML**..... 576
**TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML, 200 MG/2 ML**. 576
*tretinoin*..... 578
*tretinoin microspheres topical gel*.....578
*tretinoin microspheres topical gel with pump 0.08 %*.....578
*triazolam*.....447
*trientine oral capsule 500 mg*.....579
**TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL**..... 580
**TRIKAFTA ORAL TABLETS, SEQUENTIAL**.....580
**TRILITAS**.....557
*trimethobenzamide oral*.....568
*trimipramine*.....228
**TRINTELLIX**.....581
**TRUDHESA**.....125
**TRULANCE**.....582
**TRULICITY**..... 209
**TRUQAP**..... 583
**TRUTAKNA**..... 584
**TRYNGOLZA**..... 585
**TRYVIO**..... 586
**TUKYSA ORAL TABLET 150 MG, 50 MG**..... 587
**TURALIO**..... 588
**TWYNEO**.....578
**TYENNE AUTOINJECTOR**..... 570
**TYENNE SUBCUTANEOUS**.....570
**TYKERB**..... 589
**TYMLOS**.....590
**TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 32-64 MCG, 48 MCG, 48-64 MCG, 48-80 MCG, 64 MCG, 80 MCG**...458
**UBRELVY ORAL TABLET 100 MG, 50 MG**..... 591
**ULORIC**.....592
**UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**..... 593

**UPTRAVI ORAL TABLETS,DOSE PACK** ..... 593
*ustekinumab subcutaneous solution* ..... 594
*ustekinumab subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml* ..... 594
*ustekinumab-aauz subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml* ..... 594
*ustekinumab-aekn subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml* ..... 594
*ustekinumab-ttwe subcutaneous solution* ... 594
*ustekinumab-ttwe subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml* ..... 594
**VALCHLOR** ..... 596
**VALIUM** ..... 447
**VALTOCO** ..... 597
**VANFLYTA** ..... 598
**VANRAFIA** ..... 599
**VELSIPITY** ..... 600
**VELTASSA ORAL POWDER IN PACKET 1 GRAM, 16.8 GRAM, 25.2 GRAM, 8.4 GRAM** ..... 601
**VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG** ..... 603
**VENCLEXTA STARTING PACK** ..... 603
*venlafaxine besylate* ..... 602
**VENXXIVA** ..... 565
**VEOZAH** ..... 604
**VERKAZIA** ..... 605
**VERQUVO** ..... 606
**VERZENIO** ..... 607
**VFEND IV** ..... 621
**VIBERZI** ..... 608
**VICTOZA 3-PAK** ..... 209
*vigabatrin* ..... 496
**VIGADRONE** ..... 496
**VIGAFYDE** ..... 609
**VIIBRYD ORAL TABLET** ..... 610
**VIJOICE ORAL GRANULES IN PACKET** ..... 611
**VIJOICE ORAL TABLET 125 MG, 250 MG/DAY (200 MG X1-50 MG X1), 50 MG** ..... 611
*vilazodone* ..... 610
**VITRAKVI ORAL CAPSULE 100 MG, 25 MG** ..... 613
**VITRAKVI ORAL SOLUTION** ..... 613
**VIVJOA** ..... 614
**VOGELXO TRANSDERMAL GEL** ..... 560
**VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP** ..... 560
**VONJO** ..... 616
**VOQUEZNA DUAL PAK** ..... 619
**VOQUEZNA ORAL TABLET 10 MG, 20 MG** ..... 617
**VOQUEZNA TRIPLE PAK** ..... 619
**VORANIGO ORAL TABLET 10 MG, 40 MG** ..... 620
*voriconazole intravenous recon soln* ..... 621
**VOSEVI** ..... 622
**VOTRIENT** ..... 623
**VOWST** ..... 180
**VOXZOGO** ..... 624
**VOYDEYA** ..... 625
**VOYXACT** ..... 599
**VRAYLAR** ..... 626
**VTAMA** ..... 627
**VUMERITY** ..... 629
**VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 25 MG, 75 MG** ..... 630
**VYNDAMAX** ..... 38
**VYVGART HYTRULO SUBCUTANEOUS SYRINGE** ..... 631
**WAINUA SUBCUTANEOUS AUTO-INJECTOR** ..... 633
**WAKIX** ..... 634
**WAYRILZ** ..... 636
**WEGOVY ORAL** ..... 639
**WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML** ..... 637
**WELIREG** ..... 641
**WEZLANA SUBCUTANEOUS SOLUTION** ..... 594
**WEZLANA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML** .. 594
**WINLEVI** ..... 578
**WINREVAIR** ..... 643
**WYOST** ..... 117
**XALKORI ORAL CAPSULE** ..... 644

**XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG** ..... 644
**XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG** ..... 447
**XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 2 MG** ... 447
**XCOPRI** ..... 645
**XCOPRI MAINTENANCE PACK** ..... 645
**XCOPRI TITRATION PACK** ..... 645
**XDEMVY** ..... 646
**XELJANZ ORAL SOLUTION** ..... 649
**XELJANZ ORAL TABLET** ..... 647
**XELJANZ XR** ..... 647
**XENAZINE ORAL TABLET 12.5 MG, 25 MG** ..... 650
**XERMELO** ..... 651
**XGEVA** ..... 652
**XHANCE** ..... 653
**XIFAXAN ORAL TABLET 550 MG** ..... 654
**XOLAIR** ..... 655
**XOLREMDI** ..... 657
**XOSPATA** ..... 658
**XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK)** ..... 659
**XTAMPZA ER** ..... 447
**XTANDI ORAL CAPSULE** ..... 660
**XTANDI ORAL TABLET 40 MG, 80 MG** ..... 660
**XTRENBO** ..... 117
**XYOSTED** ..... 560
**XYREM** ..... 661
**XYWAV** ..... 663
**YARGESA** ..... 668
**YESINTEK SUBCUTANEOUS SOLUTION** ..... 444
**YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML** .. 444
**YIMMUGO** ..... 245
**YONSA** ..... 665
**YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML, 294 MCG/0.98 ML, 420 MCG/1.4 ML** ..... 666
**YUFLYMA(CF) AI CROHN'S-UC-HS** . 442
**YUFLYMA(CF) AUTOINJECTOR** ..... 442
**YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML** ..... 442
**YULITHIRA** ..... 12
**YUSIMRY(CF) PEN** ..... 7
**YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG** ..... 458
**YUVIWEL SUBCUTANEOUS RECON SOLN 1.3 MG, 2.8 MG, 5.5 MG** ..... 667
*zaleplon oral capsule 10 mg, 5 mg* ..... 447
**ZANAFLEX ORAL CAPSULE 8 MG** ... 569
**ZAVESCA** ..... 668
**ZAVZPRET** ..... 670
**ZEJULA** ..... 671
**ZELBORAF** ..... 672
**ZELSUVMI** ..... 673
**ZELVYSIA** ..... 297
**ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG** ..... 21
**ZENBEXUS** ..... 674
**ZEPBOUND KWIKPEN** ..... 677
**ZEPBOUND SUBCUTANEOUS PEN INJECTOR** ..... 675
**ZEPOSIA** ..... 679
**ZEPOSIA STARTER KIT (28-DAY)** ..... 679
**ZEPOSIA STARTER PACK (7-DAY)** ... 679
**ZERVIATE** ..... 401
**ZIANA** ..... 578
**ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML, 23 MG/0.574 ML, 32.4 MG/0.81 ML** ..... 357
*zileuton* ..... 309
**ZITUVIMET** ..... 130
**ZITUVIMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-1,000 MG, 50-500 MG** ..... 130
**ZITUVIO ORAL TABLET 100 MG, 25 MG, 50 MG** ..... 130
**ZOKINVY** ..... 680
**ZOLINZA** ..... 681
*zolpidem* ..... 447, 682

**ZOMACTON**..... 215
**ZONALON**..... 129
**ZONISADE**..... 683
**ZORYVE**..... 684, 685, 686, 687
**ZTALMY**..... 689
**ZTLIDO**..... 690
**ZUNVEYL**..... 691
**ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG**..... 692
**ZYKADIA**..... 693
**ZYMFENTRA**..... 694
**ZYTIGA ORAL TABLET 250 MG, 500 MG**..... 696

# Section: Step Therapy

# Brand ADHD

## Products Affected

- **ADDERALL 20 MG TABLET**
- **ADDERALL 5 MG TABLET**
- **ADDERALL 7.5 MG TABLET**
- **ADDERALL XR 10 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 15 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 20 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 25 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 30 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 5 MG CAPSULE,EXTENDED RELEASE**
- **ADZENYS XR-ODT 12.5 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 15.7 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 18.8 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 3.1 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 6.3 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 9.4 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- *amphetamine er 12.5 mg extended release-disintegrating 24 hr tablet*
- *amphetamine er 15.7 mg extended release-disintegrating 24 hr tablet*
- *amphetamine er 18.8 mg extended release-disintegrating 24 hr tablet*
- *amphetamine er 3.1 mg extended release-disintegrating 24 hr tablet*
- *amphetamine er 6.3 mg extended release-disintegrating 24 hr tablet*
- *amphetamine er 9.4 mg extended release-disintegrating 24 hr tablet*
- **ARYNTA 10 MG/ML ORAL SOLUTION**
- **AZSTARYS 26.1 MG-5.2 MG CAPSULE**
- **AZSTARYS 39.2 MG-7.8 MG CAPSULE**
- **AZSTARYS 52.3 MG-10.4 MG CAPSULE**
- **CONCERTA 18 MG TABLET,EXTENDED RELEASE**
- **CONCERTA 27 MG TABLET,EXTENDED RELEASE**
- **CONCERTA 36 MG TABLET,EXTENDED RELEASE**
- **CONCERTA 54 MG TABLET,EXTENDED RELEASE**
- **COTEMPLA XR-ODT 17.3 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **COTEMPLA XR-ODT 25.9 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **COTEMPLA XR-ODT 8.6 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **DEXEDRINE SPANSULE 10 MG CAPSULE,EXTENDED RELEASE**
- *dextroamphetamine sulfate er 10 mg capsule,extended release*
- *dextroamphetamine sulfate er 15 mg capsule,extended release*
- *dextroamphetamine sulfate er 5 mg capsule,extended release*
- *dextroamphetamine-amphetamine er 12.5 mg capsule, 3 bead, ext rel 24hr*
- *dextroamphetamine-amphetamine er 25 mg capsule,3 bead,ext release 24hr*
- *dextroamphetamine-amphetamine er 37.5 mg capsule, 3 bead, ext rel 24hr*
- *dextroamphetamine-amphetamine er 50 mg capsule,3 bead,ext release 24hr*
- **DYANAVEL XR 10 MG TABLET, EXTENDED RELEASE**
- **DYANAVEL XR 15 MG TABLET, EXTENDED RELEASE**

- **DYANAVEL XR 2.5 MG/ML ORAL 24 HR EXTENDED RELEASE SUSPENSION**
- **DYANAVEL XR 20 MG TABLET, EXTENDED RELEASE**
- **DYANAVEL XR 5 MG TABLET, EXTENDED RELEASE**
- **FOCALIN 10 MG TABLET**
- **FOCALIN 2.5 MG TABLET**
- **FOCALIN 5 MG TABLET**
- **FOCALIN XR 10 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 15 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 20 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 25 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 30 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 35 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 40 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 5 MG CAPSULE,EXTENDED RELEASE**
- **JORNAY PM 100 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 20 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 40 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 60 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 80 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- *lisdexamfetamine 10 mg capsule*
- *lisdexamfetamine 10 mg chewable tablet*
- *lisdexamfetamine 20 mg capsule*
- *lisdexamfetamine 20 mg chewable tablet*
- *lisdexamfetamine 30 mg capsule*
- *lisdexamfetamine 30 mg chewable tablet*
- *lisdexamfetamine 40 mg capsule*
- *lisdexamfetamine 40 mg chewable tablet*
- *lisdexamfetamine 50 mg capsule*
- *lisdexamfetamine 50 mg chewable tablet*
- *lisdexamfetamine 60 mg capsule*
- *lisdexamfetamine 60 mg chewable tablet*
- *lisdexamfetamine 70 mg capsule*
- **METADATE CD 10 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 20 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 30 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 40 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 50 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 60 MG CAPSULE,EXTENDED RELEASE**
- **METHYLIN 10 MG/5 ML ORAL SOLUTION**
- **METHYLIN 5 MG/5 ML ORAL SOLUTION**
- *methylphenidate 17.3 mg er,ir disintegrating 24 hr tablet*
- *methylphenidate 25.9 mg er,ir disintegrating 24 hr tablet*
- *methylphenidate 8.6 mg er,ir disintegrating 24 hr tablet*
- *methylphenidate er 10 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 15 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 20 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 30 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 40 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 50 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 60 mg capsule,extended*

*release (40-60) sprinkle*

- **MYDAYIS 12.5 MG CAPSULE EXTENDED RELEASE 24 HR**
- **MYDAYIS 25 MG CAPSULE EXTENDED RELEASE 24 HR**
- **MYDAYIS 37.5 MG CAPSULE EXTENDED RELEASE 24 HR**
- **MYDAYIS 50 MG CAPSULE EXTENDED RELEASE 24 HR**
- **QUILLICHEW ER 20 MG CHEWABLE TABLET, EXTENDED RELEASE**
- **QUILLICHEW ER 30 MG CHEWABLE TABLET, EXTENDED RELEASE**
- **QUILLICHEW ER 40 MG CHEWABLE, EXTENDED RELEASE TABLET**
- **QUILLIVANT XR 5 MG/ML (25 MG/5 ML) ORAL SUSPENSION,EXTEND RELEASE 24HR**
- **RELEXXII 18 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 27 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 36 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 45 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 54 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 63 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 72 MG TABLET,EXTENDED RELEASE**
- **RITALIN 10 MG TABLET**
- **RITALIN 20 MG TABLET**
- **RITALIN 5 MG TABLET**
- **VYVANSE 10 MG CAPSULE**
- **VYVANSE 10 MG CHEWABLE TABLET**
- **VYVANSE 20 MG CAPSULE**
- **VYVANSE 20 MG CHEWABLE TABLET**
- **VYVANSE 30 MG CAPSULE**
- **VYVANSE 30 MG CHEWABLE TABLET**
- **VYVANSE 40 MG CAPSULE**
- **VYVANSE 40 MG CHEWABLE TABLET**
- **VYVANSE 50 MG CAPSULE**
- **VYVANSE 50 MG CHEWABLE TABLET**
- **VYVANSE 60 MG CAPSULE**
- **VYVANSE 60 MG CHEWABLE TABLET**
- **VYVANSE 70 MG CAPSULE**
- **XELSTRYM 13.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**
- **XELSTRYM 18 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**
- **XELSTRYM 4.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**
- **XELSTRYM 9 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of 2 of the following generic ADHD medications (Step 1 drug) when being utilized for the same medically accepted indication: methylphenidate (i.e. generics of Concerta, Metadate CD, Methylin, Relexxii, Ritalin/Ritalin LA), atomoxetine, dextroamphetamine/amphetamine (i.e. generics of Adderall/Adderal XR), or dexmethylphenidate in the last 180 days. |

# Brand Albuterol

## Products Affected

- *albuterol sulfate hfa 90 mcg/actuation aerosol inhaler (nda020983)* **MCG/ACTUATION BREATH ACTIVATED**
- **PROAIR RESPICLICK 90**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of albuterol (generic Proair HFA) in the last 90 days |

# Brand Epinephrine

## Products Affected

- **AUVI-Q 0.1 MG/0.1 ML INJECTION,AUTO-INJECTOR**
- **AUVI-Q 0.15 MG/0.15 ML AUTO-INJECTOR (FOR 33 LB TO 66 LB PATIENTS)**
- **AUVI-Q 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR**
- **EPIPEN 2-PAK 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR**
- **EPIPEN JR 2-PAK 0.15 MG/0.3 ML INJECTION,AUTO-INJECTOR**
- **NEFFY 1 MG/SPRAY (0.1 ML) NASAL SPRAY**
- **NEFFY 2 MG/SPRAY (0.1 ML) NASAL SPRAY**

## Details

| | |
|---|---|
| **Criteria** | Require a trial of generic epinephrine injection in the last 90 days |

# Brand Levalbuterol

## Products Affected

- **XOPENEX HFA 45 MCG/ACTUATION AEROSOL INHALER**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of albuterol (generic Proair HFA) and generic levalbuterol in the last 180 days |

# Celecoxib

## Products Affected

- **CELEBREX 100 MG CAPSULE**
- **CELEBREX 200 MG CAPSULE**
- **CELEBREX 400 MG CAPSULE**
- **CELEBREX 50 MG CAPSULE**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic celecoxib and 1 other formulary generic NSAID (Step 1 drugs) in the last 180 days |

# Clonidine ER

## Products Affected

- *clonidine hcl er 0.17 mg tablet,extended release 24 hr*
- **NEXICLON XR 0.17 MG TABLET,EXTENDED RELEASE**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic clonidine IR tablet (Step 1 drug) in the last 90 days |

# Colony Stimulating Factors

## Products Affected

- **ARMLUPEG 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **FULPHILA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **FYLNETRA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **GRANIX 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE**
- **GRANIX 300 MCG/ML SUBCUTANEOUS SOLUTION**
- **GRANIX 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE**
- **NEULASTA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE**
- **NEUPOGEN 300 MCG/ML INJECTION SOLUTION**
- **NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE**
- **NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION**
- **NYVEPRIA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **RELEUKO 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE**
- **RELEUKO 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE**
- **ROLVEDON 13.2 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **STIMUFEND 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **UDENYCA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **UDENYCA AUTOINJECTOR 6 MG/0.6 ML SUBCUTANEOUS AUTO-INJECTOR**
- **ZIEXTENZO 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Zarxio and Nivestym (step 1 drugs) in the last 180 days when being utilized for the same medically accepted indication and age |

# Dry Eye

## Products Affected

- **CEQUA 0.09 % EYE DROPS IN A DROPPERETTE**
- **MIEBO (PF) 100 % EYE DROPS**
- **TRYPTYR 0.003 % EYE DROPS IN A DROPPERETTE**
- **TYRVAYA 0.03 MG/SPRAY NASAL SPRAY**
- **VEVYE 0.1 % EYE DROPS**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Xiidra and one of the following: Restasis or cyclosporine eye drop (i.e. generic Restasis), in the last 180 days |

# Dymista

## Products Affected

- **DYMISTA 137 MCG-50 MCG/SPRAY NASAL SPRAY**
- **RYALTRIS 665 MCG-25 MCG/SPRAY NASAL SPRAY**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic azelastine/fluticasone spray in the last 90 days |

# Entresto Tablet

## Products Affected

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

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic sacubitril/valsartan tablets (Step 1 drug) in the last 90 days |

# Erythroid Stimulants

## Products Affected

- **ARANESP 10 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 100 MCG/0.5 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 100 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 150 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 200 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 200 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 25 MCG/0.42 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 25 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 300 MCG/0.6 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 40 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 40 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 500 MCG/ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 60 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 60 MCG/ML (IN POLYSORBATE) INJECTION**
- **EPOGEN 10,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 2,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 20,000 UNIT/2 ML INJECTION SOLUTION**
- **EPOGEN 20,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 3,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 4,000 UNIT/ML INJECTION SOLUTION**
- **MIRCERA 100 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 120 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 150 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 200 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 30 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 50 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 75 MCG/0.3 ML INJECTION SYRINGE**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Procrit and Retacrit (Step 1 drugs) in the last 180 days |

# Fortamet

## Products Affected

- *metformin er 1,000 mg tablet,extended release 24hr (osmotic)*
- *metformin er 500 mg tablet,extended release 24hr (osmotic)*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic metformin IR tablets and generic metformin ER (i.e. generic Glucophage XR) tablets in the last 180 days |

# Glumetza

## Products Affected

- *metformin er 1,000 mg 24 hr tablet,extended release (gastric reten.)*
- *metformin er 500 mg 24 hr tablet,extended release (gastric retention)*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic metformin IR tablets and generic metformin ER (i.e. generic Glucophage XR) tablets in the last 180 days |

# Herpetic Keratitis

## Products Affected

- **ZIRGAN 0.15 % EYE GEL**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic trifluridine eye drops (Step 1 drug) in the last 90 days when utilized for the same medically accepted indication and age |

# Inhaled LAMA

## Products Affected

- **INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION**
- **SPIRIVA WITH HANDIHALER 18 MCG AND INHALATION CAPSULES**
- *tiotropium bromide 18 mcg capsule with inhalation device*
- **TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED**
- **TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED (30 ACTUAT)**
- *umeclidinium 62.5 mcg/actuation blister powder for inhalation*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Spiriva Respimat (Step 1 drug) in the last 90 days |

# Inhaled LAMA/LABA

## Products Affected

- *umeclidinium 62.5 mcg-vilanterol 25 mcg/actuation powdr for inhalation*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Anoro Ellipta (Step 1 drug) in the last 90 days |

# Lactulose

## Products Affected

- **KRISTALOSE 10 GRAM ORAL PACKET**
- **KRISTALOSE 20 GRAM ORAL PACKET**
- *lactulose 10 gram oral packet*
- *lactulose 20 gram oral packet*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of lactulose solution (Step 1 drug) in the last 90 days |

# Metformin IR

## Products Affected

- *metformin 625 mg tablet*
- *metformin 750 mg tablet*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic metformin IR 500mg tablets, 850mg tablets, or 1000mg tablets (step 1 drug) in the last 90 days |

# Mirabegron ER

## Products Affected

- *mirabegron er 25 mg tablet,extended release 24 hr*
- *mirabegron er 50 mg tablet,extended release 24 hr*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Myrbetriq (Step 1 drug) in the last 90 days |

# Mirabegron ER Liquid

## Products Affected

- *mirabegron er 8 mg/ml oral suspension,extended release*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Myrbetriq Suspension (Step 1 drug) in the last 90 days |

# Mupirocin

## Products Affected

- *mupirocin calcium 2 % topical cream*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic mupirocin ointment (Step 1 drug) in the last 90 days |

# Pancreatic Enzymes

## Products Affected

- **PANCREAZE 10,500 UNIT-35,500 UNIT-61,500 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 16,800 UNIT-56,800 UNIT-98,400 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 2,600 UNIT-8,800 UNIT-15,200 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 21,000 UNIT-54,700 UNIT-83,900 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 37,000-97,300-149,900 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 4,200 UNIT-14,200 UNIT-24,600 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 16,000 UNIT-57,500 UNIT-60,500 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 24,000-86,250-90,750 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 4,000 UNIT-14,375 UNIT-15,125 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 8,000 UNIT-28,750 UNIT-30,250 UNIT CAPSULE,DELAYED RELEASE**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Creon or Zenpep (Step 1 drug) in the last 90 days. |

# Pennsaid

## Products Affected

- *diclofenac 20 mg/gram/actuation (2 %) topical soln metered-dose pump*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Diclofenac 1.5% (Step 1 drug) in the last 90 days |

# Prostaglandins

## Products Affected

- **IYUZEH (PF) 0.005 % EYE DROPS IN A DROPPERETTE**
- **VYZULTA 0.024 % EYE DROPS**
- **ZIOPTAN (PF) 0.0015 % EYE DROPS IN A DROPPERETTE**
- **ZOLYMBUS 0.01 % EYE GEL IN A DROPPERETTE**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of brand Lumigan (Step 1 drug) plus one other preferred generic glaucoma drug (Step 1 drug) in the last 180 days. |

# Pulmonary Antiinflammatory

## Products Affected

- *beclomethasone dipropionate 40 mcg/actuation aerosol inhaler*
- *beclomethasone dipropionate 80 mcg/actuation aerosol inhaler*
- *fluticasone propionate 100 mcg/actuation blister powder for inhalation*
- *fluticasone propionate 110 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 220 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 250 mcg/actuation blister powder for inhalation*
- *fluticasone propionate 44 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 50 mcg/actuation blister powder for inhalation*

## Details

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

# Pulmonary Antiinflammatory Combo

## Products Affected

- **ADVAIR DISKUS 100 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- **ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- **ADVAIR DISKUS 500 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- *fluticasone 113 mcg-salmeterol 14 mcg/actuation breath activated powdr*
- *fluticasone 232 mcg-salmeterol 14 mcg/actuation breath activated powdr*
- *fluticasone 55 mcg-salmeterol 14 mcg/actuation breath activated powder*
- **SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER**
- **SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER**

## Details

| | |
|---|---|
| **Criteria** | Require a trial of 2 of the following (Step 1 drugs) when utilized for the same medically accepted indication and age group: Advair HFA, Breo Ellipta, Dulera, and generic fluticasone furoate-vilanterol Ellipta in the last 180 days |

# Rapid Acting Insulin

## Products Affected

- **AFREZZA (REGULAR INSULIN) 8 UNIT (90)/12 UNIT (90) CARTRIDGE,INHALER**
- **AFREZZA 12 UNIT CARTRIDGE WITH INHALER**
- **AFREZZA 4 UNIT (60)/8 UNIT (60)/12 UNIT (60) CARTRIDGE WITH INHALER**
- **AFREZZA 4 UNIT (90)/8 UNIT (90) CARTRIDGE WITH INHALER**
- **AFREZZA 4 UNIT CARTRIDGE WITH INHALER**
- **AFREZZA 8 UNIT CARTRIDGE WITH INHALER**
- **KIRSTY 100 UNIT/ML SUBCUTANEOUS SOLUTION**
- **KIRSTY PEN 100 UNIT/ML (3 ML) SUBCUTANEOUS**
- **MERILOG 100 UNIT/ML SUBCUTANEOUS SOLUTION**
- **MERILOG SOLOSTAR 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Humalog, insulin lispro, Fiasp, or Novolog (Step 1 drug) in the last 90 days |

# Rho Kinase Inhibitors

## Products Affected

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

## Details

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

# Riomet

## Products Affected

- *metformin 500 mg/5 ml oral solution*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic metformin IR tablets in the last 90 days<br>-OR- documentation supporting the inability to swallow or difficulty swallowing tablets containing metformin |

# Rytary

## Products Affected

- *carbidopa er 23.75 mg-levodopa 95 mg capsule,extended release*
- *carbidopa er 36.25 mg-levodopa 145 mg capsule,extended release*
- *carbidopa er 48.75 mg-levodopa 195 mg capsule,extended release*
- *carbidopa er 61.25 mg-levodopa 245 mg capsule,extended release*
- **CREXONT 35 MG-140 MG CAPSULE, EXTENDED RELEASE**
- **CREXONT 52.5 MG-210 MG CAPSULE, EXTENDED RELEASE**
- **CREXONT 70 MG-280 MG CAPSULE, EXTENDED RELEASE**
- **CREXONT 87.5 MG-350 MG CAPSULE, EXTENDED RELEASE**
- **DHIVY 25 MG-100 MG TABLET**
- **RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE**

## Details

| | |
|---|---|
| **Criteria** | Require a trial of generic carbidopa/levodopa tablets, carbidopa/levodopa orally disintegrating tablets, carbidopa/levodopa ER tablets, or carbidopa/levodopa/entacapone tablets (Step 1 drug) in the last 90 days |

# SGLT2 Agents

## Products Affected

- *dapagliflozin 10 mg-metformin er 1,000 mg tablet,ext rel 24hr*
- *dapagliflozin 10 mg-metformin er 500 mg tablet, ext rel 24hr*
- *dapagliflozin 5 mg-metformin er 1,000 mg tablet, ext rel 24hr*
- *dapagliflozin 5 mg-metformin er 500 mg tablet,ext rel 24hr*
- **FARXIGA 10 MG TABLET**
- **FARXIGA 5 MG TABLET**
- **INPEFA 200 MG TABLET**
- **INPEFA 400 MG TABLET**
- **INVOKAMET 150 MG-1,000 MG TABLET**
- **INVOKAMET 150 MG-500 MG TABLET**
- **INVOKAMET 50 MG-1,000 MG TABLET**
- **INVOKAMET 50 MG-500 MG TABLET**
- **INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE**
- **INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE**
- **INVOKANA 100 MG TABLET**
- **INVOKANA 300 MG TABLET**
- **SEGLUROMET 2.5 MG-1,000 MG TABLET**
- **SEGLUROMET 2.5 MG-500 MG TABLET**
- **SEGLUROMET 7.5 MG-1,000 MG TABLET**
- **SEGLUROMET 7.5 MG-500 MG TABLET**
- **STEGLATRO 15 MG TABLET**
- **STEGLATRO 5 MG TABLET**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of dapagliflozin/Xigduo XR and Jardiance/Synjardy/Synjardy XR (Step 1 drugs) in the last 180 days. |

# Short Acting Insulin

## Products Affected

- **NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION**
- **NOVOLIN 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML (70-30) SUBCUTANEOUS**
- **NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN**
- **NOVOLIN N NPH U-100 INSULIN ISOPHANE 100 UNIT/ML SUBCUTANEOUS SUSP**
- **NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN**
- **NOVOLIN R REGULAR U-100 INSULIN 100 UNIT/ML INJECTION SOLUTION**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Humulin product (Step 1 drug) in the last 90 days |

# Sleeper Meds

## Products Affected

- **BELSOMRA 10 MG TABLET**
- **BELSOMRA 15 MG TABLET**
- **BELSOMRA 20 MG TABLET**
- **BELSOMRA 5 MG TABLET**
- **DAYVIGO 10 MG TABLET**
- **DAYVIGO 5 MG TABLET**
- **QUVIVIQ 25 MG TABLET**
- **QUVIVIQ 50 MG TABLET**

## Details

| | |
|---|---|
| **Criteria** | Require a trial of 2 of the following (Step 1 drug): generic zolpidem tablet/zolpidem ER tablet, zaleplon or eszopiclone in the last 180 days |

# Soaanz

## Products Affected

- **SOAANZ 40 MG TABLET**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic furosemide tablets and generic torsemide tablets in the last 180 days |

# Suboxone

## Products Affected

- **SUBOXONE 12 MG-3 MG SUBLINGUAL FILM**
- **SUBOXONE 2 MG-0.5 MG SUBLINGUAL FILM**
- **SUBOXONE 4 MG-1 MG SUBLINGUAL FILM**
- **SUBOXONE 8 MG-2 MG SUBLINGUAL FILM**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of Zubsolv (Step 1 drug) in the last 90 days |

# Topical Antifungals

## Products Affected

- *econazole nitrate 1 % topical foam*
- **ERTACZO 2 % TOPICAL CREAM**
- **EXELDERM 1 % TOPICAL CREAM**
- **KETODAN 2 % TOPICAL FOAM**
- *naftifine 1 % topical cream*
- *naftifine 2 % topical cream*
- *naftifine 2 % topical gel*
- **NAFTIN 2 % TOPICAL GEL**
- *oxiconazole 1 % topical cream*

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic econazole cream and one of the following: generic ketoconazole cream or ketoconazole shampoo (Step 1 drugs),when being utilized for the same medically accepted indication, in the last 180 days |

# Topical Psoriasis

## Products Affected

- *calcipotriene 0.005 % topical foam*
- *calcipotriene-betamethasone 0.005 %-0.064 % topical ointment*
- *calcipotriene-betamethasone 0.005 %-0.064 % topical suspension*
- *calcitriol 3 mcg/gram topical ointment*
- **ENSTILAR 0.005 %-0.064 % TOPICAL FOAM**
- **SORILUX 0.005 % TOPICAL FOAM**
- **TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION**
- **VECTICAL 3 MCG/GRAM TOPICAL OINTMENT**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic calcipotriene cream, ointment or solution (Step 1 drug) in the last 90 days when utilized for the same medically accepted indication and age |

# Topical Rosacea

## Products Affected

- *azelaic acid 15 % topical gel*
- *brimonidine 0.33 % topical gel with pump*
- **EPSOLAY 5 % TOPICAL CREAM**
- **FINACEA 15 % TOPICAL FOAM**
- *ivermectin 1 % topical cream*
- **MIRVASO 0.33 % TOPICAL GEL**
- **NORITATE 1 % TOPICAL CREAM WITH PUMP**
- *oxymetazoline 1 % topical cream*
- **RHOFADE 1 % TOPICAL CREAM**
- **SOOLANTRA 1 % TOPICAL CREAM**
- **ZILXI 1.5 % TOPICAL FOAM**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic metronidazole cream, lotion, or gel (Step 1 drug) in the last 90 days. |

# Ursodiol

## Products Affected

- **RELTONE 200 MG CAPSULE**
- **RELTONE 400 MG CAPSULE**
- *ursodiol 200 mg capsule*
- *ursodiol 400 mg capsule*
- **URSOLIGN 150 MG CAPSULE**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of generic ursodiol 250mg tablet, 300mg capsule or 500mg tablet (step 1 drug) in the last 90 days |

# Vabrinty

## Products Affected

- **VABRINTY (4 MONTH) 30 MG SUBCUTANEOUS SYRINGE**
- **VABRINTY 22.5 MG (3 MONTH) SUBCUTANEOUS SYRINGE**
- **VABRINTY 45 MG (6 MONTH) SUBCUTANEOUS SYRINGE**
- **VABRINTY 7.5 MG (1 MONTH) SUBCUTANEOUS SYRINGE**

## Details

| | |
|---|---|
| **Criteria** | Require a trial of Eligard (Step 1 drug) in the last 180 days when being utilized for the same medically accepted indication |

# Vyscoxa

## Products Affected

- **VYSCOXA 10 MG/ML ORAL SUSPENSION**

## Details

| | |
|---|---|
| **Criteria** | Require a 1 month trial of 2 generic NSAIDs (Step 1 drug) in the last 180 days |

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*dapagliflozin 10 mg-metformin er 1,000 mg tablet,ext rel 24hr* ..... 33

*dapagliflozin 10 mg-metformin er 500 mg tablet, ext rel 24hr* ..... 33
*dapagliflozin 5 mg-metformin er 1,000 mg tablet, ext rel 24hr* ..... 33
*dapagliflozin 5 mg-metformin er 500 mg tablet,ext rel 24hr* ..... 33
**DAYVIGO 10 MG TABLET** ..... 35
**DAYVIGO 5 MG TABLET** ..... 35
**DEXEDRINE SPANSULE 10 MG CAPSULE,EXTENDED RELEASE** ..... 1
*dextroamphetamine sulfate er 10 mg capsule,extended release* ..... 1
*dextroamphetamine sulfate er 15 mg capsule,extended release* ..... 1
*dextroamphetamine sulfate er 5 mg capsule,extended release* ..... 1
*dextroamphetamine-amphetamine er 12.5 mg capsule, 3 bead, ext rel 24hr* ..... 1
*dextroamphetamine-amphetamine er 25 mg capsule,3 bead,ext release 24hr* ..... 1
*dextroamphetamine-amphetamine er 37.5 mg capsule, 3 bead, ext rel 24hr* ..... 1
*dextroamphetamine-amphetamine er 50 mg capsule,3 bead,ext release 24hr* ..... 1
**DHIVY 25 MG-100 MG TABLET** ..... 32
*diclofenac 20 mg/gram/actuation (2 %) topical soln metered-dose pump* ..... 25
**DYANAVEL XR 10 MG TABLET, EXTENDED RELEASE** ..... 1
**DYANAVEL XR 15 MG TABLET, EXTENDED RELEASE** ..... 1
**DYANAVEL XR 2.5 MG/ML ORAL 24 HR EXTENDED RELEASE SUSPENSION** ..... 1
**DYANAVEL XR 20 MG TABLET, EXTENDED RELEASE** ..... 1
**DYANAVEL XR 5 MG TABLET, EXTENDED RELEASE** ..... 1
**DYMISTA 137 MCG-50 MCG/SPRAY NASAL SPRAY** ..... 11
*econazole nitrate 1 % topical foam* ..... 38
**ENSTILAR 0.005 %-0.064 % TOPICAL FOAM** ..... 39
**ENTRESTO 24 MG-26 MG TABLET** ..... 12
**ENTRESTO 49 MG-51 MG TABLET** ..... 12
**ENTRESTO 97 MG-103 MG TABLET** ... 12
**EPIPEN 2-PAK 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR** ..... 5
**EPIPEN JR 2-PAK 0.15 MG/0.3 ML INJECTION,AUTO-INJECTOR** ..... 5
**EPOGEN 10,000 UNIT/ML INJECTION SOLUTION** ..... 13
**EPOGEN 2,000 UNIT/ML INJECTION SOLUTION** ..... 13
**EPOGEN 20,000 UNIT/2 ML INJECTION SOLUTION** ..... 13
**EPOGEN 20,000 UNIT/ML INJECTION SOLUTION** ..... 13
**EPOGEN 3,000 UNIT/ML INJECTION SOLUTION** ..... 13
**EPOGEN 4,000 UNIT/ML INJECTION SOLUTION** ..... 13
**EPSOLAY 5 % TOPICAL CREAM** ..... 40
**ERTACZO 2 % TOPICAL CREAM** ..... 38
**EXELDERM 1 % TOPICAL CREAM** .... 38
**FARXIGA 10 MG TABLET** ..... 33
**FARXIGA 5 MG TABLET** ..... 33
**FINACEA 15 % TOPICAL FOAM** ..... 40
*fluticasone 113 mcg-salmeterol 14 mcg/actuation breath activated powdr* ..... 28
*fluticasone 232 mcg-salmeterol 14 mcg/actuation breath activated powdr* ..... 28
*fluticasone 55 mcg-salmeterol 14 mcg/actuation breath activated powder* ..... 28
*fluticasone propionate 100 mcg/actuation blister powder for inhalation* ..... 27
*fluticasone propionate 110 mcg/actuation hfa aerosol inhaler* ..... 27
*fluticasone propionate 220 mcg/actuation hfa aerosol inhaler* ..... 27
*fluticasone propionate 250 mcg/actuation blister powder for inhalation* ..... 27
*fluticasone propionate 44 mcg/actuation hfa aerosol inhaler* ..... 27
*fluticasone propionate 50 mcg/actuation blister powder for inhalation* ..... 27
**FOCALIN 10 MG TABLET** ..... 1
**FOCALIN 2.5 MG TABLET** ..... 1
**FOCALIN 5 MG TABLET** ..... 1
**FOCALIN XR 10 MG CAPSULE,EXTENDED RELEASE** ..... 1

**FOCALIN XR 15 MG CAPSULE,EXTENDED RELEASE** ..... 1
**FOCALIN XR 20 MG CAPSULE,EXTENDED RELEASE** ..... 1
**FOCALIN XR 25 MG CAPSULE,EXTENDED RELEASE** ..... 1
**FOCALIN XR 30 MG CAPSULE,EXTENDED RELEASE** ..... 1
**FOCALIN XR 35 MG CAPSULE,EXTENDED RELEASE** ..... 1
**FOCALIN XR 40 MG CAPSULE,EXTENDED RELEASE** ..... 1
**FOCALIN XR 5 MG CAPSULE,EXTENDED RELEASE** ..... 1
**FULPHILA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE** ..... 9
**FYLNETRA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE** ..... 9
**GRANIX 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE** ..... 9
**GRANIX 300 MCG/ML SUBCUTANEOUS SOLUTION** ..... 9
**GRANIX 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE** ..... 9
**INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION** ..... 17
**INPEFA 200 MG TABLET** ..... 33
**INPEFA 400 MG TABLET** ..... 33
**INVOKAMET 150 MG-1,000 MG TABLET** ..... 33
**INVOKAMET 150 MG-500 MG TABLET** ..... 33
**INVOKAMET 50 MG-1,000 MG TABLET** ..... 33
**INVOKAMET 50 MG-500 MG TABLET** ..... 33
**INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE** ..... 33
**INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE** ..... 33
**INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE** ..... 33
**INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE** ..... 33
**INVOKANA 100 MG TABLET** ..... 33
**INVOKANA 300 MG TABLET** ..... 33
*ivermectin 1 % topical cream* ..... 40
**IYUZEH (PF) 0.005 % EYE DROPS IN A DROPPERETTE** ..... 26
**JORNAY PM 100 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE** ..... 1
**JORNAY PM 20 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE** ..... 1
**JORNAY PM 40 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE** ..... 1
**JORNAY PM 60 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE** ..... 1
**JORNAY PM 80 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE** ..... 1
**KETODAN 2 % TOPICAL FOAM** ..... 38
**KIRSTY 100 UNIT/ML SUBCUTANEOUS SOLUTION** ..... 29
**KIRSTY PEN 100 UNIT/ML (3 ML) SUBCUTANEOUS** ..... 29
**KRISTALOSE 10 GRAM ORAL PACKET** ..... 19
**KRISTALOSE 20 GRAM ORAL PACKET** ..... 19
*lactulose 10 gram oral packet* ..... 19
*lactulose 20 gram oral packet* ..... 19
*lisdexamfetamine 10 mg capsule* ..... 1
*lisdexamfetamine 10 mg chewable tablet* ..... 1
*lisdexamfetamine 20 mg capsule* ..... 1
*lisdexamfetamine 20 mg chewable tablet* ..... 1
*lisdexamfetamine 30 mg capsule* ..... 1
*lisdexamfetamine 30 mg chewable tablet* ..... 1
*lisdexamfetamine 40 mg capsule* ..... 1
*lisdexamfetamine 40 mg chewable tablet* ..... 1
*lisdexamfetamine 50 mg capsule* ..... 1
*lisdexamfetamine 50 mg chewable tablet* ..... 1
*lisdexamfetamine 60 mg capsule* ..... 1

*lisdexamfetamine 60 mg chewable tablet*..... 1
*lisdexamfetamine 70 mg capsule*..... 1
**MERILOG 100 UNIT/ML SUBCUTANEOUS SOLUTION**..... 29
**MERILOG SOLOSTAR 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN**..... 29
**METADATE CD 10 MG CAPSULE,EXTENDED RELEASE**.....1
**METADATE CD 20 MG CAPSULE,EXTENDED RELEASE**.....1
**METADATE CD 30 MG CAPSULE,EXTENDED RELEASE**.....1
**METADATE CD 40 MG CAPSULE,EXTENDED RELEASE**.....1
**METADATE CD 50 MG CAPSULE,EXTENDED RELEASE**.....1
**METADATE CD 60 MG CAPSULE,EXTENDED RELEASE**.....1
*metformin 500 mg/5 ml oral solution*..... 31
*metformin 625 mg tablet*.....20
*metformin 750 mg tablet*.....20
*metformin er 1,000 mg 24 hr tablet,extended release (gastric reten.)*..... 15
*metformin er 1,000 mg tablet,extended release 24hr (osmotic)*.....14
*metformin er 500 mg 24 hr tablet,extended release (gastric retention)*..... 15
*metformin er 500 mg tablet,extended release 24hr (osmotic)*.....14
**METHYLIN 10 MG/5 ML ORAL SOLUTION**.....1
**METHYLIN 5 MG/5 ML ORAL SOLUTION**.....1
*methylphenidate 17.3 mg er,ir disintegrating 24 hr tablet*.....1
*methylphenidate 25.9 mg er,ir disintegrating 24 hr tablet*.....1
*methylphenidate 8.6 mg er,ir disintegrating 24 hr tablet*..... 1
*methylphenidate er 10 mg capsule,extended release (40-60) sprinkle*..... 1
*methylphenidate er 15 mg capsule,extended release (40-60) sprinkle*..... 1
*methylphenidate er 20 mg capsule,extended release (40-60) sprinkle*..... 1
*methylphenidate er 30 mg capsule,extended release (40-60) sprinkle*..... 1
*methylphenidate er 40 mg capsule,extended release (40-60) sprinkle*..... 1
*methylphenidate er 50 mg capsule,extended release (40-60) sprinkle*..... 1
*methylphenidate er 60 mg capsule,extended release (40-60) sprinkle*..... 1
**MIEBO (PF) 100 % EYE DROPS**..... 10
*mirabegron er 25 mg tablet,extended release 24 hr*.....21
*mirabegron er 50 mg tablet,extended release 24 hr*.....21
*mirabegron er 8 mg/ml oral suspension,extended release*.....22
**MIRCERA 100 MCG/0.3 ML INJECTION SYRINGE**.....13
**MIRCERA 120 MCG/0.3 ML INJECTION SYRINGE**.....13
**MIRCERA 150 MCG/0.3 ML INJECTION SYRINGE**.....13
**MIRCERA 200 MCG/0.3 ML INJECTION SYRINGE**.....13
**MIRCERA 30 MCG/0.3 ML INJECTION SYRINGE**.....13
**MIRCERA 50 MCG/0.3 ML INJECTION SYRINGE**.....13
**MIRCERA 75 MCG/0.3 ML INJECTION SYRINGE**.....13
**MIRVASO 0.33 % TOPICAL GEL WITH PUMP**..... 40
*mupirocin calcium 2 % topical cream*.....23
**MYDAYIS 12.5 MG CAPSULE EXTENDED RELEASE 24 HR**..... 1
**MYDAYIS 25 MG CAPSULE EXTENDED RELEASE 24 HR**..... 1
**MYDAYIS 37.5 MG CAPSULE EXTENDED RELEASE 24 HR**..... 1
**MYDAYIS 50 MG CAPSULE EXTENDED RELEASE 24 HR**..... 1
*naftifine 1 % topical cream*..... 38
*naftifine 2 % topical cream*..... 38
*naftifine 2 % topical gel*..... 38
**NAFTIN 2 % TOPICAL GEL**..... 38
**NEFFY 1 MG/SPRAY (0.1 ML) NASAL SPRAY**.....5

**NEFFY 2 MG/SPRAY (0.1 ML) NASAL SPRAY** ..... 5
**NEULASTA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE** ..... 9
**NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE** ..... 9
**NEUPOGEN 300 MCG/ML INJECTION SOLUTION** ..... 9
**NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE** ..... 9
**NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION** ..... 9
**NEXICLON XR 0.17 MG TABLET,EXTENDED RELEASE** ..... 8
**NORITATE 1 % TOPICAL CREAM** ..... 40
**NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION** ..... 34
**NOVOLIN 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML (70-30) SUBCUTANEOUS** ..... 34
**NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN** ..... 34
**NOVOLIN N NPH U-100 INSULIN ISOPHANE 100 UNIT/ML SUBCUTANEOUS SUSP** ..... 34
**NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN** ..... 34
**NOVOLIN R REGULAR U-100 INSULIN 100 UNIT/ML INJECTION SOLUTION** ..... 34
**NYVEPRIA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE** ..... 9
*oxiconazole 1 % topical cream* ..... 38
*oxymetazoline 1 % topical cream* ..... 40
**PANCREAZE 10,500 UNIT-35,500 UNIT-61,500 UNIT CAPSULE,DELAYED RELEASE** ..... 24
**PANCREAZE 16,800 UNIT-56,800 UNIT-98,400 UNIT CAPSULE,DELAYED RELEASE** ..... 24
**PANCREAZE 2,600 UNIT-8,800 UNIT-15,200 UNIT CAPSULE,DELAYED RELEASE** ..... 24
**PANCREAZE 21,000 UNIT-54,700 UNIT-83,900 UNIT CAPSULE,DELAYED RELEASE** ..... 24
**PANCREAZE 37,000-97,300-149,900 UNIT CAPSULE,DELAYED RELEASE** 24
**PANCREAZE 4,200 UNIT-14,200 UNIT-24,600 UNIT CAPSULE,DELAYED RELEASE** ..... 24
**PERTZYE 16,000 UNIT-57,500 UNIT-60,500 UNIT CAPSULE,DELAYED RELEASE** ..... 24
**PERTZYE 24,000-86,250-90,750 UNIT CAPSULE,DELAYED RELEASE** ..... 24
**PERTZYE 4,000 UNIT-14,375 UNIT-15,125 UNIT CAPSULE,DELAYED RELEASE** ..... 24
**PERTZYE 8,000 UNIT-28,750 UNIT-30,250 UNIT CAPSULE,DELAYED RELEASE** ..... 24
**PROAIR RESPICLICK 90 MCG/ACTUATION BREATH ACTIVATED** ..... 4
**QUILLICHEW ER 20 MG CHEWABLE TABLET, EXTENDED RELEASE** ..... 1
**QUILLICHEW ER 30 MG CHEWABLE TABLET, EXTENDED RELEASE** ..... 1
**QUILLICHEW ER 40 MG CHEWABLE, EXTENDED RELEASE TABLET** ..... 1
**QUILLIVANT XR 5 MG/ML (25 MG/5 ML) ORAL SUSPENSION,EXTEND RELEASE 24HR** ..... 1
**QUVIVIQ 25 MG TABLET** ..... 35
**QUVIVIQ 50 MG TABLET** ..... 35
**RELEUKO 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE** ..... 9
**RELEUKO 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE** ..... 9
**RELEXXII 18 MG TABLET,EXTENDED RELEASE** ..... 1
**RELEXXII 27 MG TABLET,EXTENDED RELEASE** ..... 1
**RELEXXII 36 MG TABLET,EXTENDED RELEASE** ..... 1

**RELEXXII 45 MG TABLET,EXTENDED RELEASE** ..... 1
**RELEXXII 54 MG TABLET,EXTENDED RELEASE** ..... 1
**RELEXXII 63 MG TABLET,EXTENDED RELEASE** ..... 1
**RELEXXII 72 MG TABLET,EXTENDED RELEASE** ..... 1
**RELTONE 200 MG CAPSULE** ..... 41
**RELTONE 400 MG CAPSULE** ..... 41
**RHOFADE 1 % TOPICAL CREAM** ..... 40
**RHOPRESSA 0.02 % EYE DROPS** ..... 30
**RITALIN 10 MG TABLET** ..... 1
**RITALIN 20 MG TABLET** ..... 1
**RITALIN 5 MG TABLET** ..... 1
**ROCKLATAN 0.02 %-0.005 % EYE DROPS** ..... 30
**ROLVEDON 13.2 MG/0.6 ML SUBCUTANEOUS SYRINGE** ..... 9
**RYALTRIS 665 MCG-25 MCG/SPRAY NASAL SPRAY** ..... 11
**RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE** ..... 32
**RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE** ..... 32
**RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE** ..... 32
**RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE** ..... 32
**SEGLUROMET 2.5 MG-1,000 MG TABLET** ..... 33
**SEGLUROMET 2.5 MG-500 MG TABLET** ..... 33
**SEGLUROMET 7.5 MG-1,000 MG TABLET** ..... 33
**SEGLUROMET 7.5 MG-500 MG TABLET** ..... 33
**SOAANZ 40 MG TABLET** ..... 36
**SOOLANTRA 1 % TOPICAL CREAM** ..... 40
**SORILUX 0.005 % TOPICAL FOAM** ..... 39
**SPIRIVA WITH HANDIHALER 18 MCG AND INHALATION CAPSULES** ..... 17
**STEGLATRO 15 MG TABLET** ..... 33
**STEGLATRO 5 MG TABLET** ..... 33
**STIMUFEND 6 MG/0.6 ML SUBCUTANEOUS SYRINGE** ..... 9
**SUBOXONE 12 MG-3 MG SUBLINGUAL FILM** ..... 37
**SUBOXONE 2 MG-0.5 MG SUBLINGUAL FILM** ..... 37
**SUBOXONE 4 MG-1 MG SUBLINGUAL FILM** ..... 37
**SUBOXONE 8 MG-2 MG SUBLINGUAL FILM** ..... 37
**SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER** ..... 28
**SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER** ..... 28
**TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION** ..... 39
*tiotropium bromide 18 mcg capsule with inhalation device* ..... 17
**TRYPTYR 0.003 % EYE DROPS IN A DROPPERETTE** ..... 10
**TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED** ..... 17
**TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED (30 ACTUAT)** ..... 17
**TYRVAYA 0.03 MG/SPRAY NASAL SPRAY** ..... 10
**UDENYCA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE** ..... 9
**UDENYCA AUTOINJECTOR 6 MG/0.6 ML SUBCUTANEOUS AUTO-INJECTOR** ..... 9
*umeclidinium 62.5 mcg/actuation blister powder for inhalation* ..... 17
*umeclidinium 62.5 mcg-vilanterol 25 mcg/actuation powdr for inhalation* ..... 18
*ursodiol 200 mg capsule* ..... 41
*ursodiol 400 mg capsule* ..... 41
**URSOLIGN 150 MG CAPSULE** ..... 41
**VABRINTY (4 MONTH) 30 MG SUBCUTANEOUS SYRINGE** ..... 42
**VABRINTY 22.5 MG (3 MONTH) SUBCUTANEOUS SYRINGE** ..... 42
**VABRINTY 45 MG (6 MONTH) SUBCUTANEOUS SYRINGE** ..... 42

**VABRINTY 7.5 MG (1 MONTH) SUBCUTANEOUS SYRINGE** ..... 42
**VECTICAL 3 MCG/GRAM TOPICAL OINTMENT** ..... 39
**VEVYE 0.1 % EYE DROPS** ..... 10
**VYSCOXA 10 MG/ML ORAL SUSPENSION** ..... 43
**VYVANSE 10 MG CAPSULE** ..... 1
**VYVANSE 10 MG CHEWABLE TABLET** ..... 1
**VYVANSE 20 MG CAPSULE** ..... 1
**VYVANSE 20 MG CHEWABLE TABLET** ..... 1
**VYVANSE 30 MG CAPSULE** ..... 1
**VYVANSE 30 MG CHEWABLE TABLET** ..... 1
**VYVANSE 40 MG CAPSULE** ..... 1
**VYVANSE 40 MG CHEWABLE TABLET** ..... 1
**VYVANSE 50 MG CAPSULE** ..... 1
**VYVANSE 50 MG CHEWABLE TABLET** ..... 1
**VYVANSE 60 MG CAPSULE** ..... 1
**VYVANSE 60 MG CHEWABLE TABLET** ..... 1
**VYVANSE 70 MG CAPSULE** ..... 1
**VYZULTA 0.024 % EYE DROPS** ..... 26
**XELSTRYM 13.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH** ..... 1
**XELSTRYM 18 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH** ..... 1
**XELSTRYM 4.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH** ..... 1
**XELSTRYM 9 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH** ..... 1
**XOPENEX HFA 45 MCG/ACTUATION AEROSOL INHALER** ..... 6
**ZIEXTENZO 6 MG/0.6 ML SUBCUTANEOUS SYRINGE** ..... 9
**ZILXI 1.5 % TOPICAL FOAM** ..... 40
**ZIOPTAN (PF) 0.0015 % EYE DROPS IN A DROPPERETTE** ..... 26
**ZIRGAN 0.15 % EYE GEL** ..... 16
**ZOLYMBUS 0.01 % EYE GEL IN A DROPPERETTE** ..... 26