

Medicare Part D: 5 Tier Closed Performance Formulary

Please click [here](#).

For Medicare Part D: Prior Authorization Criteria

Please click [here](#).

For Medicare Part D: Step Therapy Criteria

Please click [here](#).

Formulary ID: 19232 Version: 19

Updated: 12/2019

Table of Contents

Anti - Infectives.....	5
Antineoplastic / Immunosuppressant Drugs.....	13
Autonomic / Cns Drugs, Neurology / Psych.....	19
Cardiovascular, Hypertension / Lipids.....	33
Dermatologicals/Topical Therapy.....	39
Diagnostics / Miscellaneous Agents.....	42
Ear, Nose / Throat Medications.....	44
Endocrine/Diabetes.....	45
Gastroenterology.....	49
Immunology, Vaccines / Biotechnology.....	52
Musculoskeletal / Rheumatology.....	56
Obstetrics / Gynecology.....	58
Ophthalmology.....	62
Respiratory And Allergy.....	64
Urologicals.....	67
Vitamins, Hematinics / Electrolytes.....	68

List of Abbreviations

T1: Cost-Sharing Tier 1 includes preferred generic drugs. This is the lowest cost-sharing tier.

T2: Cost-Sharing Tier 2 includes generic drugs.

T3: Cost-Sharing Tier 3 includes preferred brand name drugs and may include some single-sourced drugs (those generic drugs made by a single manufacturer).

T4: Cost-Sharing Tier 4 includes non-preferred brand name drugs and may include some single-sourced generic drugs (those generic drugs made by a single manufacturer).

T5: Cost-Sharing Tier 5 includes specialty drugs. This is the highest cost-sharing tier.

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

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

List of Patterns

lowercase italics: Generic drugs

UPPERCASE BOLD: Brand name drugs

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
Anti - Infectives		
<i>abacavir</i>	T3	
<i>abacavir-lamivudine</i>	T5	
<i>abacavir-lamivudine-zidovudine</i>	T5	
ABELCET	T5	PA-BvD
<i>acyclovir oral capsule</i>	T2	
<i>acyclovir oral suspension 200 mg/5 ml</i>	T4	
<i>acyclovir oral tablet</i>	T2	
<i>acyclovir sodium intravenous solution</i>	T4	PA-BvD
<i>adefovir</i>	T5	
<i>albendazole</i>	T4	
ALINIA	T4	
<i>amantadine hcl oral capsule</i>	T4	QL (124 EA per 31 days)
<i>amantadine hcl oral solution</i>	T4	QL (1240 ML per 31 days)
<i>amantadine hcl oral tablet</i>	T4	QL (124 EA per 31 days)
AMBISOME	T4	PA-BvD
<i>amikacin injection solution 500 mg/2 ml</i>	T3	
<i>amoxicillin oral capsule</i>	T1	
<i>amoxicillin oral suspension for reconstitution</i>	T1	
<i>amoxicillin oral tablet</i>	T1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	T1	
<i>amoxicillin-pot clavulanate</i>	T2	
<i>amphotericin b</i>	T4	PA-BvD
<i>ampicillin oral capsule 500 mg</i>	T2	
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	T2	
<i>ampicillin-sulbactam injection</i>	T2	
APTIVUS	T5	
ARIKAYCE	T5	PA
<i>atazanavir</i>	T3	
<i>atovaquone</i>	T5	
<i>atovaquone-proguanil</i>	T4	
ATRIPLA	T5	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
AZACTAM INJECTION RECON SOLN 2 GRAM	T4	
<i>azithromycin</i>	T2	
<i>aztreonam injection recon soln 1 gram</i>	T3	
BETHKIS	T4	PA
BICILLIN C-R	T3	
BICILLIN L-A	T3	
BIKTARVY	T5	QL (31 EA per 31 days)
CANCIDAS INTRAVENOUS RECON SOLN 50 MG	T5	
CANCIDAS INTRAVENOUS RECON SOLN 70 MG	T4	
<i>caspofungin</i>	T4	
CAYSTON	T5	
<i>cefaclor oral capsule</i>	T2	
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml</i>	T2	
<i>cefaclor oral tablet extended release 12 hr</i>	T3	
<i>cefadroxil oral capsule</i>	T2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	T2	
<i>cefadroxil oral tablet</i>	T2	
<i>cefazolin injection recon soln 1 gram, 10 gram, 500 mg</i>	T3	
<i>cefdinir</i>	T2	
<i>cefepime injection</i>	T4	
<i>cefixime oral capsule</i>	T3	
<i>cefotaxime injection recon soln 1 gram, 500 mg</i>	T2	
<i>cefoxitin</i>	T4	
<i>cefpodoxime</i>	T4	
<i>cefprozil</i>	T3	
<i>ceftazidime</i>	T4	
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	T3	
<i>cefuroxime axetil oral tablet</i>	T3	
<i>cefuroxime sodium injection recon soln 750 mg</i>	T3	
<i>cefuroxime sodium intravenous</i>	T3	
<i>cephalexin</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>chloroquine phosphate</i>	T3	
CIMDUO	T5	QL (31 EA per 31 days)
<i>ciprofloxacin hcl oral</i>	T1	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	T2	
<i>ciprofloxacin oral suspension,microcapsule recon 500 mg/5 ml</i>	T2	
<i>clarithromycin oral suspension for reconstitution</i>	T4	
<i>clarithromycin oral tablet</i>	T2	
<i>clarithromycin oral tablet extended release 24 hr</i>	T2	
<i>clindamycin hcl</i>	T2	
<i>clindamycin in 5 % dextrose</i>	T2	
<i>clindamycin palmitate hcl</i>	T2	
<i>clindamycin phosphate injection</i>	T2	
<i>clindamycin phosphate intravenous solution 600 mg/4 ml</i>	T2	
<i>clotrimazole mucous membrane</i>	T3	
COARTEM	T4	
<i>colistin (colistimethate na)</i>	T4	
COMPLERA	T5	
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	T4	
<i>dapsone oral</i>	T3	
<i>daptomycin</i>	T5	
DELSTRIGO	T5	QL (31 EA per 31 days)
DESCOVY	T5	QL (31 EA per 31 days)
<i>dicloxacillin</i>	T2	
<i>didanosine oral capsule,delayed release(dr/ec) 200 mg, 250 mg, 400 mg</i>	T4	
DIFICID	T5	QL (20 EA per 10 days)
DOVATO	T5	QL (31 EA per 31 days)
DOXY-100	T2	
<i>doxycycline hyclate oral capsule</i>	T2	
<i>doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg</i>	T2	
<i>doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg, 200 mg, 50 mg</i>	T2	
<i>doxycycline monohydrate oral capsule</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>doxycycline monohydrate oral suspension for reconstitution</i>	T2	
<i>doxycycline monohydrate oral tablet</i>	T2	
EDURANT	T5	
<i>efavirenz</i>	T3	
EMTRIVA	T3	
EMVERM	T5	
<i>entecavir</i>	T5	
EPCLUSA	T5	PA; QL (28 EA per 28 days)
EPIVIR HBV ORAL SOLUTION	T4	
ERAXIS(WATER DILUENT)	T4	
<i>ertapenem</i>	T4	
ERY-TAB	T4	
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	T4	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	T4	
<i>erythromycin ethylsuccinate oral suspension for reconstitution</i>	T2	
<i>erythromycin ethylsuccinate oral tablet</i>	T2	
<i>erythromycin oral</i>	T2	
<i>ethambutol</i>	T4	
EVOTAZ	T4	
<i>famciclovir</i>	T3	
FIRVANQ	T4	
<i>fluconazole</i>	T2	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml</i>	T2	
<i>flucytosine</i>	T4	
<i>fosamprenavir</i>	T5	
FUZEON SUBCUTANEOUS RECON SOLN	T5	
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	T2	
<i>gentamicin injection solution 40 mg/ml</i>	T1	
GENVOYA	T5	
<i>griseofulvin microsize</i>	T4	
<i>griseofulvin ultramicrosize</i>	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
HARVONI ORAL TABLET 90-400 MG	T5	PA; QL (28 EA per 28 days)
<i>hydroxychloroquine</i>	T2	
<i>imipenem-cilastatin</i>	T4	
INTELENCE ORAL TABLET 100 MG, 200 MG	T5	
INTELENCE ORAL TABLET 25 MG	T4	
INVANZ INJECTION	T4	
INVIRASE ORAL TABLET	T5	
ISENTRESS HD	T4	
ISENTRESS ORAL POWDER IN PACKET	T3	
ISENTRESS ORAL TABLET	T5	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	T5	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	T3	
<i>isoniazid oral solution</i>	T2	
<i>isoniazid oral tablet</i>	T1	
<i>itraconazole oral capsule</i>	T4	PA
<i>itraconazole oral solution</i>	T5	PA
<i>ivermectin oral</i>	T3	
JULUCA	T5	
KALETRA ORAL TABLET 100-25 MG	T3	
KALETRA ORAL TABLET 200-50 MG	T5	
<i>ketoconazole oral</i>	T4	
<i>lamivudine</i>	T2	
<i>lamivudine-zidovudine</i>	T2	
<i>ledipasvir-sofosbuvir</i>	T5	PA; QL (28 EA per 28 days)
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	T2	
<i>levofloxacin intravenous</i>	T2	
<i>levofloxacin oral</i>	T2	
LEXIVA ORAL SUSPENSION	T4	
<i>linezolid in dextrose 5%</i>	T4	
<i>linezolid oral suspension for reconstitution</i>	T5	
<i>linezolid oral tablet</i>	T4	
<i>lopinavir-ritonavir</i>	T5	
MAVYRET	T5	PA; QL (84 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>mefloquine</i>	T3	
<i>meropenem</i>	T4	
<i>methenamine hippurate</i>	T4	
<i>metronidazole in nacl (iso-os)</i>	T2	
<i>metronidazole oral tablet</i>	T2	
<i>minocycline</i>	T2	
MONDOXYNE NL ORAL CAPSULE 100 MG, 75 MG	T2	
MORGIDOX ORAL CAPSULE 50 MG	T3	
MYCAMINE	T5	
<i>nafcillin injection</i>	T4	
NEBUPENT	T4	PA-BvD
<i>neomycin</i>	T2	
<i>nevirapine</i>	T2	
<i>nitrofurantoin</i>	T2	PA; QL (1800 ML per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 100 mg</i>	T2	PA; QL (90 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	T2	PA; QL (360 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 50 mg</i>	T2	PA; QL (180 EA per 365 days)
<i>nitrofurantoin monohyd/m-cryst</i>	T2	PA; QL (90 EA per 365 days)
NORVIR ORAL POWDER IN PACKET	T3	
NORVIR ORAL SOLUTION	T3	
NUZYRA	T5	
NUZYRA (7 DAY WITH LOAD DOSE)	T5	
NUZYRA (7 DAY)	T5	
<i>nystatin oral suspension</i>	T2	
<i>nystatin oral tablet</i>	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	T2	
<i>oseltamivir oral capsule 30 mg</i>	T2	QL (170 EA per 365 days)
<i>oseltamivir oral capsule 45 mg, 75 mg</i>	T2	QL (90 EA per 365 days)
<i>oseltamivir oral suspension for reconstitution</i>	T3	QL (1080 ML per 365 days)
<i>oxacillin in dextrose(iso-osm)</i>	T4	
<i>oxacillin injection recon soln 1 gram, 2 gram</i>	T2	
<i>paromomycin</i>	T4	
PASER	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml</i>	T4	
<i>penicillin g potassium injection recon soln 20 million unit</i>	T4	
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	T4	
<i>penicillin v potassium</i>	T1	
PENTAM	T4	
PIFELTRO	T5	QL (62 EA per 31 days)
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	T4	
<i>praziquantel</i>	T3	
PREZCOBIX	T5	
PREZISTA ORAL SUSPENSION	T5	
PREZISTA ORAL TABLET 150 MG, 75 MG	T3	
PREZISTA ORAL TABLET 600 MG, 800 MG	T5	
PRIFTIN	T4	
<i>primaquine</i>	T3	
<i>pyrazinamide</i>	T4	
<i>quinine sulfate</i>	T4	PA; QL (42 EA per 28 days)
RELENZA DISKHALER	T3	
RESCRIPTOR ORAL TABLET	T4	
REYATAZ ORAL POWDER IN PACKET	T4	
<i>ribavirin oral capsule</i>	T3	
<i>ribavirin oral tablet 200 mg</i>	T3	
<i>rifabutin</i>	T4	
<i>rifampin</i>	T4	
RIFATER	T4	
<i>rimantadine</i>	T4	
<i>ritonavir</i>	T3	
SELZENTRY ORAL SOLUTION	T5	
SELZENTRY ORAL TABLET 150 MG, 300 MG, 75 MG	T5	
SELZENTRY ORAL TABLET 25 MG	T4	
SIRTURO	T5	
SIVEXTRO INTRAVENOUS	T5	
SIVEXTRO ORAL	T5	QL (6 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>sofosbuvir-velpatasvir</i>	T5	PA; QL (28 EA per 28 days)
SOVALDI ORAL TABLET 400 MG	T5	PA; QL (28 EA per 28 days)
<i>stavudine oral capsule</i>	T4	
<i>streptomycin</i>	T4	
STRIBILD	T5	
<i>sulfadiazine</i>	T4	
<i>sulfamethoxazole-trimethoprim oral</i>	T1	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	T3	
SYMFI	T5	QL (31 EA per 31 days)
SYMFI LO	T5	QL (31 EA per 31 days)
SYMTUZA	T5	QL (31 EA per 31 days)
TAZICEF INJECTION	T4	
TEFLARO	T4	
<i>tenofovir disoproxil fumarate</i>	T3	
<i>terbinafine hcl oral</i>	T2	QL (90 EA per 180 days)
<i>tetracycline</i>	T4	
<i>tigecycline</i>	T4	
TIVICAY ORAL TABLET 10 MG	T4	
TIVICAY ORAL TABLET 25 MG, 50 MG	T5	
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	T3	PA; QL (224 EA per 56 days)
<i>tobramycin in 0.225 % nacl</i>	T5	PA
<i>tobramycin sulfate injection solution</i>	T4	
TOLSURA	T5	PA; QL (130 EA per 31 days)
TRECATOR	T4	
<i>trimethoprim</i>	T2	
TRIUMEQ	T5	
TRUVADA	T5	
TYBOST	T3	
TYGACIL	T5	
VABOMERE	T4	
<i>valacyclovir</i>	T3	
<i>valganciclovir oral recon soln</i>	T4	
<i>valganciclovir oral tablet</i>	T5	
<i>vancomycin intravenous recon soln 1,000 mg, 500 mg, 750 mg</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>vancomycin intravenous recon soln 10 gram</i>	T3	
<i>vancomycin intravenous recon soln 250 mg</i>	T4	
<i>vancomycin oral capsule 125 mg</i>	T4	
<i>vancomycin oral capsule 250 mg</i>	T5	
<i>vancomycin oral recon soln</i>	T4	
VEMLIDY	T5	QL (31 EA per 31 days)
VIDEX 2 GRAM PEDIATRIC	T4	
VIDEX EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 125 MG	T4	
VIEKIRA PAK	T5	PA; QL (112 EA per 28 days)
VIRACEPT ORAL TABLET	T5	
VIREAD ORAL POWDER	T4	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	T4	
<i>voriconazole intravenous</i>	T4	
<i>voriconazole oral suspension for reconstitution</i>	T4	
<i>voriconazole oral tablet</i>	T5	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	T4	QL (9 EA per 3 days)
XIFAXAN ORAL TABLET 550 MG	T5	PA; QL (62 EA per 31 days)
XOFLUZA	T3	QL (2 EA per 365 days)
ZEPATIER	T5	PA; QL (28 EA per 28 days)
<i>zidovudine</i>	T2	
Antineoplastic / Immunosuppressant Drugs		
<i>abiraterone</i>	T5	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)
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 (30 EA per 365 days)
<i>anastrozole</i>	T2	
<i>azathioprine</i>	T2	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
BALVERSA	T5	PA-NS
<i>bexarotene</i>	T5	PA-NS
<i>bicalutamide</i>	T3	
BOSULIF	T5	PA-NS
BRAFTOVI ORAL CAPSULE 75 MG	T5	PA-NS; QL (186 EA per 31 days)
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CALQUENCE	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA	T5	PA-NS
COMETRIQ	T5	PA-NS
COPIKTRA	T5	PA-NS; QL (62 EA per 31 days)
COTELLIC	T5	PA-NS; LA
<i>cyclophosphamide oral capsule 25 mg</i>	T5	PA-BvD
<i>cyclophosphamide oral capsule 50 mg</i>	T4	PA-BvD
<i>cyclosporine modified</i>	T2	PA-BvD
<i>cyclosporine oral capsule</i>	T2	PA-BvD
DAURISMO ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
DAURISMO ORAL TABLET 25 MG	T5	PA-NS; QL (62 EA per 31 days)
DROXIA	T4	
EMCYT	T4	
ERIVEDGE	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA	T5	PA-NS; QL (124 EA per 31 days)
<i>erlotinib</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>exemestane</i>	T4	
FARYDAK	T5	PA-NS
<i>flutamide</i>	T4	
GENGRAF ORAL CAPSULE 100 MG, 25 MG	T2	PA-BvD
GENGRAF ORAL SOLUTION	T2	PA-BvD
GILOTRIF	T5	PA-NS; QL (31 EA per 31 days)
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	T4	
<i>hydroxyurea</i>	T2	
IBRANCE	T5	PA-NS; QL (21 EA per 28 days)
ICLUSIG ORAL TABLET 15 MG	T5	PA-NS; QL (31 EA per 31 days)
ICLUSIG ORAL TABLET 45 MG	T5	PA-NS; QL (62 EA per 31 days)
IDHIFA 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 page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
IDHIFA ORAL TABLET 50 MG	T5	PA-NS; QL (62 EA per 31 days)
<i>imatinib oral tablet 100 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>imatinib oral tablet 400 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
IMBRUVICA ORAL CAPSULE 140 MG	T5	PA-NS; QL (124 EA per 31 days)
IMBRUVICA ORAL CAPSULE 70 MG	T5	PA-NS; QL (31 EA per 31 days)
IMBRUVICA ORAL TABLET	T5	PA-NS; QL (31 EA per 31 days)
INLYTA	T5	PA-NS; QL (124 EA per 31 days)
INREBIC	T5	PA-NS; QL (124 EA per 31 days)
IRESSA	T5	PA-NS
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	T5	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	T5	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	T5	PA-NS; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
LENVIMA	T5	PA-NS
<i>letrozole</i>	T2	
<i>leucovorin calcium oral</i>	T3	
LEUKERAN	T5	
<i>leuprolide subcutaneous kit</i>	T3	
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)
LUPRON DEPOT (3 MONTH)	T5	
LUPRON DEPOT (4 MONTH)	T5	
LUPRON DEPOT (6 MONTH)	T5	
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	T4	
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG	T5	
LYNPARZA ORAL TABLET	T5	PA-NS; QL (124 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
LYSODREN	T3	
MATULANE	T5	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml</i>	T4	PA
<i>megestrol oral tablet</i>	T4	PA-NS
MEKINIST	T5	PA-NS
MEKTOVI	T5	PA-NS; QL (186 EA per 31 days)
<i>mercaptopurine</i>	T2	
MESNEX ORAL	T4	
<i>methotrexate sodium</i>	T2	PA-BvD
<i>methotrexate sodium (pf) injection solution</i>	T2	PA-BvD
<i>mycophenolate mofetil</i>	T2	PA-BvD
<i>mycophenolate sodium</i>	T4	PA-BvD
NEORAL	T3	PA-BvD
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
NEXAVAR	T5	PA-NS; QL (124 EA per 31 days)
<i>nilutamide</i>	T5	
NINLARO	T5	PA-NS
NUBEQA	T5	PA-NS; QL (124 EA per 31 days)
<i>octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	T3	
<i>octreotide acetate injection solution 500 mcg/ml</i>	T5	
ODOMZO	T5	PA-NS; LA
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (28 EA per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	T5	PA-NS; QL (56 EA per 28 days)
POMALYST	T5	PA-NS; QL (21 EA per 28 days)
PROGRAF ORAL GRANULES IN PACKET	T4	PA-BvD
PURIXAN	T4	
RAPAMUNE ORAL SOLUTION	T5	PA-BvD
RAPAMUNE ORAL TABLET 0.5 MG	T4	PA-BvD
RAPAMUNE ORAL TABLET 1 MG, 2 MG	T5	PA-BvD
REVLIMID	T5	PA-NS; QL (21 EA per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	T5	PA-NS; QL (155 EA per 31 days)
ROZLYTREK ORAL CAPSULE 200 MG	T5	PA-NS; QL (93 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
RUBRACA	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE ORAL SOLUTION	T3	PA-BvD
SIGNIFOR	T5	PA
SIKLOS	T4	
<i>sirolimus oral solution</i>	T4	PA-BvD
<i>sirolimus oral tablet 0.5 mg, 2 mg</i>	T2	PA-BvD
<i>sirolimus oral tablet 1 mg</i>	T4	PA-BvD
SOLTAMOX	T4	
SOMATULINE DEPOT	T5	
SPRYCEL	T5	PA-NS; QL (31 EA per 31 days)
STIVARGA	T5	PA-NS; QL (84 EA per 28 days)
SUTENT	T5	PA-NS
SYNRIBO	T5	
TABLOID	T4	
<i>tacrolimus oral capsule 0.5 mg, 1 mg</i>	T2	PA-BvD
<i>tacrolimus oral capsule 5 mg</i>	T4	PA-BvD
TAFINLAR	T5	PA-NS
TAGRISSE	T5	PA-NS; LA; QL (31 EA per 31 days)
TALZENNA ORAL CAPSULE 0.25 MG	T5	PA-NS; QL (93 EA per 31 days)
TALZENNA ORAL CAPSULE 1 MG	T5	PA-NS; QL (31 EA per 31 days)
<i>tamoxifen</i>	T1	
TARCEVA	T5	PA-NS; QL (31 EA per 31 days)
TARGRETIN TOPICAL	T5	PA-NS
TASIGNA	T5	PA-NS; QL (124 EA per 31 days)
THALOMID ORAL CAPSULE 100 MG, 150 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 200 MG	T5	PA-NS; QL (56 EA per 28 days)
TIBSOVO	T5	PA-NS; QL (62 EA per 31 days)
<i>toremifene</i>	T4	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG, 22.5 MG	T3	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG	T5	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>tretinoin (chemotherapy)</i>	T5	
TURALIO	T5	PA-NS; QL (124 EA per 31 days)
TYKERB	T5	PA-NS
VENCLEXTA ORAL TABLET 10 MG	T4	PA-NS
VENCLEXTA ORAL TABLET 100 MG, 50 MG	T5	PA-NS
VENCLEXTA STARTING PACK	T5	PA-NS
VERZENIO	T5	PA-NS; QL (62 EA per 31 days)
VITRAKVI ORAL CAPSULE 100 MG	T5	PA-NS; QL (62 EA per 31 days)
VITRAKVI ORAL CAPSULE 25 MG	T5	PA-NS; QL (186 EA per 31 days)
VITRAKVI ORAL SOLUTION	T5	PA-NS; QL (310 ML per 31 days)
VIZIMPRO	T5	PA-NS; QL (31 EA per 31 days)
VOTRIENT	T5	PA-NS; QL (124 EA per 31 days)
XALKORI	T5	PA-NS; QL (62 EA per 31 days)
XATMEP	T4	PA-BvD
XERMELO	T5	PA; QL (93 EA per 31 days)
XGEVA	T5	
XOSPATA	T5	PA-NS; QL (124 EA per 31 days)
XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5)	T5	PA-NS; QL (20 EA per 28 days)
XPOVIO ORAL TABLET 160 MG/WEEK (20 MG X 8)	T5	PA-NS; QL (32 EA per 28 days)
XPOVIO ORAL TABLET 60 MG/WEEK (20 MG X 3)	T5	PA-NS; QL (12 EA per 28 days)
XPOVIO ORAL TABLET 80 MG/WEEK (20 MG X 4)	T5	PA-NS; QL (16 EA per 28 days)
XTANDI	T5	PA-NS; QL (124 EA per 31 days)
YONSA	T5	PA-NS; QL (124 EA per 31 days)
ZEJULA	T5	PA-NS; QL (93 EA per 31 days)
ZELBORAF	T5	PA-NS
ZOLINZA	T5	PA-NS
ZORTRESS ORAL TABLET 0.25 MG, 0.75 MG, 1 MG	T5	PA-BvD
ZORTRESS ORAL TABLET 0.5 MG	T4	PA-BvD
ZYDELIG	T5	PA-NS; QL (62 EA per 31 days)
ZYKADIA	T5	PA-NS
ZYTIGA ORAL TABLET 250 MG	T5	PA-NS; QL (124 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
ZYTIGA ORAL TABLET 500 MG	T5	PA-NS; QL (62 EA per 31 days)
Autonomic / Cns Drugs, Neurology / Psych		
ABILIFY MAINTENA	T5	QL (1 EA per 28 days)
ABSTRAL SUBLINGUAL TABLET 100 MCG	T4	PA; QL (124 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 200 MCG, 300 MCG	T5	PA; QL (124 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 400 MCG	T5	PA; QL (119 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 600 MCG	T5	PA; QL (79 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 800 MCG	T5	PA; QL (60 EA per 31 days)
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	T2	PA; QL (5167 ML per 31 days)
<i>acetaminophen-codeine oral tablet</i>	T2	PA; QL (403 EA per 31 days)
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)
<i>alprazolam oral tablet 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>amitriptyline</i>	T2	PA-NS
<i>amoxapine</i>	T2	
<i>amphetamine sulfate</i>	T2	
AMPYRA	T5	PA; QL (62 EA per 31 days)
APOKYN	T5	PA
APTIOM	T5	
<i>aripiprazole oral solution</i>	T4	PA-NS
<i>aripiprazole oral tablet</i>	T4	PA-NS
<i>aripiprazole oral tablet,disintegrating 10 mg</i>	T4	PA-NS
<i>aripiprazole oral tablet,disintegrating 15 mg</i>	T5	PA-NS
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
<i>atomoxetine oral capsule 10 mg, 25 mg, 40 mg</i>	T4	QL (62 EA per 31 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	T4	QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>atomoxetine oral capsule 18 mg</i>	T4	QL (124 EA per 31 days)
AUBAGIO	T5	PA; QL (31 EA per 31 days)
<i>baclofen oral tablet 10 mg, 20 mg</i>	T2	
BANZEL ORAL SUSPENSION	T5	PA-NS
BANZEL ORAL TABLET 200 MG	T4	PA-NS
BANZEL ORAL TABLET 400 MG	T5	PA-NS
<i>benztropine oral</i>	T2	PA
BRIVIACT ORAL	T4	
<i>bromocriptine</i>	T4	
BUNAVAIL BUCCAL FILM 2.1-0.3 MG	T4	ST; QL (31 EA per 31 days)
BUNAVAIL BUCCAL FILM 4.2-0.7 MG, 6.3-1 MG	T4	ST; QL (62 EA per 31 days)
<i>buprenorphine</i>	T4	PA; QL (4 EA per 28 days)
<i>buprenorphine hcl sublingual tablet 2 mg</i>	T3	QL (93 EA per 31 days)
<i>buprenorphine hcl sublingual tablet 8 mg</i>	T3	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 12-3 mg</i>	T3	ST; QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg</i>	T3	ST; QL (93 EA per 31 days)
<i>bupropion hcl oral tablet</i>	T3	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	T3	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	T3	QL (31 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 450 mg</i>	T4	
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	T3	QL (62 EA per 31 days)
<i>buspirone</i>	T2	
<i>butalbital-acetaminophen oral capsule</i>	T2	QL (403 EA per 31 days)
<i>butalbital-acetaminophen oral tablet 50-300 mg</i>	T2	QL (403 EA per 31 days)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	T2	QL (372 EA per 31 days)
<i>butorphanol tartrate nasal</i>	T4	QL (5 ML per 28 days)
BUTRANS	T4	PA; QL (4 EA per 28 days)
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	T2	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	T1	
<i>carbamazepine oral tablet</i>	T1	
<i>carbamazepine oral tablet extended release 12 hr</i>	T2	
<i>carbamazepine oral tablet, chewable</i>	T1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>carbidopa-levodopa</i>	T2	
<i>carbidopa-levodopa-entacapone</i>	T4	
<i>celecoxib</i>	T4	QL (62 EA per 31 days)
CELONTIN ORAL CAPSULE 300 MG	T4	
<i>chlorpromazine oral</i>	T4	
<i>citalopram</i>	T1	
<i>clobazam oral suspension</i>	T4	PA-NS
<i>clobazam oral tablet 10 mg</i>	T4	PA-NS
<i>clobazam oral tablet 20 mg</i>	T5	PA-NS
<i>clomipramine</i>	T4	PA-NS
<i>clonazepam oral tablet 0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>clonazepam oral tablet 1 mg</i>	T2	QL (124 EA per 31 days)
<i>clonazepam oral tablet 2 mg</i>	T2	QL (310 EA per 31 days)
<i>clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>clonazepam oral tablet,disintegrating 1 mg</i>	T2	QL (124 EA per 31 days)
<i>clonazepam oral tablet,disintegrating 2 mg</i>	T2	QL (310 EA per 31 days)
<i>clorazepate dipotassium oral tablet 15 mg</i>	T2	QL (186 EA per 31 days)
<i>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</i>	T2	QL (93 EA per 31 days)
<i>clozapine oral tablet</i>	T2	
<i>clozapine oral tablet,disintegrating</i>	T4	
<i>cyclobenzaprine oral tablet</i>	T2	PA
<i>dalfampridine</i>	T5	PA; QL (62 EA per 31 days)
<i>dantrolene oral</i>	T4	
<i>desipramine</i>	T4	
<i>desvenlafaxine succinate</i>	T4	QL (31 EA per 31 days)
<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	T2	QL (62 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 20 mg</i>	T2	QL (93 EA per 31 days)
DIASTAT	T4	
DIAZEPAM INTENSOL	T2	QL (248 ML per 31 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	T2	QL (1500 ML per 31 days)
<i>diazepam oral tablet</i>	T2	QL (124 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>diclofenac epolamine</i>	T4	PA; QL (62 EA per 31 days)
<i>diclofenac potassium</i>	T2	
<i>diclofenac sodium oral</i>	T2	
<i>diclofenac sodium topical drops</i>	T2	QL (450 ML per 28 days)
<i>diclofenac sodium topical gel 1 %</i>	T3	QL (300 GM per 30 days)
<i>diflunisal</i>	T4	
<i>dihydroergotamine nasal</i>	T2	QL (8 ML per 31 days)
DILANTIN	T4	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	
DILANTIN-125	T4	
<i>divalproex oral capsule, delayed rel sprinkle</i>	T2	
<i>divalproex oral tablet extended release 24 hr</i>	T3	
<i>divalproex oral tablet, delayed release (dr/ec)</i>	T2	
<i>donepezil</i>	T2	
<i>doxepin oral</i>	T2	PA-NS
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 60 mg</i>	T3	QL (62 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 30 mg, 40 mg</i>	T3	QL (31 EA per 31 days)
DURAMORPH (PF) INJECTION SOLUTION 0.5 MG/ML	T3	PA; QL (4000 ML per 30 days)
DURAMORPH (PF) INJECTION SOLUTION 1 MG/ML	T3	PA; QL (2000 ML per 30 days)
EMSAM	T5	QL (30 EA per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	T3	PA; QL (372 EA per 31 days)
<i>entacapone</i>	T2	
EPIDIOLEX	T5	PA-NS
EPITOL	T1	
<i>ergotamine-caffeine</i>	T2	
<i>escitalopram oxalate oral solution</i>	T4	QL (620 ML per 31 days)
<i>escitalopram oxalate oral tablet 10 mg</i>	T4	QL (45 EA per 30 days)
<i>escitalopram oxalate oral tablet 20 mg, 5 mg</i>	T4	QL (31 EA per 31 days)
<i>ethosuximide</i>	T2	
<i>etodolac</i>	T2	
FANAPT	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>felbamate</i>	T4	
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg</i>	T5	PA; QL (40 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 1,600 mcg</i>	T5	PA; QL (30 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	T4	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 100 mcg, 200 mcg</i>	T5	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr</i>	T4	PA; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr</i>	T4	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 25 mcg/hr</i>	T2	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 50 mcg/hr</i>	T2	PA; QL (17 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 75 mcg/hr</i>	T4	PA; QL (12 EA per 30 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG	T5	PA; QL (124 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 400 MCG	T5	PA; QL (119 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 600 MCG	T5	PA; QL (79 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 800 MCG	T5	PA; QL (59 EA per 31 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	T4	PA-NS; QL (56 EA per 365 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG	T4	PA-NS; QL (31 EA per 31 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	T4	PA-NS; QL (93 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
FIRDAPSE	T5	PA; QL (248 EA per 31 days)
FLECTOR	T4	PA; QL (62 EA per 31 days)
<i>fluoxetine oral capsule</i>	T1	
<i>fluoxetine oral solution</i>	T1	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	T1	
<i>fluphenazine decanoate</i>	T4	
<i>fluphenazine hcl</i>	T2	
<i>flurbiprofen</i>	T2	
<i>fluvoxamine</i>	T2	
FYCOMPA ORAL SUSPENSION	T4	
FYCOMPA ORAL TABLET	T4	
<i>gabapentin oral capsule</i>	T2	PA-NS
<i>gabapentin oral solution 250 mg/5 ml</i>	T2	PA-NS
<i>gabapentin oral tablet 600 mg, 800 mg</i>	T2	PA-NS
<i>galantamine</i>	T4	
GEODON INTRAMUSCULAR	T4	
GILENYA ORAL CAPSULE 0.5 MG	T5	PA; QL (31 EA per 31 days)
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	T5	QL (31 ML per 31 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	T5	QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	T5	QL (31 ML per 31 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	T5	QL (12 ML per 28 days)
<i>guanfacine oral tablet extended release 24 hr</i>	T4	PA
<i>guanidine</i>	T2	
<i>haloperidol</i>	T2	
<i>haloperidol decanoate</i>	T2	
<i>haloperidol lactate</i>	T2	
HETLIOZ	T5	PA
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	T4	PA; QL (5723 ML per 31 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	T3	PA; QL (155 EA per 31 days)
<i>hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml</i>	T2	PA; QL (124 ML per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>hydromorphone injection syringe 2 mg/ml</i>	T2	PA; QL (155 ML per 31 days)
<i>hydromorphone oral liquid</i>	T2	PA; QL (1550 ML per 31 days)
<i>hydromorphone oral tablet</i>	T2	PA; QL (186 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	
<i>ibuprofen oral suspension</i>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>imipramine hcl</i>	T2	PA-NS
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	T5	PA
<i>indomethacin oral</i>	T2	
INGREZZA INITIATION PACK	T5	PA; QL (56 EA per 365 days)
INGREZZA ORAL CAPSULE 40 MG	T5	PA; QL (62 EA per 31 days)
INGREZZA ORAL CAPSULE 80 MG	T5	PA; QL (31 EA per 31 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 78 MG/0.5 ML	T5	
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T4	
INVEGA TRINZA	T5	
<i>ketoprofen oral capsule 25 mg</i>	T3	
<i>ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg</i>	T3	
<i>lamotrigine oral tablet</i>	T2	
<i>lamotrigine oral tablet extended release 24hr</i>	T4	
<i>lamotrigine oral tablet, chewable dispersible</i>	T2	
<i>lamotrigine oral tablets,dose pack</i>	T2	
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)
LAZANDA NASAL SPRAY, NON-AEROSOL 100 MCG/SPRAY	T5	PA; QL (31 EA per 31 days)
LAZANDA NASAL SPRAY, NON-AEROSOL 300 MCG/SPRAY	T5	PA; QL (16 EA per 31 days)
LAZANDA NASAL SPRAY, NON-AEROSOL 400 MCG/SPRAY	T5	PA; QL (12 EA per 31 days)
<i>levetiracetam oral solution 100 mg/ml</i>	T2	
<i>levetiracetam oral tablet</i>	T2	
<i>levetiracetam oral tablet extended release 24 hr</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>lithium carbonate oral capsule</i>	T1	
<i>lithium carbonate oral tablet</i>	T1	
<i>lithium carbonate oral tablet extended release</i>	T2	
<i>lithium citrate oral solution 8 meq/5 ml</i>	T2	
<i>lorazepam oral concentrate</i>	T2	QL (155 ML per 31 days)
<i>lorazepam oral tablet 0.5 mg</i>	T2	QL (124 EA per 31 days)
<i>lorazepam oral tablet 1 mg</i>	T2	QL (186 EA per 31 days)
<i>lorazepam oral tablet 2 mg</i>	T2	QL (155 EA per 31 days)
LORCET (HYDROCODONE)	T2	PA; QL (372 EA per 31 days)
LORCET HD	T2	PA; QL (372 EA per 31 days)
LORCET PLUS ORAL TABLET 7.5-325 MG	T2	PA; QL (372 EA per 31 days)
<i>loxapine succinate</i>	T2	
LUCEMYRA	T4	
LYRICA CR	T4	PA; QL (31 EA per 31 days)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	T4	PA-NS; QL (93 EA per 31 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	T4	PA-NS; QL (62 EA per 31 days)
LYRICA ORAL SOLUTION	T4	PA-NS; QL (930 ML per 31 days)
<i>maprotiline</i>	T2	
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)
MAYZENT ORAL TABLET 0.25 MG	T5	PA; QL (155 EA per 31 days)
MAYZENT ORAL TABLET 2 MG	T5	PA; QL (31 EA per 31 days)
<i>meloxicam oral tablet</i>	T1	
<i>memantine oral capsule,sprinkle,er 24hr</i>	T3	
<i>memantine oral solution</i>	T3	
<i>memantine oral tablet</i>	T3	
<i>memantine oral tablets,dose pack</i>	T4	
MESTINON ORAL SYRUP	T5	
METADATE ER	T4	QL (93 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>methadone oral solution 10 mg/5 ml</i>	T2	PA; QL (1033 ML per 31 days)
<i>methadone oral solution 5 mg/5 ml</i>	T2	PA; QL (2066 ML per 31 days)
<i>methadone oral tablet 10 mg</i>	T2	PA; QL (206 EA per 31 days)
<i>methadone oral tablet 5 mg</i>	T2	PA; QL (248 EA per 31 days)
<i>methylphenidate hcl oral capsule, er biphasic 30-70</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 10 mg</i>	T2	QL (186 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 20 mg</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 40 mg</i>	T2	QL (62 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 60 mg</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral solution</i>	T2	
<i>methylphenidate hcl oral tablet</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 10 mg</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 20 mg</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 36 mg, 54 mg</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet,chewable 10 mg</i>	T2	QL (186 EA per 31 days)
<i>methylphenidate hcl oral tablet,chewable 2.5 mg, 5 mg</i>	T2	QL (93 EA per 31 days)
MIGERGOT	T5	
<i>mirtazapine</i>	T2	
<i>modafinil</i>	T3	PA; QL (31 EA per 31 days)
<i>molindone</i>	T2	
<i>morphine concentrate oral solution</i>	T2	PA; QL (310 ML per 31 days)
<i>morphine oral capsule, er multiphase 24 hr 120 mg</i>	T3	PA; QL (51 EA per 31 days)
<i>morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg</i>	T3	PA; QL (62 EA per 31 days)
<i>morphine oral capsule,extend.release pellets</i>	T3	PA; QL (62 EA per 31 days)
<i>morphine oral solution 10 mg/5 ml</i>	T2	PA; QL (2800 ML per 31 days)
<i>morphine oral solution 20 mg/5 ml (4 mg/ml)</i>	T2	PA; QL (1400 ML per 31 days)
<i>morphine oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<i>morphine oral tablet extended release 100 mg</i>	T3	PA; QL (62 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>morphine oral tablet extended release 15 mg, 30 mg, 60 mg</i>	T3	PA; QL (100 EA per 31 days)
<i>morphine oral tablet extended release 200 mg</i>	T3	PA; QL (31 EA per 31 days)
<i>nabumetone</i>	T2	
<i>naloxone</i>	T2	
<i>naltrexone</i>	T3	
NAMENDA XR ORAL CAP,SPRINKLE,ER 24HR DOSE PACK	T4	PA
NAMZARIC	T4	PA
<i>naproxen oral suspension</i>	T2	
<i>naproxen oral tablet</i>	T1	
<i>naproxen oral tablet,delayed release (dr/ec)</i>	T2	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T4	
<i>naproxen sodium oral tablet, er multiphase 24 hr</i>	T4	
<i>naratriptan oral tablet 1 mg</i>	T3	QL (20 EA per 28 days)
<i>naratriptan oral tablet 2.5 mg</i>	T3	QL (8 EA per 28 days)
NARCAN NASAL SPRAY,NON-AEROSOL 4 MG/ACTUATION	T3	
<i>nefazodone</i>	T4	
NEUPRO	T4	
<i>nortriptyline</i>	T2	
NOURIANZ	T5	PA; QL (31 EA per 31 days)
NUEDEXTA	T3	PA
NUPLAZID ORAL CAPSULE	T5	PA-NS
NUPLAZID ORAL TABLET 10 MG	T5	PA-NS
<i>olanzapine intramuscular</i>	T2	
<i>olanzapine oral</i>	T2	QL (31 EA per 31 days)
ONFI ORAL SUSPENSION	T4	PA-NS
ONFI ORAL TABLET 10 MG, 20 MG	T5	PA-NS
<i>oxcarbazepine</i>	T2	
<i>oxycodone oral capsule</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral concentrate</i>	T2	PA; QL (180 ML per 31 days)
<i>oxycodone oral solution</i>	T2	PA; QL (4133 ML per 31 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral tablet 30 mg</i>	T3	PA; QL (138 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	T3	PA; QL (372 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	T4	QL (31 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	T4	QL (62 EA per 31 days)
<i>paroxetine hcl oral tablet</i>	T1	
<i>paroxetine mesylate(menop.sym)</i>	T4	
PAXIL ORAL SUSPENSION	T4	
PEGANONE	T4	
<i>perphenazine</i>	T4	
PERSERIS	T5	
<i>phenelzine</i>	T2	
<i>phenobarbital</i>	T2	
PHENYTEK	T4	
<i>phenytoin oral suspension 125 mg/5 ml</i>	T2	
<i>phenytoin oral tablet,chewable</i>	T2	
<i>phenytoin sodium extended</i>	T2	
<i>pimozide</i>	T4	
<i>piroxicam</i>	T4	
<i>pramipexole oral tablet</i>	T2	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	T2	PA-NS; QL (62 EA per 31 days)
<i>pregabalin oral solution</i>	T2	PA-NS; QL (930 ML per 31 days)
<i>primidone</i>	T2	
<i>protriptyline</i>	T4	
<i>pyridostigmine bromide</i>	T3	
<i>quetiapine</i>	T3	QL (62 EA per 31 days)
<i>ramelteon</i>	T4	
<i>rasagiline</i>	T3	
REXULTI	T5	PA-NS; QL (31 EA per 31 days)
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 37.5 MG/2 ML	T4	
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 25 MG/2 ML, 50 MG/2 ML	T5	
<i>risperidone oral solution</i>	T2	QL (496 ML per 31 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T2	QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>risperidone oral tablet 3 mg</i>	T2	QL (93 EA per 31 days)
<i>risperidone oral tablet 4 mg</i>	T2	QL (124 EA per 31 days)
<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T4	QL (31 EA per 31 days)
<i>risperidone oral tablet,disintegrating 3 mg</i>	T4	QL (93 EA per 31 days)
<i>risperidone oral tablet,disintegrating 4 mg</i>	T4	QL (124 EA per 31 days)
<i>rivastigmine</i>	T3	QL (30 EA per 30 days)
<i>rivastigmine tartrate</i>	T3	
<i>rizatriptan oral tablet 10 mg</i>	T3	QL (12 EA per 28 days)
<i>rizatriptan oral tablet 5 mg</i>	T3	QL (24 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 10 mg</i>	T3	QL (12 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 5 mg</i>	T3	QL (24 EA per 28 days)
<i>ropinirole</i>	T2	
ROWEEPRA	T2	
ROWEEPRA XR	T2	
RUZURGI	T5	PA; QL (310 EA per 31 days)
SABRIL	T5	PA-NS
SAPHRIS	T4	QL (62 EA per 31 days)
<i>selegiline hcl</i>	T2	
<i>sertraline</i>	T1	
SILENOR	T4	PA
SPRITAM	T4	
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY	T5	PA; QL (124 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 400 MCG/SPRAY	T5	PA; QL (86 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 600 MCG/SPRAY	T5	PA; QL (57 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 800 MCG/SPRAY	T5	PA; QL (43 EA per 31 days)
<i>sulindac</i>	T2	
<i>sumatriptan nasal spray, non-aerosol 20 mg/actuation</i>	T2	QL (8 EA per 28 days)
<i>sumatriptan nasal spray, non-aerosol 5 mg/actuation</i>	T2	QL (32 EA per 28 days)
<i>sumatriptan succinate oral tablet 100 mg</i>	T2	QL (9 EA per 28 days)
<i>sumatriptan succinate oral tablet 25 mg</i>	T2	QL (36 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>sumatriptan succinate oral tablet 50 mg</i>	T2	QL (18 EA per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml</i>	T2	QL (6 ML per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	T2	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	T2	QL (6 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	T2	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous solution</i>	T2	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml</i>	T2	QL (4 ML per 28 days)
SUNOSI	T4	PA; QL (31 EA per 31 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	T5	PA-NS
SYMPAZAN ORAL FILM 5 MG	T4	PA-NS
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG (14)- 240 MG (46)	T5	PA; QL (120 EA per 365 days)
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 240 MG	T5	PA; QL (62 EA per 31 days)
TEGRETOL ORAL SUSPENSION	T4	
TEGRETOL ORAL TABLET	T4	
TEGRETOL XR	T4	
TEGSEDI	T5	PA; QL (6 ML per 28 days)
<i>temazepam</i>	T2	QL (31 EA per 31 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>tetrabenazine oral tablet 25 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>thioridazine</i>	T4	
<i>thiothixene</i>	T4	
<i>tiagabine</i>	T4	
<i>tizanidine</i>	T2	
<i>tolcapone</i>	T5	
<i>topiramate oral capsule, sprinkle</i>	T2	
<i>topiramate oral capsule,sprinkle,er 24hr 100 mg, 200 mg, 25 mg, 50 mg</i>	T4	
<i>topiramate oral tablet</i>	T2	
<i>tramadol oral capsule,er biphase 24 hr 25-75 100 mg, 200 mg</i>	T4	PA; QL (30 EA per 30 days)
<i>tramadol oral tablet</i>	T2	PA; QL (240 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>tramadol-acetaminophen</i>	T2	PA; QL (372 EA per 31 days)
<i>tranylcypromine</i>	T4	
<i>trazodone oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>trifluoperazine</i>	T4	
<i>trimipramine</i>	T3	PA-NS
TRINTELLIX	T3	PA-NS
<i>valproic acid</i>	T2	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	T2	
<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg</i>	T2	QL (31 EA per 31 days)
<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	T2	QL (93 EA per 31 days)
<i>venlafaxine oral tablet</i>	T2	
<i>venlafaxine oral tablet extended release 24hr</i>	T4	QL (31 EA per 31 days)
VERSACLOZ	T4	
<i>vigabatrin</i>	T5	PA-NS
VIGADRONE	T5	PA-NS
VIIBRYD ORAL TABLET	T3	PA-NS; QL (31 EA per 31 days)
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)	T3	PA-NS; QL (60 EA per 365 days)
VIMPAT ORAL SOLUTION	T4	PA-NS
VIMPAT ORAL TABLET	T4	PA-NS
VIVITROL	T5	
VRAYLAR ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
VRAYLAR ORAL CAPSULE,DOSE PACK	T4	PA-NS; QL (14 EA per 365 days)
XYREM	T5	PA; QL (540 ML per 30 days)
<i>zaleplon</i>	T4	
<i>ziprasidone hcl</i>	T4	QL (62 EA per 31 days)
<i>zolmitriptan oral tablet 2.5 mg</i>	T4	QL (16 EA per 28 days)
<i>zolmitriptan oral tablet 5 mg</i>	T4	QL (8 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 2.5 mg</i>	T4	QL (16 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 5 mg</i>	T4	QL (8 EA per 28 days)
<i>zolpidem oral tablet</i>	T4	
<i>zonisamide</i>	T2	
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG, 2.9-0.71 MG	T3	QL (93 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 8.6-2.1 MG	T3	QL (62 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 5.7-1.4 MG	T3	QL (31 EA per 31 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	T4	QL (2 EA per 28 days)
Cardiovascular, Hypertension / Lipids		
<i>acebutolol</i>	T2	
<i>amiloride</i>	T2	
<i>amiloride-hydrochlorothiazide</i>	T2	
<i>amiodarone oral</i>	T2	
<i>amlodipine</i>	T1	
<i>amlodipine-benazepril</i>	T1	
<i>amlodipine-olmesartan</i>	T4	QL (31 EA per 31 days)
<i>amlodipine-valsartan</i>	T2	
<i>amlodipine-valsartan-hcthiazid</i>	T2	
<i>aspirin-dipyridamole</i>	T4	
<i>atenolol</i>	T1	
<i>atenolol-chlorthalidone</i>	T2	
<i>atorvastatin</i>	T1	
<i>benazepril</i>	T1	
<i>benazepril-hydrochlorothiazide</i>	T1	
<i>bisoprolol fumarate</i>	T2	
<i>bisoprolol-hydrochlorothiazide</i>	T1	
BRILINTA	T3	
<i>bumetanide</i>	T2	
BYSTOLIC	T4	
CABLIVI INJECTION KIT	T5	PA
<i>candesartan</i>	T1	
<i>candesartan-hydrochlorothiazid</i>	T1	
<i>captopril</i>	T1	
<i>captopril-hydrochlorothiazide</i>	T1	
CARTIA XT	T1	
<i>carvedilol</i>	T1	
<i>carvedilol phosphate</i>	T4	
<i>chlorothiazide</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>cholestyramine (with sugar) oral powder in packet</i>	T2	
CHOLESTYRAMINE LIGHT ORAL POWDER	T2	
<i>cilostazol</i>	T2	
<i>clonidine</i>	T4	
<i>clonidine hcl oral tablet</i>	T1	
<i>clopidogrel oral tablet 75 mg</i>	T2	
<i>colesevelam</i>	T3	
<i>colestipol oral packet</i>	T4	
<i>colestipol oral tablet</i>	T4	
CORLANOR ORAL SOLUTION	T4	PA; QL (420 ML per 28 days)
CORLANOR ORAL TABLET 5 MG	T4	PA; QL (93 EA per 31 days)
CORLANOR ORAL TABLET 7.5 MG	T4	PA; QL (62 EA per 31 days)
COUMADIN ORAL	T4	
DEMSER	T3	
DIGITEK ORAL TABLET 125 MCG (0.125 MG)	T1	PA
DIGITEK ORAL TABLET 250 MCG (0.25 MG)	T2	PA
DIGOX ORAL TABLET 125 MCG (0.125 MG)	T1	PA
DIGOX ORAL TABLET 250 MCG (0.25 MG)	T2	PA
<i>digoxin oral solution 50 mcg/ml (0.05 mg/ml)</i>	T2	PA
<i>digoxin oral tablet 125 mcg (0.125 mg)</i>	T1	PA
<i>digoxin oral tablet 250 mcg (0.25 mg)</i>	T2	PA
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	T1	
<i>diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg</i>	T1	
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	
<i>diltiazem hcl oral tablet</i>	T1	
DILT-XR	T1	
<i>dofetilide</i>	T3	
DOPTELET (10 TAB PACK)	T5	PA
DOPTELET (15 TAB PACK)	T5	PA
DOPTELET (30 TAB PACK)	T5	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>doxazosin</i>	T2	
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 31 days)
ELIQUIS ORAL TABLETS,DOSE PACK	T3	QL (74 EA per 31 days)
<i>enalapril maleate</i>	T1	
<i>enalapril-hydrochlorothiazide</i>	T1	
<i>enoxaparin subcutaneous syringe 100 mg/ml, 120 mg/0.8 ml, 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml</i>	T4	
<i>enoxaparin subcutaneous syringe 150 mg/ml</i>	T5	
ENTRESTO	T3	QL (62 EA per 31 days)
<i>eplerenone</i>	T4	
<i>ethacrynic acid</i>	T2	
<i>ezetimibe</i>	T2	
<i>ezetimibe-simvastatin</i>	T3	
<i>felodipine</i>	T2	
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg</i>	T2	
<i>fenofibrate nanocrystallized oral tablet 145 mg, 48 mg</i>	T2	
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	T2	
<i>flecainide</i>	T2	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	T5	
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	T4	
<i>fosinopril</i>	T1	
<i>fosinopril-hydrochlorothiazide</i>	T1	
<i>furosemide injection</i>	T2	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	T2	
<i>furosemide oral tablet</i>	T1	
<i>gemfibrozil</i>	T2	
<i>heparin (porcine) injection solution</i>	T2	
<i>hydralazine oral</i>	T2	
<i>hydrochlorothiazide</i>	T1	
<i>indapamide</i>	T2	
<i>irbesartan</i>	T1	QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>irbesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<i>isosorbide dinitrate oral</i>	T2	
<i>isosorbide mononitrate</i>	T2	
<i>isradipine</i>	T4	
JANTOVEN	T2	
JUXTAPID	T5	PA
<i>labetalol oral</i>	T1	
<i>lisinopril</i>	T1	
<i>lisinopril-hydrochlorothiazide</i>	T1	
<i>losartan oral tablet 100 mg</i>	T1	QL (31 EA per 31 days)
<i>losartan oral tablet 25 mg</i>	T1	QL (93 EA per 31 days)
<i>losartan oral tablet 50 mg</i>	T1	QL (62 EA per 31 days)
<i>losartan-hydrochlorothiazide</i>	T1	
<i>lovastatin</i>	T1	
<i>metolazone</i>	T2	
<i>metoprolol succinate</i>	T2	
<i>metoprolol ta-hydrochlorothiaz</i>	T2	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>mexiletine</i>	T4	
<i>minoxidil oral</i>	T2	
<i>moexipril</i>	T1	
MULPLETA	T5	PA
MULTAQ	T4	
<i>nadolol</i>	T4	
<i>niacin oral tablet extended release 24 hr 1,000 mg, 750 mg</i>	T4	
<i>niacin oral tablet extended release 24 hr 500 mg</i>	T4	QL (31 EA per 31 days)
NIACOR	T4	
<i>nicardipine oral</i>	T4	
<i>nifedipine oral tablet extended release</i>	T2	
<i>nifedipine oral tablet extended release 24hr</i>	T2	
<i>nimodipine</i>	T5	
NITRO-BID	T2	
NITRO-DUR	T4	
<i>nitroglycerin sublingual</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>nitroglycerin transdermal patch 24 hour</i>	T2	
<i>nitroglycerin translingual spray,non-aerosol</i>	T3	
NYMALIZE ORAL SOLUTION 30 MG/10 ML	T4	
<i>olmesartan-amlodipin-hcthiazid</i>	T4	
<i>omega-3 acid ethyl esters</i>	T4	
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	T4	PA; QL (93 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG	T5	PA; QL (186 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG	T5	PA; QL (521 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG	T5	PA; QL (261 EA per 31 days)
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	T2	
<i>pentoxifylline</i>	T2	
<i>perindopril erbumine</i>	T1	
<i>pindolol</i>	T4	
PRADAXA	T4	QL (62 EA per 31 days)
PRALUENT PEN	T5	PA; QL (2 ML per 28 days)
<i>prasugrel</i>	T3	
<i>pravastatin</i>	T1	
<i>prazosin</i>	T2	
PREVALITE ORAL POWDER IN PACKET	T4	
PROMACTA ORAL POWDER IN PACKET	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)
<i>propafenone oral capsule,extended release 12 hr</i>	T3	
<i>propafenone oral tablet</i>	T2	
<i>propranolol oral capsule,extended release 24 hr</i>	T4	
<i>propranolol oral solution</i>	T2	
<i>propranolol oral tablet</i>	T2	
<i>propranolol-hydrochlorothiazid</i>	T2	
QBRELIS	T4	
<i>quinapril</i>	T1	
<i>quinapril-hydrochlorothiazide</i>	T1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>quinidine gluconate oral</i>	T2	
<i>quinidine sulfate oral tablet</i>	T2	
<i>ramipril</i>	T1	
<i>ranolazine</i>	T3	QL (62 EA per 31 days)
REPATHA PUSHTRONEX	T5	PA; QL (3.5 ML per 28 days)
REPATHA SURECLICK	T5	PA; QL (2 ML per 28 days)
REPATHA SYRINGE	T5	PA; QL (2 ML per 28 days)
<i>rosuvastatin</i>	T2	
<i>simvastatin</i>	T1	
SORINE	T1	
SOTALOL AF ORAL TABLET 120 MG	T1	
<i>sotalol oral</i>	T1	
<i>spironolactone</i>	T1	
<i>spironolacton-hydrochlorothiaz</i>	T2	
TAVALISSE	T5	PA; QL (62 EA per 31 days)
TAZTIA XT	T2	
<i>telmisartan</i>	T2	
<i>telmisartan-amlodipine</i>	T3	
<i>telmisartan-hydrochlorothiazid</i>	T2	
<i>terazosin</i>	T1	
<i>timolol maleate oral</i>	T1	
<i>torseamide oral</i>	T2	
<i>trandolapril</i>	T1	
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	T1	
<i>triamterene-hydrochlorothiazid oral tablet</i>	T1	
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	T5	PA; QL (62 EA per 31 days)
UPTRAVI ORAL TABLET 200 MCG	T5	PA; QL (224 EA per 28 days)
UPTRAVI ORAL TABLETS,DOSE PACK	T5	PA; QL (200 EA per 28 days)
<i>valsartan oral tablet 160 mg, 40 mg, 80 mg</i>	T1	QL (62 EA per 31 days)
<i>valsartan oral tablet 320 mg</i>	T2	QL (31 EA per 31 days)
<i>valsartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
VASCEPA	T4	
<i>verapamil oral</i>	T2	
VYNDAQEL	T5	PA; QL (124 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>warfarin</i>	T1	
WELCHOL ORAL POWDER IN PACKET	T3	
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)
XARELTO ORAL TABLETS,DOSE PACK	T3	QL (51 EA per 30 days)
YOSPRALA	T4	PA; QL (31 EA per 31 days)
ZONTIVITY	T4	
Dermatologicals/Topical Therapy		
<i>acitretin</i>	T4	PA
<i>acyclovir topical cream</i>	T4	
<i>acyclovir topical ointment</i>	T3	
<i>adapalene topical cream</i>	T4	PA
<i>adapalene topical gel</i>	T4	PA
<i>adapalene topical solution</i>	T4	PA
<i>adapalene topical swab</i>	T4	PA
<i>adapalene-benzoyl peroxide</i>	T4	
ALA-CORT TOPICAL CREAM 1 %	T1	
ALA-CORT TOPICAL CREAM 2.5 %	T2	
<i>alclometasone</i>	T3	
<i>ammonium lactate</i>	T2	
AMNESTEEM	T4	
AVITA	T4	PA
BESER	T2	
<i>betamethasone dipropionate</i>	T2	
<i>betamethasone valerate</i>	T2	
<i>betamethasone, augmented</i>	T2	
<i>calcipotriene</i>	T4	QL (60 GM per 28 days)
<i>calcitriol topical</i>	T2	
<i>ciclopirox topical cream</i>	T2	QL (90 GM per 28 days)
<i>ciclopirox topical gel</i>	T2	QL (45 GM per 28 days)
<i>ciclopirox topical shampoo</i>	T2	
<i>ciclopirox topical solution</i>	T2	
<i>ciclopirox topical suspension</i>	T2	QL (60 ML per 28 days)
CLARAVIS	T4	
CLINDACIN P	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin phosphate topical foam</i>	T2	
<i>clindamycin phosphate topical gel</i>	T2	
<i>clindamycin phosphate topical lotion</i>	T2	
<i>clindamycin phosphate topical solution</i>	T2	
<i>clindamycin phosphate topical swab</i>	T2	
<i>clindamycin-tretinoin</i>	T2	
<i>clotrimazole topical</i>	T3	
<i>clotrimazole-betamethasone</i>	T2	
COSENTYX (2 SYRINGES)	T5	PA; QL (2 ML per 28 days)
COSENTYX PEN (2 PENS)	T5	PA; QL (2 ML per 28 days)
<i>dapsone topical</i>	T4	
DENAVIR	T4	
<i>desoximetasone</i>	T4	
<i>diclofenac sodium topical gel 3 %</i>	T5	PA; QL (100 GM per 28 days)
<i>doxepin topical</i>	T5	QL (45 GM per 28 days)
DUOBRII	T5	PA; QL (200 GM per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 300 MG/2 ML	T5	PA; QL (4 ML per 28 days)
ERY PADS	T2	
ERYGEL	T3	
<i>erythromycin with ethanol topical gel</i>	T2	
<i>erythromycin with ethanol topical solution</i>	T2	
<i>erythromycin-benzoyl peroxide</i>	T4	
EURAX	T4	
<i>fluocinolone and shower cap</i>	T4	
<i>fluocinolone topical cream</i>	T4	
<i>fluocinolone topical ointment</i>	T4	
<i>fluocinolone topical solution</i>	T4	
<i>fluocinonide topical cream 0.1 %</i>	T4	QL (120 GM per 28 days)
<i>fluocinonide topical gel</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical ointment</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical solution</i>	T2	QL (60 ML per 28 days)
FLUOCINONIDE-E	T2	QL (60 GM per 28 days)
<i>fluorouracil topical cream 0.5 %</i>	T5	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>fluorouracil topical cream 5 %</i>	T3	
<i>fluorouracil topical solution 2 %</i>	T2	
<i>fluorouracil topical solution 5 %</i>	T3	
<i>flurandrenolide</i>	T3	
<i>fluticasone propionate topical</i>	T2	
<i>gentamicin topical</i>	T2	
<i>halobetasol propionate topical cream</i>	T4	
<i>halobetasol propionate topical ointment</i>	T4	
<i>hydrocortisone butyrate</i>	T2	
<i>hydrocortisone topical cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone topical lotion 2.5 %</i>	T1	
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	T1	
<i>hydrocortisone valerate</i>	T2	
<i>imiquimod topical cream in packet</i>	T2	
<i>isotretinoin</i>	T4	
<i>ketoconazole topical</i>	T2	
<i>lidocaine hcl mucous membrane jelly</i>	T2	PA; QL (60 ML per 28 days)
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	T2	PA; QL (50 ML per 28 days)
<i>lidocaine topical adhesive patch,medicated</i>	T2	PA; QL (93 EA per 31 days)
<i>lidocaine topical ointment</i>	T2	PA; QL (50 GM per 28 days)
LIDOCAINE VISCOUS	T2	
<i>lidocaine-prilocaine topical cream</i>	T2	PA; QL (30 GM per 28 days)
<i>malathion</i>	T4	
<i>methoxsalen</i>	T2	
<i>metronidazole topical cream</i>	T4	
<i>metronidazole topical gel 0.75 %</i>	T4	
<i>metronidazole topical gel 1 %</i>	T2	
<i>metronidazole topical lotion</i>	T4	
<i>mometasone topical</i>	T2	
<i>mupirocin</i>	T2	
<i>mupirocin calcium</i>	T2	
MYORISAN	T4	
NOLIX	T3	
NYAMYC	T2	
<i>nystatin topical</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
NYSTOP	T2	
PANRETIN	T5	
<i>permethrin topical cream</i>	T2	
<i>podofilox</i>	T3	
REGRANEX	T5	PA
SANTYL	T4	
<i>selenium sulfide topical lotion</i>	T2	
SILIQ	T5	PA; QL (6 ML per 28 days)
<i>silver sulfadiazine</i>	T2	
SKYRIZI SUBCUTANEOUS SYRINGE KIT	T5	PA; QL (1 EA per 28 days)
SSD	T2	
STELARA SUBCUTANEOUS SOLUTION	T5	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 28 days)
<i>sulfacetamide sodium (acne)</i>	T2	
SULFAMYLON TOPICAL CREAM	T3	
<i>tacrolimus topical</i>	T4	
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE	T5	PA; QL (1 ML per 28 days)
<i>tazarotene</i>	T4	PA
TAZORAC TOPICAL CREAM 0.05 %	T4	PA
TAZORAC TOPICAL GEL	T4	PA
<i>tretinoin</i>	T2	PA
<i>tretinoin microspheres topical gel</i>	T2	PA
<i>triamcinolone acetonide topical aerosol</i>	T2	
<i>triamcinolone acetonide topical cream</i>	T2	
<i>triamcinolone acetonide topical lotion</i>	T2	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	T2	
TRIDERM TOPICAL CREAM 0.1 %	T2	
VALCHLOR	T4	PA-NS
Diagnostics / Miscellaneous Agents		
<i>acamprosate</i>	T4	
<i>alendronate oral tablet 40 mg</i>	T1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>anagrelide</i>	T4	
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
AURYXIA	T5	PA
<i>bupropion hcl (smoking deter)</i>	T3	QL (62 EA per 31 days)
CARBAGLU	T5	PA
<i>cevimeline</i>	T4	
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
<i>d10 %-0.45 % sodium chloride</i>	T2	
<i>d2.5 %-0.45 % sodium chloride</i>	T2	
<i>d5 % and 0.9 % sodium chloride</i>	T2	
<i>d5 %-0.45 % sodium chloride</i>	T2	
<i>deferasirox</i>	T5	
<i>dextrose 10 % and 0.2 % nacl</i>	T2	
<i>dextrose 10 % in water (d10w)</i>	T2	
<i>dextrose 5 % in water (d5w) intravenous parenteral solution</i>	T2	
<i>dextrose 5%-0.2 % sod chloride</i>	T2	
<i>dextrose 5%-0.3 % sod.chloride</i>	T2	
DEXTROSE WITH SODIUM CHLORIDE	T2	
<i>disulfiram</i>	T4	
ENDARI	T4	PA; QL (180 EA per 30 days)
EXJADE	T5	
FERRIPROX	T5	
INCRELEX	T5	PA
KIONEX (WITH SORBITOL)	T4	
<i>levocarnitine (with sugar)</i>	T4	PA-BvD
<i>levocarnitine oral tablet</i>	T4	PA-BvD
LOKELMA	T3	PA; QL (93 EA per 31 days)
<i>midodrine</i>	T4	
NICOTROL	T4	
NICOTROL NS	T3	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
NITYR	T5	
NORTHERA	T5	PA
ORFADIN	T5	
<i>pilocarpine hcl oral</i>	T2	
PROLASTIN-C INTRAVENOUS RECON SOLN	T5	PA
RAVICTI	T5	PA
<i>riluzole</i>	T4	
<i>risedronate oral tablet 30 mg</i>	T2	
<i>sevelamer carbonate</i>	T3	
<i>sevelamer hcl</i>	T4	
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	T2	
<i>sodium chloride irrigation</i>	T2	
<i>sodium phenylbutyrate</i>	T5	
<i>sodium polystyrene sulfonate oral powder</i>	T4	
SPS (WITH SORBITOL) ORAL	T2	
TIGLUTIK	T5	PA
<i>trientine</i>	T4	
VELTASSA	T3	PA; QL (30 EA per 30 days)
XURIDEN	T5	PA
ZEMAIRA	T5	PA
Ear, Nose / Throat Medications		
<i>acetic acid otic (ear)</i>	T3	
<i>azelastine nasal</i>	T2	
<i>chlorhexidine gluconate mucous membrane</i>	T1	
CIPRO HC	T4	
CIPRODEX	T3	
FLAC OTIC OIL	T4	
<i>fluocinolone acetonide oil</i>	T4	
<i>ipratropium bromide nasal</i>	T1	
<i>neomycin-polymyxin-hc otic (ear)</i>	T3	
<i>ofloxacin otic (ear)</i>	T2	
<i>olopatadine nasal</i>	T2	
OTOVEL	T4	
<i>triamcinolone acetonide dental</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
Endocrine/Diabetes		
<i>acarbose</i>	T2	QL (93 EA per 31 days)
ACTHAR	T5	PA
ALCOHOL PADS	T4	
ANADROL-50	T4	PA
ANDRODERM	T3	PA
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	
BAQSIMI	T3	
BASAGLAR KWIKPEN U-100 INSULIN	T4	
<i>cabergoline</i>	T4	
<i>calcitonin (salmon)</i>	T3	PA-BvD
<i>calcitriol oral</i>	T2	PA-BvD
CERDELGA	T5	PA
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	T5	PA-BvD; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 90 mg</i>	T5	PA-BvD; QL (124 EA per 31 days)
<i>cortisone</i>	T4	
<i>danazol</i>	T4	
<i>desmopressin nasal spray,non-aerosol</i>	T2	
<i>desmopressin oral</i>	T2	
DEXAMETHASONE INTENSOL	T2	
<i>dexamethasone oral elixir</i>	T2	
<i>dexamethasone oral tablet</i>	T2	
<i>dexamethasone oral tablets,dose pack</i>	T2	
<i>doxercalciferol oral capsule 0.5 mcg</i>	T2	PA-BvD
<i>doxercalciferol oral capsule 1 mcg</i>	T5	PA-BvD
<i>doxercalciferol oral capsule 2.5 mcg</i>	T4	PA-BvD
EMFLAZA	T5	PA
FIASP FLEXTOUCH U-100 INSULIN	T4	
FIASP U-100 INSULIN	T4	
<i>fludrocortisone</i>	T2	
GALAFOLD	T5	PA; QL (14 EA per 28 days)
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T3	
<i>glimepiride</i>	T1	
<i>glipizide</i>	T1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>glipizide-metformin</i>	T1	
GLUCAGEN HYPOKIT	T3	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
<i>glyburide</i>	T2	PA
<i>glyburide micronized</i>	T2	PA
<i>glyburide-metformin</i>	T2	PA
GLYXAMBI	T3	QL (31 EA per 31 days)
HUMALOG JUNIOR KWIKPEN U-100	T3	
HUMALOG KWIKPEN INSULIN	T3	
HUMALOG MIX 50-50 INSULN U-100	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) INSULIN	T3	
HUMULIN R U-500 (CONC) KWIKPEN	T3	
<i>hydrocortisone oral</i>	T1	
<i>insulin lispro</i>	T3	
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge</i>	T4	
INVOKAMET	T3	QL (62 EA per 31 days)
INVOKAMET XR	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 100 MG	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 300 MG	T3	QL (31 EA per 31 days)
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)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
JARDIANCE	T3	
JENTADUETO	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	T5	PA
KORLYM	T5	PA
KUVAN ORAL TABLET,SOLUBLE	T5	PA
LANTUS SOLOSTAR U-100 INSULIN	T3	
LANTUS U-100 INSULIN	T3	
LEVEMIR FLEXTOUCH U-100 INSULN	T3	
LEVEMIR U-100 INSULIN	T3	
<i>levothyroxine oral</i>	T1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	T2	
<i>liothyronine oral</i>	T2	
<i>metformin oral tablet</i>	T1	
<i>metformin oral tablet extended release 24 hr</i>	T1	
<i>metformin oral tablet extended release 24hr</i>	NF	
<i>metformin oral tablet,er gast.retention 24 hr</i>	NF	
<i>methimazole oral tablet 10 mg, 5 mg</i>	T2	
<i>methylprednisolone</i>	T2	
<i>miglustat</i>	T5	PA
MYALEPT	T5	PA
<i>nateglinide</i>	T1	QL (93 EA per 31 days)
NATPARA	T5	PA
NOVOLIN 70/30 U-100 INSULIN	T3	
NOVOLIN N NPH U-100 INSULIN	T3	
NOVOLIN R REGULAR U-100 INSULN	T3	
NOVOLOG FLEXPEN U-100 INSULIN	T3	
NOVOLOG MIX 70-30 U-100 INSULN	T3	
NOVOLOG MIX 70-30FLEXPEN U-100	T3	
NOVOLOG PENFILL U-100 INSULIN	T3	
NOVOLOG U-100 INSULIN ASPART	T3	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
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)
<i>oxandrolone oral tablet 10 mg</i>	T5	PA
<i>oxandrolone oral tablet 2.5 mg</i>	T3	PA
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML)	T3	QL (1.5 ML per 28 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/DOSE (2 MG/1.5 ML)	T3	QL (3 ML per 28 days)
PALYNZIQ	T5	PA
<i>paricalcitol oral</i>	T4	PA-BvD
<i>pen needle, diabetic needle 29 gauge x 1/2"</i>	T4	
<i>pioglitazone</i>	T1	QL (31 EA per 31 days)
<i>pioglitazone-metformin</i>	T2	QL (93 EA per 31 days)
<i>prednisolone oral solution 15 mg/5 ml</i>	T2	
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	T2	
PREDNISONE INTENSOL	T2	
<i>prednisone oral solution</i>	T2	
<i>prednisone oral tablet</i>	T1	
<i>prednisone oral tablets,dose pack</i>	T2	
PROGLYCEM	T4	
<i>propylthiouracil</i>	T2	
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	T2	QL (124 EA per 31 days)
<i>repaglinide oral tablet 2 mg</i>	T2	QL (248 EA per 31 days)
SAMSCA	T5	PA
SENSIPAR ORAL TABLET 30 MG, 60 MG	T5	PA-BvD; QL (62 EA per 31 days)
SENSIPAR ORAL TABLET 90 MG	T5	PA-BvD; QL (124 EA per 31 days)
SOMAVERT	T5	
STIMATE	T3	
SYMLINPEN 120	T3	QL (10.8 ML per 28 days)
SYMLINPEN 60	T3	QL (6 ML per 28 days)
SYNAREL	T5	
SYNJARDY	T3	QL (62 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	T3	QL (31 EA per 31 days)
SYNTHROID	T3	
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	T3	PA
<i>testosterone enanthate</i>	T3	PA
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	T3	PA
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)</i>	T3	PA
TIROSINT ORAL CAPSULE 175 MCG, 200 MCG	T4	
<i>tolbutamide</i>	T2	
TOUJEO MAX U-300 SOLOSTAR	T3	
TOUJEO SOLOSTAR U-300 INSULIN	T3	
TRADJENTA	T3	QL (31 EA per 31 days)
TRESIBA FLEXTOUCH U-100	T3	
TRESIBA FLEXTOUCH U-200	T3	
TRESIBA U-100 INSULIN	T3	
TRULICITY	T3	QL (2 ML per 28 days)
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	T1	
VICTOZA 3-PAK	T3	QL (9 ML per 30 days)
XULTOPHY 100/3.6	T3	
ZAVESCA	T5	PA
Gastroenterology		
<i>alosetron</i>	T5	
AMITIZA	T3	QL (62 EA per 31 days)
<i>aprepitant</i>	T4	PA-BvD
ASACOL HD	T3	
<i>balsalazide</i>	T4	
BONJESTA	T4	PA; QL (62 EA per 31 days)
<i>budesonide oral</i>	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
CANASA	T3	
CHOLBAM	T5	PA
CIMZIA	T5	PA; QL (2 EA per 28 days)
CIMZIA POWDER FOR RECONST	T5	PA; QL (6 EA per 28 days)
CLENPIQ	T4	
COLOCORT	T4	
COMPRO	T4	
CONSTULOSE	T2	
CREON	T3	
<i>cromolyn oral</i>	T5	
CYSTADANE	T4	
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)	T3	
<i>dicyclomine oral capsule</i>	T2	
<i>dicyclomine oral solution</i>	T2	
<i>dicyclomine oral tablet</i>	T2	
<i>diphenoxylate-atropine</i>	T2	
<i>doxylamine-pyridoxine (vit b6)</i>	T4	PA; QL (124 EA per 31 days)
<i>dronabinol</i>	T4	PA-BvD
ENULOSE	T2	
<i>esomeprazole magnesium</i>	T4	QL (31 EA per 31 days)
<i>famotidine oral suspension</i>	T2	
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T2	
GAVILYTE-G	T2	
GAVILYTE-N	T2	
GENERLAC	T2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T2	
GOLYTELY ORAL POWDER IN PACKET	T4	
<i>granisetron hcl oral</i>	T3	PA-BvD
<i>hydrocortisone rectal</i>	T1	
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	T4	
<i>lactulose oral packet</i>	T4	
<i>lactulose oral solution 10 gram/15 ml</i>	T2	
LINZESS	T3	QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>loperamide oral capsule</i>	T2	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	T2	
<i>mesalamine oral capsule (with del rel tablets)</i>	T3	
<i>mesalamine oral tablet,delayed release (dr/ec)</i>	T4	
<i>mesalamine rectal enema</i>	T4	
<i>metoclopramide hcl oral solution</i>	T2	
<i>metoclopramide hcl oral tablet</i>	T2	
<i>misoprostol</i>	T2	
MOVANTI^K	T3	QL (31 EA per 31 days)
MOVIPREP	T4	
MYTESI	T4	QL (62 EA per 31 days)
OICALIVA	T5	PA; QL (31 EA per 31 days)
<i>omeprazole oral capsule,delayed release(dr/ec)</i>	T1	
<i>ondansetron</i>	T2	PA-BvD
<i>ondansetron hcl oral</i>	T3	PA-BvD
<i>pantoprazole oral</i>	T2	
<i>peg 3350-electrolytes</i>	T2	
<i>peg-electrolyte soln</i>	T2	
PENTASA	T3	
<i>prochlorperazine</i>	T2	
<i>prochlorperazine maleate</i>	T2	
PROCTO-PAK	T4	
PROCTOSOL HC TOPICAL	T4	
PROCTOZONE-HC	T4	
<i>rabeprazole oral tablet,delayed release (dr/ec)</i>	T2	QL (62 EA per 31 days)
<i>ranitidine hcl oral syrup</i>	T2	
<i>ranitidine hcl oral tablet 150 mg, 300 mg</i>	T1	
RECTIV	T4	
RELISTOR ORAL	T5	PA; QL (93 EA per 31 days)
<i>scopolamine base</i>	T4	QL (10 EA per 30 days)
SUCRAID	T5	
<i>sucralfate oral tablet</i>	T2	
<i>sulfasalazine</i>	T2	
SUPREP BOWEL PREP KIT	T3	
SYMPROIC	T4	PA; QL (31 EA per 31 days)
TRILYTE WITH FLAVOR PACKETS	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>ursodiol oral capsule</i>	T4	
<i>ursodiol oral tablet</i>	T3	
VIBERZI	T5	PA; QL (62 EA per 31 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, 3,000-10,000 -14,000-UNIT, 5,000-17,000- 24,000 UNIT	T3	
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 25,000-79,000- 105,000 UNIT, 40,000-126,000- 168,000 UNIT	T5	
Immunology, Vaccines / Biotechnology		
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 300 MCG/ML	T5	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	T4	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML, 60 MCG/0.3 ML	T4	PA-BvD
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	T5	PA-BvD
ARCALYST	T5	PA
<i>bcg vaccine, live (pf)</i>	T4	
BETASERON SUBCUTANEOUS KIT	T5	QL (14 EA per 28 days)
BEXSERO	T3	
BOOSTRIX TDAP	T3	
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG	T5	PA
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	T5	PA
FULPHILA	T5	
GAMMAGARD LIQUID	T5	PA
GAMMAGARD S-D (IGA < 1 MCG/ML)	T5	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T4	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 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
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG/ML (36 UNIT/ML)	T5	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 5 MG/ML (15 UNIT/ML)	T4	PA
GRANIX SUBCUTANEOUS SOLUTION	T5	
GRANIX SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML	T4	
GRANIX SUBCUTANEOUS SYRINGE 480 MCG/0.8 ML	T5	
HAVRIX (PF)	T3	
HIBERIX (PF)	T3	
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT)	T5	PA
HUMATROPE INJECTION CARTRIDGE 6 MG (18 UNIT)	T4	PA
HUMATROPE INJECTION RECON SOLN	T5	PA
IMOVAX RABIES VACCINE (PF)	T3	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	T3	
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)	T4	PA-NS
INTRON A INJECTION RECON SOLN 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML)	T5	PA-NS
INTRON A INJECTION SOLUTION 10 MILLION UNIT/ML	T4	PA-NS
INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML	T5	PA-NS
IPOL	T3	
IXIARO (PF)	T3	
KINRIX (PF)	T3	
LEUKINE INJECTION RECON SOLN	T5	PA
MENACTRA (PF) INTRAMUSCULAR SOLUTION	T3	
MENVEO A-C-Y-W-135-DIP (PF)	T3	
M-M-R II (PF)	T3	
NIVESTYM	T5	
NORDITROPIN FLEXP RO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML)	T5	PA
NORDITROPIN FLEXP RO SUBCUTANEOUS PEN INJECTOR 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
NUTROPIN AQ NUSPIN	T5	PA
OCTAGAM	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	T4	PA
PANZYGA	T5	PA
PEDIARIX (PF)	T3	PA-BvD
PEDVAX HIB (PF)	T3	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
PEGASYS	T5	PA
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML	T5	PA
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 40,000 UNIT/ML	T5	PA-BvD
PROQUAD (PF)	T3	
QUADRACEL (PF)	T3	
RABAVERT (PF)	T3	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	T3	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T4	PA-BvD
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	T5	PA-BvD
ROTARIX	T3	
ROTATEQ VACCINE	T3	
SAIZEN	T5	PA
SAIZEN SAIZENPREP	T5	PA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	T5	PA
SHINGRIX (PF)	T3	
SYLATRON	T5	PA-NS
TDVAX	T3	
TENIVAC (PF) INTRAMUSCULAR SYRINGE	T3	
<i>tetanus,diphtheria tox ped(pf)</i>	T4	
TRUMENBA	T3	
TWINRIX (PF) INTRAMUSCULAR SYRINGE	T3	
TYPHIM VI	T3	
UDENYCA	T5	
VAQTA (PF)	T3	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
VARIVAX (PF)	T3	
VARIZIG INTRAMUSCULAR SOLUTION	T4	
YF-VAX (PF)	T3	
ZARXIO	T5	
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG	T5	PA
ZOMACTON SUBCUTANEOUS RECON SOLN 5 MG	T4	PA
ZORBTIVE	T5	PA
ZOSTAVAX (PF)	T4	
Musculoskeletal / Rheumatology		
ACTEMRA ACTPEN	T5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
<i>alendronate oral tablet 10 mg, 35 mg, 5 mg, 70 mg</i>	T1	
<i>allopurinol</i>	T1	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
<i>colchicine oral tablet</i>	T4	QL (124 EA per 31 days)
DEPEN TITRATABS	T5	
ENBREL MINI	T5	PA; QL (7.84 ML per 28 days)
ENBREL SUBCUTANEOUS RECON SOLN	T5	PA; QL (8 EA 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 (7.84 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (7.84 ML per 28 days)
EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	T5	PA; QL (2.34 ML per 28 days)
<i>febuxostat</i>	T3	PA
FORTEO	T5	PA; QL (2.4 ML per 28 days)
HUMIRA	T5	PA; QL (2 EA per 28 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	T5	PA; QL (3 EA per 28 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (6 PACK)	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN	T5	PA; QL (2 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN CROHNS-UC-HS START	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN PSOR-UEVITS-ADOL HS	T5	PA; QL (4 EA per 28 days)
HUMIRA(CF)	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	T5	PA; QL (2 EA per 28 days)
<i>ibandronate oral</i>	T4	
KEVZARA SUBCUTANEOUS SYRINGE	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
<i>leflunomide</i>	T3	
MITIGARE	T3	QL (62 EA per 31 days)
OLUMIANT ORAL TABLET 2 MG	T5	PA; QL (31 EA per 31 days)
ORENCIA CLICKJECT	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	T5	PA; QL (2.8 ML per 28 days)
OTEZLA	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (55 EA per 28 days)
<i>penicillamine</i>	T5	
<i>probenecid</i>	T2	
<i>probenecid-colchicine</i>	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)
<i>raloxifene</i>	T3	
RIDAURA	T4	
RINVOQ ER	T5	PA; QL (31 EA per 31 days)
<i>risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>risedronate oral tablet, delayed release (dr/ec)</i>	T2	
SAVELLA	T4	PA
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
TYMLOS	T5	PA; QL (1.56 ML per 31 days)
ULORIC	T3	PA
XELJANZ	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
Obstetrics / Gynecology		
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
AMABELZ	T2	
AMETHIA	T2	
AMETHIA LO	T2	
APRI	T2	
ARANELLE (28)	T2	
AVIANE	T2	
BALZIVA (28)	T2	
BLISOVI FE 1.5/30 (28)	T2	
BRIELLYN	T2	
CAMILA	T2	
CAMRESE LO	T2	
CAZIANZ (28)	T2	
<i>clindamycin phosphate vaginal</i>	T2	
CLINDESSE	T4	
CRINONE	T4	PA
CRYSELLE (28)	T2	
CYCLAFEM 1/35 (28)	T2	
CYCLAFEM 7/7/7 (28)	T2	
CYRED EQ	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	T4	
<i>desogestrel-ethinyl estradiol</i>	T2	
<i>drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4)</i>	T2	
<i>drospirenone-ethinyl estradiol</i>	T2	
EMOQUETTE	T2	
ENPRESSE	T2	
ENSKYCE	T2	
ERRIN	T2	
ESTARYLLA	T2	
<i>estradiol oral</i>	T2	
<i>estradiol transdermal patch weekly</i>	T2	
<i>estradiol vaginal</i>	T4	
<i>estradiol valerate intramuscular oil 20 mg/ml</i>	T2	
<i>estradiol-norethindrone acet</i>	T2	
<i>ethynodiol diac-eth estradiol</i>	T2	
FAYOSIM	T2	
FEMYNOR	T2	
FYAVOLV	T4	
GYNAZOLE-1	T4	
HAILEY 24 FE	T2	
INCASSIA	T2	
INTRAROSA	T4	PA; QL (28 EA per 28 days)
INTROVALE	T2	
ISIBLOOM	T2	
JASMIEL (28)	T2	
JINTELI	T4	
JULEBER	T2	
JUNEL 1.5/30 (21)	T2	
JUNEL 1/20 (21)	T2	
JUNEL FE 1.5/30 (28)	T2	
JUNEL FE 1/20 (28)	T2	
JUNEL FE 24	T2	
KARIVA (28)	T2	
KELNOR 1/35 (28)	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
KELNOR 1-50	T2	
KURVELO (28)	T2	
<i>l norgest/e.estradiol-e.estrad</i>	T2	
LARISSIA	T2	
LESSINA	T2	
LEVONEST (28)	T2	
<i>levonorgestrel-ethinyl estrad</i>	T2	
<i>levonorg-eth estrad triphasic</i>	T2	
LEVORA-28	T2	
LOPREEZA ORAL TABLET 1-0.5 MG	T2	
LORYNA (28)	T2	
LOW-OGESTREL (28)	T2	
LUTERA (28)	T2	
LYZA	T2	
MARLISSA (28)	T2	
<i>medroxyprogesterone</i>	T2	
MELODETTA 24 FE	T2	
<i>metronidazole vaginal</i>	T2	
MIBELAS 24 FE	T2	
MICONAZOLE-3 VAGINAL SUPPOSITORY	T2	
MICROGESTIN 1.5/30 (21)	T2	
MICROGESTIN 1/20 (21)	T2	
MICROGESTIN FE 1.5/30 (28)	T2	
MICROGESTIN FE 1/20 (28)	T2	
MILI	T2	
NECON 0.5/35 (28)	T2	
<i>noreth-ethinyl estradiol-iron</i>	T2	
<i>norethindrone (contraceptive)</i>	T2	
<i>norethindrone acetate</i>	T2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-20 mg-mcg, 1-5 mg-mcg</i>	T2	
<i>norethindrone-e.estradiol-iron oral tablet,chewable</i>	T2	
<i>norgestimate-ethinyl estradiol</i>	T2	
NORTREL 0.5/35 (28)	T2	
NORTREL 1/35 (21)	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
NORTREL 1/35 (28)	T2	
NORTREL 7/7/7 (28)	T2	
NUVARING	T3	
OGESTREL (28)	T2	
ORSYTHIA	T2	
PIMTREA (28)	T2	
PIRMELLA ORAL TABLET 1-35 MG-MCG	T2	
PORTIA 28	T2	
PREMARIN VAGINAL	T3	
PREVIFEM	T2	
RECLIPSEN (28)	T2	
RIVELSA	T2	
SETLAKIN	T2	
SPRINTEC (28)	T2	
SRONYX	T2	
SYEDA	T2	
TARINA 24 FE	T2	
<i>terconazole</i>	T2	
<i>tranexamic acid oral</i>	T3	
TRI-ESTARYLLA	T2	
TRI-LEGEST FE	T2	
TRI-LO-ESTARYLLA	T2	
TRI-LO-SPRINTEC	T2	
TRI-MILI	T2	
TRI-PREVIFEM (28)	T2	
TRI-SPRINTEC (28)	T2	
TRIVORA (28)	T2	
TRI-VYLIBRA	T2	
TRI-VYLIBRA LO	T2	
TYDEMY	T2	
VANDAZOLE	T2	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VIENVA	T2	
VYFEMLA (28)	T2	
VYLIBRA	T2	
YUVAFEM	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
ZARAH	T2	
ZOVIA 1/35E (28)	T2	
Ophthalmology		
<i>acetazolamide</i>	T3	
ALOMIDE	T3	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
<i>apraclonidine</i>	T2	
<i>azelastine ophthalmic (eye)</i>	T2	
AZOPT	T3	
<i>bacitracin ophthalmic (eye)</i>	T2	
<i>bacitracin-polymyxin b ophthalmic (eye)</i>	T2	
BESIVANCE	T4	
<i>betaxolol ophthalmic (eye)</i>	T4	
BLEPHAMIDE	T4	
BLEPHAMIDE S.O.P.	T4	
<i>brimonidine</i>	T2	
<i>bromfenac</i>	T4	
<i>carteolol</i>	T2	
CILOXAN OPHTHALMIC (EYE) OINTMENT	T3	
<i>ciprofloxacin hcl ophthalmic (eye)</i>	T2	
COMBIGAN	T3	
<i>cromolyn ophthalmic (eye)</i>	T2	
CYSTARAN	T5	
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	T2	
<i>diclofenac sodium ophthalmic (eye)</i>	T3	
<i>dorzolamide</i>	T2	
<i>dorzolamide-timolol</i>	T2	
DUREZOL	T3	
<i>erythromycin ophthalmic (eye)</i>	T2	
<i>fluorometholone</i>	T3	
<i>flurbiprofen sodium</i>	T2	
<i>gatifloxacin</i>	T4	
GENTAK OPHTHALMIC (EYE) OINTMENT	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>gentamicin ophthalmic (eye) drops</i>	T2	
ILEVRO	T3	
<i>ketorolac ophthalmic (eye)</i>	T3	
LACRISERT	T4	
LASTACAFT	T4	
<i>latanoprost</i>	T2	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	T2	
<i>levofloxacin ophthalmic (eye)</i>	T2	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
<i>methazolamide</i>	T4	
MOXEZA	T4	
<i>moxifloxacin ophthalmic (eye)</i>	T4	
NATACYN	T4	
<i>neomycin-bacitracin-poly-hc</i>	T3	
<i>neomycin-bacitracin-polymyxin</i>	T3	
<i>neomycin-polymyxin b-dexameth</i>	T2	
<i>neomycin-polymyxin-gramicidin</i>	T3	
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	T3	
<i>ofloxacin ophthalmic (eye)</i>	T2	
<i>olopatadine ophthalmic (eye) drops 0.2 %</i>	T3	
OXERVATE	T5	PA; QL (112 ML per 56 days)
PAZEO	T3	
PHOSPHOLINE IODIDE	T4	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T2	
<i>polymyxin b sulf-trimethoprim</i>	T2	
<i>prednisolone acetate</i>	T3	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	T3	
RESTASIS	T3	QL (60 EA per 30 days)
SIMBRINZA	T3	
<i>sulfacetamide sodium ophthalmic (eye)</i>	T2	
<i>sulfacetamide-prednisolone</i>	T2	
<i>timolol maleate ophthalmic (eye) drops</i>	T1	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	T3	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
TOBRADEX ST	T3	
<i>tobramycin</i>	T2	
<i>tobramycin-dexamethasone</i>	T4	
TOBREX OPHTHALMIC (EYE) OINTMENT	T4	
TRAVATAN Z	T3	
<i>trifluridine</i>	T2	
XIIDRA	T4	QL (60 EA per 30 days)
ZIRGAN	T4	
ZYLET	T4	
Respiratory And Allergy		
<i>acetylcysteine</i>	T2	PA-BvD
ADCIRCA	T5	PA; QL (62 EA per 31 days)
ADEMPAS	T5	PA; QL (93 EA per 31 days)
ADVAIR HFA	T4	QL (12 GM per 30 days)
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml</i>	T2	PA-BvD
<i>albuterol sulfate oral syrup</i>	T1	
<i>albuterol sulfate oral tablet</i>	T4	
<i>albuterol sulfate oral tablet extended release 12 hr</i>	T4	
ALYQ	T5	PA; QL (62 EA per 31 days)
<i>ambrisentan</i>	T5	PA; QL (31 EA per 31 days)
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
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)
BECONASE AQ	T4	
BERINERT INTRAVENOUS KIT	T5	PA
<i>bosentan</i>	T5	PA; QL (62 EA per 31 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>budesonide inhalation</i>	T2	PA-BvD
<i>cetirizine oral solution 1 mg/ml</i>	T2	
CINRYZE	T5	PA; QL (20 EA per 28 days)
COMBIVENT RESPIMAT	T4	QL (4 GM per 30 days)
<i>cromolyn inhalation</i>	T2	PA-BvD
<i>cyproheptadine</i>	T4	PA
DALIRESP	T4	QL (31 EA per 31 days)
<i>desloratadine</i>	T2	
<i>dexchlorpheniramine maleate oral solution</i>	T2	
DYMISTA	T4	
<i>epinephrine injection auto-injector</i>	T3	
ESBRIET ORAL CAPSULE	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 267 MG	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 801 MG	T5	PA; QL (93 EA per 31 days)
FASENRA	T5	PA
FIRAZYR	T5	PA; QL (18 ML per 30 days)
<i>flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)</i>	T2	
<i>fluticasone propionate nasal</i>	T2	
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated</i>	T3	QL (1 EA per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	T3	QL (60 EA per 30 days)
HAEGARDA	T5	PA
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	T2	PA
<i>hydroxyzine hcl oral tablet</i>	T2	PA
<i>icatibant</i>	T5	PA; QL (18 ML per 30 days)
INCRUSE ELLIPTA	T3	QL (30 EA per 30 days)
<i>ipratropium bromide inhalation</i>	T2	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET 25 MG	T5	PA; QL (62 EA per 31 days)
KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
LETAIRIS	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 page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>levalbuterol hcl inhalation solution for nebulization 1.25 mg/0.5 ml, 1.25 mg/3 ml</i>	T2	PA-BvD
<i>levalbuterol tartrate</i>	T4	QL (30 GM per 30 days)
<i>levocetirizine</i>	T2	
<i>mometasone nasal</i>	T3	
<i>montelukast oral granules in packet</i>	T2	QL (31 EA per 31 days)
<i>montelukast oral tablet</i>	T3	QL (31 EA per 31 days)
<i>montelukast oral tablet,chewable</i>	T2	QL (31 EA per 31 days)
NUCALA	T5	PA
OFEV	T5	PA; QL (62 EA per 31 days)
OMNARIS	T4	
OPSUMIT	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)
PHENADOZ RECTAL SUPPOSITORY 12.5 MG	T4	
PROAIR HFA	T3	QL (17 GM per 30 days)
PROAIR RESPICLICK	T3	QL (2 EA per 30 days)
<i>promethazine oral syrup</i>	T2	PA
<i>promethazine rectal suppository 12.5 mg, 25 mg</i>	T3	
<i>promethazine rectal suppository 50 mg</i>	T4	
<i>promethazine-phenylephrine</i>	T2	PA
PROMETHEGAN RECTAL SUPPOSITORY 25 MG, 50 MG	T4	
PULMOZYME	T5	PA
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	T3	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	T3	QL (21.2 GM per 30 days)
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	T5	PA; QL (224 ML per 31 days)
REVATIO ORAL TABLET	T5	PA; QL (93 EA per 31 days)
RUCONEST	T5	PA
SEREVENT DISKUS	T4	QL (60 EA per 30 days)
<i>sildenafil (pulm.hypertension) oral suspension for reconstitution</i>	T5	PA; QL (224 ML per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>sildenafil (pulm.hypertension) oral tablet</i>	T3	PA; QL (93 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER	T3	QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T4	QL (4 GM per 30 days)
SYMBICORT	T3	QL (10.2 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
<i>tadalafil (pulm. hypertension)</i>	T5	PA; QL (62 EA per 31 days)
TAKHZYRO	T5	PA; QL (4 ML per 28 days)
<i>terbutaline oral</i>	T4	
THEO-24	T4	
<i>theophylline oral solution</i>	T2	
<i>theophylline oral tablet extended release 12 hr 300 mg</i>	T2	
<i>theophylline oral tablet extended release 24 hr</i>	T2	
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)
VENTAVIS	T5	PA-BvD
VENTOLIN HFA	T3	QL (36 GM per 30 days)
WIXELA INHUB	T3	QL (60 EA per 30 days)
XOLAIR	T5	PA
YUPELRI	T4	PA-BvD
<i>zafirlukast</i>	T4	
<i>zileuton</i>	T5	PA
Urologicals		
<i>alfuzosin</i>	T2	QL (31 EA per 31 days)
<i>bethanechol chloride</i>	T2	
CIALIS ORAL TABLET 2.5 MG	T4	PA; QL (62 EA per 31 days)
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T4	
<i>darifenacin</i>	T3	QL (31 EA per 31 days)
<i>dutasteride</i>	T3	QL (31 EA per 31 days)
<i>dutasteride-tamsulosin</i>	T4	QL (31 EA per 31 days)
ELMIRON	T5	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>finasteride oral tablet 5 mg</i>	T2	
MYRBETRIQ	T3	QL (31 EA per 31 days)
<i>oxybutynin chloride oral syrup</i>	T2	
<i>oxybutynin chloride oral tablet</i>	T2	
<i>oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg</i>	T3	QL (31 EA per 31 days)
<i>oxybutynin chloride oral tablet extended release 24hr 15 mg</i>	T3	QL (62 EA per 31 days)
<i>potassium citrate</i>	T4	
RAPAFLO	T3	
<i>solifenacin</i>	T4	QL (31 EA per 31 days)
<i>tadalafil oral tablet 2.5 mg</i>	T4	PA; QL (62 EA per 31 days)
<i>tadalafil oral tablet 5 mg</i>	T4	PA; QL (31 EA per 31 days)
<i>tamsulosin</i>	T1	
<i>tolterodine oral capsule,extended release 24hr</i>	T4	QL (31 EA per 31 days)
<i>tolterodine oral tablet</i>	T4	QL (62 EA per 31 days)
<i>trospium oral capsule,extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>trospium oral tablet</i>	T2	QL (93 EA per 31 days)
Vitamins, Hematinics / Electrolytes		
AMINOSYN II 10 %	T4	PA-BvD
AMINOSYN II 15 %	T4	PA-BvD
AMINOSYN-PF 10 %	T4	PA-BvD
AMINOSYN-PF 7 % (SULFITE-FREE)	T4	PA-BvD
<i>calcium acetate oral capsule</i>	T2	
<i>calcium acetate oral tablet 667 mg</i>	T2	
CLINIMIX 5%/D15W SULFITE FREE	T4	PA-BvD
CLINIMIX 5%/D25W SULFITE-FREE	T4	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T4	PA-BvD
CLINIMIX 4.25%-D25W SULF-FREE	T4	PA-BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	T4	PA-BvD
CLINISOL SF 15 %	T4	PA-BvD
<i>fluoride (sodium) oral tablet</i>	T2	
FREAMINE HBC 6.9 %	T4	PA-BvD
HEPATAMINE 8%	T4	PA-BvD
INTRALIPID INTRAVENOUS EMULSION 20 %	T2	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
INTRALIPID INTRAVENOUS EMULSION 30 %	T4	PA-BvD
IONOSOL-MB IN D5W	T4	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T3	PA-BvD
ISOLYTE-S	T3	PA-BvD
KLOR-CON	T2	
KLOR-CON 10	T2	
KLOR-CON 8	T2	
KLOR-CON M10	T2	
KLOR-CON M15	T2	
KLOR-CON M20	T2	
KLOR-CON SPRINKLE ORAL CAPSULE, EXTENDED RELEASE 8 MEQ	T2	
<i>magnesium sulfate injection</i>	T2	
NEPHRAMINE 5.4 %	T3	PA-BvD
NORMOSOL-M IN 5 % DEXTROSE	T4	PA-BvD
NORMOSOL-R IN 5 % DEXTROSE	T4	PA-BvD
NORMOSOL-R PH 7.4	T4	PA-BvD
PLASMA-LYTE 148	T4	PA-BvD
PLASMA-LYTE A	T4	PA-BvD
PLENAMINE	T3	PA-BvD
<i>potassium chlorid-d5-0.45%nacl</i>	T2	
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	T2	
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 40 meq/l</i>	T2	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml</i>	T2	
<i>potassium chloride intravenous</i>	T2	
<i>potassium chloride oral capsule, extended release</i>	T2	
<i>potassium chloride oral liquid</i>	T2	
<i>potassium chloride oral tablet extended release</i>	T2	
<i>potassium chloride oral tablet,er particles/crystals</i>	T1	
<i>potassium chloride-0.45 % nacl</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride-d5-0.9%nacl</i>	T2	
PREMASOL 10 %	T3	PA-BvD
PREMASOL 6 %	T3	PA-BvD
PRENATAL VITAMIN PLUS LOW IRON	T2	
PROCALAMINE 3%	T4	PA-BvD
PROSOL 20 %	T4	PA-BvD
<i>sodium chloride 0.45 % intravenous parenteral solution</i>	T2	
<i>sodium chloride 3 %</i>	T2	
<i>sodium chloride 5 %</i>	T2	
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 page 3 of this booklet.

Index of Drugs

<i>abacavir</i>	5	AMABELZ	58	<i>armodafinil</i>	19
<i>abacavir-lamivudine</i>	5	<i>amantadine hcl</i>	5	ASACOL HD	49
<i>abacavir-lamivudine-zidovudine</i> ..	5	AMBISOME	5	ASMANEX HFA	64
ABELCET	5	<i>ambrisentan</i>	64	ASMANEX TWISTHALER	64
ABILIFY MAINTENA	19	AMETHIA	58	<i>aspirin-dipyridamole</i>	33
<i>abiraterone</i>	13	AMETHIA LO	58	ASSURE ID INSULIN	
ABSTRAL	19	<i>amikacin</i>	5	SAFETY	45
<i>acamprosate</i>	42	<i>amiloride</i>	33	<i>atazanavir</i>	5
<i>acarbose</i>	45	<i>amiloride-hydrochlorothiazide</i> ...	33	<i>atenolol</i>	33
<i>acebutolol</i>	33	AMINOSYN II 10 %	68	<i>atenolol-chlorthalidone</i>	33
<i>acetaminophen-codeine</i>	19	AMINOSYN II 15 %	68	<i>atomoxetine</i>	19, 20
<i>acetazolamide</i>	62	AMINOSYN-PF 10 %	68	<i>atorvastatin</i>	33
<i>acetic acid</i>	44	AMINOSYN-PF 7 %		<i>atovaquone</i>	5
<i>acetylcysteine</i>	64	(SULFITE-FREE)	68	<i>atovaquone-proguanil</i>	5
<i>acitretin</i>	39	<i>amiodarone</i>	33	ATRIPLA	5
ACTEMRA	56	AMITIZA	49	ATROVENT HFA	64
ACTEMRA ACTPEN	56	<i>amitriptyline</i>	19	AUBAGIO	20
ACTHAR	45	<i>amlodipine</i>	33	AUGMENTIN	5
ACTHIB (PF)	52	<i>amlodipine-benazepril</i>	33	AURYXIA	43
ACTIMMUNE	52	<i>amlodipine-olmesartan</i>	33	AVIANE	58
<i>acyclovir</i>	5, 39	<i>amlodipine-valsartan</i>	33	AVITA	39
<i>acyclovir sodium</i>	5	<i>amlodipine-valsartan-hcthiacid</i> ..	33	AZACTAM	6
ADACEL(TDAP		<i>ammonium lactate</i>	39	<i>azathioprine</i>	13
ADOLESN/ADULT)(PF)	52	AMNESTEEM	39	<i>azelastine</i>	44, 62
<i>adapalene</i>	39	<i>amoxapine</i>	19	<i>azithromycin</i>	6
<i>adapalene-benzoyl peroxide</i>	39	<i>amoxicillin</i>	5	AZOPT	62
ADCIRCA	64	<i>amoxicillin-pot clavulanate</i>	5	<i>aztreonam</i>	6
<i>adefovir</i>	5	<i>amphetamine sulfate</i>	19	<i>bacitracin</i>	62
ADEMPAS	64	<i>amphotericin b</i>	5	<i>bacitracin-polymyxin b</i>	62
ADVAIR HFA	64	<i>ampicillin</i>	5	<i>baclofen</i>	20
AFINITOR	13	<i>ampicillin sodium</i>	5	<i>balsalazide</i>	49
AFINITOR DISPERZ	13	<i>ampicillin-sulbactam</i>	5	BALVERSA	14
AIMOVIG AUTOINJECTOR	19	AMPYRA	19	BALZIVA (28)	58
ALA-CORT	39	ANADROL-50	45	BANZEL	20
<i>albendazole</i>	5	<i>anagrelide</i>	43	BAQSIMI	45
<i>albuterol sulfate</i>	64	<i>anastrozole</i>	13	BASAGLAR KWIKPEN U-	
<i>alclometasone</i>	39	ANDRODERM	45	100 INSULIN	45
ALCOHOL PADS	45	ANORO ELLIPTA	64	<i>bcg vaccine, live (pf)</i>	52
ALECENSA	13	APOKYN	19	BECONASE AQ	64
<i>alendronate</i>	42, 56	<i>apraclonidine</i>	62	<i>benazepril</i>	33
<i>alfuzosin</i>	67	<i>aprepitant</i>	49	<i>benazepril-hydrochlorothiazide</i> ..	33
ALINIA	5	APRI	58	BENLYSTA	56
<i>allopurinol</i>	56	APTIOM	19	<i>benztropine</i>	20
ALOMIDE	62	APTIVUS	5	BERINERT	64
<i>alosetron</i>	49	ARALAST NP	43	BESER	39
ALPHAGAN P	62	ARANELLE (28)	58	BESIVANCE	62
<i>alprazolam</i>	19	ARANESP (IN		<i>betamethasone dipropionate</i>	39
ALTAVERA (28)	58	POLYSORBATE)	52	<i>betamethasone valerate</i>	39
ALUNBRIG	13	ARCALYST	52	<i>betamethasone, augmented</i>	39
ALYACEN 1/35 (28)	58	ARIKAYCE	5	BETASERON	52
ALYQ	64	<i>aripiprazole</i>	19	<i>betaxolol</i>	62

<i>bethanechol chloride</i>	67	CAPRELSA	14	CILOXAN	62
BETHKIS	6	<i>captopril</i>	33	CIMDUO	7
<i>bexarotene</i>	14	<i>captopril-hydrochlorothiazide</i>	33	CIMZIA	50
BEXSERO	52	CARBAGLU	43	CIMZIA POWDER FOR	
<i>bicalutamide</i>	14	<i>carbamazepine</i>	20	RECONST	50
BICILLIN C-R	6	<i>carbidopa-levodopa</i>	21	<i>cinacalcet</i>	45
BICILLIN L-A	6	<i>carbidopa-levodopa-entacapone</i> 21		CINRYZE	65
BIKTARVY	6	<i>carteolol</i>	62	CIPRO HC	44
<i>bisoprolol fumarate</i>	33	CARTIA XT	33	CIPRODEX	44
<i>bisoprolol-hydrochlorothiazide</i> ..	33	<i>carvedilol</i>	33	<i>ciprofloxacin</i>	7
BLEPHAMIDE	62	<i>carvedilol phosphate</i>	33	<i>ciprofloxacin hcl</i>	7, 62
BLEPHAMIDE S.O.P.	62	<i>casprofungin</i>	6	<i>ciprofloxacin in 5 % dextrose</i>	7
BLISOVI FE 1.5/30 (28)	58	CAYSTON	6	<i>citalopram</i>	21
BONJESTA	49	CAZIENT (28)	58	CLARAVIS	39
BOOSTRIX TDAP	52	<i>cefaclor</i>	6	<i>clarithromycin</i>	7
<i>bosentan</i>	64	<i>cefadroxil</i>	6	CLENPIQ	50
BOSULIF	14	<i>cefazolin</i>	6	CLINDACIN P	39
BRAFTOVI	14	<i>cefdinir</i>	6	<i>clindamycin hcl</i>	7
BREO ELLIPTA	64	<i>cefepime</i>	6	<i>clindamycin in 5 % dextrose</i>	7
BRIELLYN	58	<i>cefixime</i>	6	<i>clindamycin palmitate hcl</i>	7
BRILINTA	33	<i>cefotaxime</i>	6	<i>clindamycin phosphate</i>	7, 40, 58
<i>brimonidine</i>	62	<i>cefoxitin</i>	6	<i>clindamycin-tretinoin</i>	40
BRIVIACT	20	<i>cefpodoxime</i>	6	CLINDESSE	58
<i>bromfenac</i>	62	<i>cefprozil</i>	6	CLINIMIX 5%/D15W	
<i>bromocriptine</i>	20	<i>ceftazidime</i>	6	SULFITE FREE	68
<i>budesonide</i>	49, 65	<i>ceftriaxone</i>	6	CLINIMIX 5%/D25W	
<i>bumetanide</i>	33	<i>cefuroxime axetil</i>	6	SULFITE-FREE	68
BUNAVAIL	20	<i>cefuroxime sodium</i>	6	CLINIMIX 4.25%/D10W	
<i>buprenorphine</i>	20	<i>celecoxib</i>	21	SULF FREE	68
<i>buprenorphine hcl</i>	20	CELONTIN	21	CLINIMIX 4.25%/D5W	
<i>buprenorphine-naloxone</i>	20	<i>cephalexin</i>	6	SULFIT FREE	43
<i>bupropion hcl</i>	20	CERDELGA	45	CLINIMIX 4.25%-D25W	
<i>bupropion hcl (smoking deter)</i>	43	<i>cetirizine</i>	65	SULF-FREE	68
<i>buspirone</i>	20	<i>cevimeline</i>	43	CLINIMIX 5%-	
<i>butalbital-acetaminophen</i>	20	CHANTIX	43	D20W(SULFITE-FREE)	68
<i>butorphanol tartrate</i>	20	CHANTIX CONTINUING		CLINISOL SF 15 %	68
BUTRANS	20	MONTH BOX	43	<i>clobazam</i>	21
BYSTOLIC	33	CHANTIX STARTING		<i>clomipramine</i>	21
<i>cabergoline</i>	45	MONTH BOX	43	<i>clonazepam</i>	21
CABLIVI	33	CHEMET	43	<i>clonidine</i>	34
CABOMETYX	14	<i>chlorhexidine gluconate</i>	44	<i>clonidine hcl</i>	34
<i>calcipotriene</i>	39	<i>chloroquine phosphate</i>	7	<i>clopidogrel</i>	34
<i>calcitonin (salmon)</i>	45	<i>chlorothiazide</i>	33	<i>clorazepate dipotassium</i>	21
<i>calcitriol</i>	39, 45	<i>chlorpromazine</i>	21	<i>clotrimazole</i>	7, 40
<i>calcium acetate</i>	68	<i>chlorthalidone</i>	34	<i>clotrimazole-betamethasone</i>	40
CALQUENCE	14	CHOLBAM	50	<i>clozapine</i>	21
CAMILA	58	<i>cholestyramine (with sugar)</i>	34	COARTEM	7
CAMRESE LO	58	CHOLESTYRAMINE		<i>colchicine</i>	56
CANASA	50	LIGHT	34	<i>colesevelam</i>	34
CANCIDAS	6	CIALIS	67	<i>colestipol</i>	34
<i>candesartan</i>	33	<i>ciclopirox</i>	39	<i>colistin (colistimethate na)</i>	7
<i>candesartan-hydrochlorothiazid</i> ..	33	<i>cilostazol</i>	34	COLOCORT	50

COMBIGAN	62	<i>desipramine</i>	21	DOVATO	7
COMBIVENT RESPIMAT	65	<i>desloratadine</i>	65	<i>doxazosin</i>	35
COMETRIQ	14	<i>desmopressin</i>	45	<i>doxepin</i>	22, 40
COMPLERA	7	<i>desogestrel-ethinyl estradiol</i>	59	<i>doxercalciferol</i>	45
COMPRO	50	<i>desoximetasone</i>	40	DOXY-100	7
CONSTULOSE	50	<i>desvenlafaxine succinate</i>	21	<i>doxycycline hyclate</i>	7
COPIKTRA	14	<i>dexamethasone</i>	45	<i>doxycycline monohydrate</i>	7, 8
CORLANOR	34	DEXAMETHASONE		<i>doxylamine-pyridoxine (vit b6)</i> ...50	
<i>cortisone</i>	45	INTENSOL	45	<i>dronabinol</i>	50
COSENTYX (2 SYRINGES) ...40		<i>dexamethasone sodium</i>		<i>drospirenone-e.estradiol-lm.fa</i> ...59	
COSENTYX PEN (2 PENS)40		<i>phosphate</i>	62	<i>drospirenone-ethinyl estradiol</i> ...59	
COTELIC	14	<i>dexchlorpheniramine maleate</i>65		DROXIA	14
COUMADIN	34	<i>dextroamphetamine-</i>		<i>duloxetine</i>	22
CREON	50	<i>amphetamine</i>	21	DUOBRII	40
CRINONE	58	<i>dextrose 10 % and 0.2 % nacl</i>43		DUPIXENT	40
CRIXIVAN	7	<i>dextrose 10 % in water (d10w)</i> ...43		DURAMORPH (PF)	22
<i>cromolyn</i>	50, 62, 65	<i>dextrose 5 % in water (d5w)</i>43		DUREZOL	62
CRYSSELLE (28)	58	<i>dextrose 5%-0.2 % sod chloride</i> .43		<i>dutasteride</i>	67
CYCLAFEM 1/35 (28)	58	<i>dextrose 5%-0.3 % sod.chloride</i> .43		<i>dutasteride-tamsulosin</i>	67
CYCLAFEM 7/7/7 (28)	58	DEXTROSE WITH SODIUM		DYMISTA	65
<i>cyclobenzaprine</i>	21	CHLORIDE	43	EDURANT	8
<i>cyclophosphamide</i>	14	DIASTAT	21	<i>efavirenz</i>	8
<i>cyclosporine</i>	14	<i>diazepam</i>	21	EGRIFTA	52
<i>cyclosporine modified</i>	14	DIAZEPAM INTENSOL	21	ELIQUIS	35
<i>cypheptadine</i>	65	<i>diclofenac epolamine</i>	22	ELMIRON	67
CYRED EQ	58	<i>diclofenac potassium</i>	22	EMCYT	14
CYSTADANE	50	<i>diclofenac sodium</i>	22, 40, 62	EMFLAZA	45
CYSTAGON	67	<i>dicloxacillin</i>	7	EMOQUETTE	59
CYSTARAN	62	<i>dicyclomine</i>	50	EMSAM	22
<i>d10 %-0.45 % sodium chloride</i> ..43		<i>didanosine</i>	7	EMTRIVA	8
<i>d2.5 %-0.45 % sodium chloride</i> ..43		DIFICID	7	EMVERM	8
<i>d5 % and 0.9 % sodium</i>		<i>diflunisal</i>	22	<i>enalapril maleate</i>	35
<i>chloride</i>	43	DIGITEK	34	<i>enalapril-hydrochlorothiazide</i> ...35	
<i>d5 %-0.45 % sodium chloride</i>43		DIGOX	34	ENBREL	56
<i>dalfampridine</i>	21	<i>digoxin</i>	34	ENBREL MINI	56
DALIRESP	65	<i>dihydroergotamine</i>	22	ENBREL SURECLICK	56
<i>danazol</i>	45	DILANTIN	22	ENDARI	43
<i>dantrolene</i>	21	DILANTIN EXTENDED	22	ENDOCET	22
<i>dapsone</i>	7, 40	DILANTIN INFATABS	22	ENERGIX-B (PF)	52
DAPTACEL (DTAP		DILANTIN-125	22	ENERGIX-B PEDIATRIC	
PEDIATRIC) (PF)	52	<i>diltiazem hcl</i>	34	(PF)	53
<i>daptomycin</i>	7	DILT-XR	34	<i>enoxaparin</i>	35
<i>darifenacin</i>	67	<i>diphenoxylate-atropine</i>	50	ENPRESSE	59
DAURISMO	14	<i>disulfiram</i>	43	ENSKYCE	59
<i>deferasirox</i>	43	<i>divalproex</i>	22	<i>entacapone</i>	22
DELSTRIGO	7	<i>dofetilide</i>	34	<i>entecavir</i>	8
DELZICOL	50	<i>donepezil</i>	22	ENTRESTO	35
DEMSEER	34	DOPTelet (10 TAB PACK) .34		ENULOSE	50
DENAVIR	40	DOPTelet (15 TAB PACK) .34		EPCLUSA	8
DEPEN TITRATABS	56	DOPTelet (30 TAB PACK) .34		EPIDIOLEX	22
DEPO-PROVERA	59	<i>dorzolamide</i>	62	<i>epinephrine</i>	65
DESCOVY	7	<i>dorzolamide-timolol</i>	62	EPITOL	22

EPIVIR HBV	8	<i>fentanyl citrate</i>	23	GAMMAGARD LIQUID	53
<i>eplerenone</i>	35	FENTORA	23	GAMMAGARD S-D (IGA < 1	
ERAXIS(WATER DILUENT) ..	8	FERRIPROX	43	MCG/ML)	53
<i>ergotamine-caffeine</i>	22	FETZIMA	23	GAMMAKED	53
ERIVEDGE	14	FIASP FLEXTOUCH U-100		GAMMAPLEX	53
ERLEADA	14	INSULIN	45	GAMMAPLEX (WITH	
<i>erlotinib</i>	14	FIASP U-100 INSULIN	45	SORBITOL)	53
ERRIN	59	<i>finasteride</i>	68	GAMUNEX-C	53
<i>ertapenem</i>	8	FIRAZYR	65	GARDASIL 9 (PF)	53
ERY PADS	40	FIRDAPSE	24	<i>gatifloxacin</i>	62
ERYGEL	40	FIRVANQ	8	GATTEX 30-VIAL	50
ERY-TAB	8	FLAC OTIC OIL	44	GAUZE PAD	45
ERYTHROCIN	8	FLEBOGAMMA DIF	53	GAVILYTE-C	50
ERYTHROCIN (AS		<i>flecainide</i>	35	GAVILYTE-G	50
STEARATE)	8	FLECTOR	24	GAVILYTE-N	50
<i>erythromycin</i>	8, 62	<i>fluconazole</i>	8	<i>gemfibrozil</i>	35
<i>erythromycin ethylsuccinate</i>	8	<i>fluconazole in nacl (iso-osm)</i>	8	GENERLAC	50
<i>erythromycin with ethanol</i>	40	<i>flucytosine</i>	8	GENGRAF	14
<i>erythromycin-benzoyl peroxide</i> ..	40	<i>fludrocortisone</i>	45	GENOTROPIN	53
ESBRIET	65	<i>flunisolide</i>	65	GENOTROPIN MINQUICK ..	53
<i>escitalopram oxalate</i>	22	<i>fluocinolone</i>	40	GENTAK	62
<i>esomeprazole magnesium</i>	50	<i>fluocinolone acetonide oil</i>	44	<i>gentamicin</i>	8, 41, 63
ESTARYLLA	59	<i>fluocinolone and shower cap</i>	40	<i>gentamicin in nacl (iso-osm)</i>	8
<i>estradiol</i>	59	<i>fluocinonide</i>	40	GENVOYA	8
<i>estradiol valerate</i>	59	FLUOCINONIDE-E	40	GEODON	24
<i>estradiol-norethindrone acet</i>	59	<i>fluoride (sodium)</i>	68	GILENYA	24
<i>ethacrynic acid</i>	35	<i>fluorometholone</i>	62	GILOTRIF	14
<i>ethambutol</i>	8	<i>fluorouracil</i>	40, 41	<i>glatiramer</i>	24
<i>ethosuximide</i>	22	<i>fluoxetine</i>	24	GLATOPA	24
<i>ethynodiol diac-eth estradiol</i>	59	<i>fluphenazine decanoate</i>	24	GLEOSTINE	14
<i>etodolac</i>	22	<i>fluphenazine hcl</i>	24	<i>glimepiride</i>	45
EURAX	40	<i>flurandrenolide</i>	41	<i>glipizide</i>	45
EVENITY	56	<i>flurbiprofen</i>	24	<i>glipizide-metformin</i>	46
EVOTAZ	8	<i>flurbiprofen sodium</i>	62	GLUCAGEN HYPOKIT	46
<i>exemestane</i>	14	<i>flutamide</i>	14	GLUCAGON EMERGENCY	
EXJADE	43	<i>fluticasone propionate</i>	41, 65	KIT (HUMAN)	46
<i>ezetimibe</i>	35	<i>fluticasone propion-salmeterol</i> ..	65	<i>glyburide</i>	46
<i>ezetimibe-simvastatin</i>	35	<i>fluvoxamine</i>	24	<i>glyburide micronized</i>	46
<i>famciclovir</i>	8	<i>fondaparinux</i>	35	<i>glyburide-metformin</i>	46
<i>famotidine</i>	50	FORTEO	56	<i>glycopyrrolate</i>	50
FANAPT	22	<i>fosamprenavir</i>	8	GLYXAMBI	46
FARYDAK	14	<i>fosinopril</i>	35	GOLYTELY	50
FASENRA	65	<i>fosinopril-hydrochlorothiazide</i> ..	35	<i>granisetron hcl</i>	50
FAYOSIM	59	FREAMINE HBC 6.9 %	68	GRANIX	53
<i>febuxostat</i>	56	FULPHILA	53	<i>griseofulvin microsize</i>	8
<i>felbamate</i>	23	<i>furosemide</i>	35	<i>griseofulvin ultramicrosize</i>	8
<i>felodipine</i>	35	FUZEON	8	<i>guanfacine</i>	24
FEMYNOR	59	FYAVOLV	59	<i>guanidine</i>	24
<i>fenofibrate</i>	35	FYCOMPA	24	GYNAZOLE-1	59
<i>fenofibrate micronized</i>	35	<i>gabapentin</i>	24	HAEGARDA	65
<i>fenofibrate nanocrystallized</i>	35	GALAFOLD	45	HAILEY 24 FE	59
<i>fentanyl</i>	23	<i>galantamine</i>	24	<i>halobetasol propionate</i>	41

<i>haloperidol</i>	24	HUMULIN R U-500 (CONC)		INVIRASE	9
<i>haloperidol decanoate</i>	24	KWIKPEN	46	INVOKAMET	46
<i>haloperidol lactate</i>	24	<i>hydralazine</i>	35	INVOKAMET XR	46
HARVONI	9	<i>hydrochlorothiazide</i>	35	INVOKANA	46
HAVRIX (PF)	53	<i>hydrocodone-acetaminophen</i>	24	IONOSOL-MB IN D5W	69
<i>heparin (porcine)</i>	35	<i>hydrocodone-ibuprofen</i>	24	IPOL	54
HEPATAMINE 8%	68	<i>hydrocortisone</i>	41, 46, 50	<i>ipratropium bromide</i>	44, 65
HETLIOZ	24	<i>hydrocortisone butyrate</i>	41	<i>ipratropium-albuterol</i>	65
HIBERIX (PF)	53	<i>hydrocortisone valerate</i>	41	<i>irbesartan</i>	35
HUMALOG JUNIOR		<i>hydrocortisone-pramoxine</i>	50	<i>irbesartan-hydrochlorothiazide</i> ..	36
KWIKPEN U-100	46	<i>hydromorphone</i>	25	IRESSA	15
HUMALOG KWIKPEN		<i>hydromorphone (pf)</i>	24	ISENTRESS	9
INSULIN	46	<i>hydroxychloroquine</i>	9	ISENTRESS HD	9
HUMALOG MIX 50-50		<i>hydroxyurea</i>	14	ISIBLOOM	59
INSULN U-100	46	<i>hydroxyzine hcl</i>	65	ISOLYTE-P IN 5 %	
HUMALOG MIX 50-50		<i>ibandronate</i>	57	DEXTROSE	69
KWIKPEN	46	IBRANCE	14	ISOLYTE-S	69
HUMALOG MIX 75-25		IBU	25	<i>isoniazid</i>	9
KWIKPEN	46	<i>ibuprofen</i>	25	<i>isosorbide dinitrate</i>	36
HUMALOG MIX 75-25(U-		<i>icatibant</i>	65	<i>isosorbide mononitrate</i>	36
100)INSULN	46	ICLUSIG	14	<i>isotretinoin</i>	41
HUMALOG U-100 INSULIN ..	46	IDHIFA	14, 15	<i>isradipine</i>	36
HUMATROPE	53	ILEVRO	63	<i>itraconazole</i>	9
HUMIRA	56	<i>imatinib</i>	15	<i>ivermectin</i>	9
HUMIRA PEDIATRIC		IMBRUVICA	15	IXIARO (PF)	54
CROHNS START	56	<i>imipenem-cilastatin</i>	9	JAKAFI	15
HUMIRA PEN	56	<i>imipramine hcl</i>	25	JANTOVEN	36
HUMIRA PEN CROHNS-		<i>imiquimod</i>	41	JANUMET	46
UC-HS START	57	IMOVAX RABIES		JANUMET XR	46
HUMIRA PEN PSOR-		VACCINE (PF)	53	JANUVIA	46
UVEITS-ADOL HS	57	INBRIJA	25	JARDIANCE	47
HUMIRA(CF)	57	INCASSIA	59	JASMIEL (28)	59
HUMIRA(CF) PEDI		INCRELEX	43	JENTADUETO	47
CROHNS STARTER	57	INCRUSE ELLIPTA	65	JENTADUETO XR	47
HUMIRA(CF) PEN	57	<i>indapamide</i>	35	JINTELI	59
HUMIRA(CF) PEN		<i>indomethacin</i>	25	JULEBER	59
CROHNS-UC-HS	57	INFANRIX (DTAP) (PF)	54	JULUCA	9
HUMIRA(CF) PEN PSOR-		INGREZZA	25	JUNEL 1.5/30 (21)	59
UV-ADOL HS	57	INGREZZA INITIATION		JUNEL 1/20 (21)	59
HUMULIN 70/30 U-100		PACK	25	JUNEL FE 1.5/30 (28)	59
INSULIN	46	INLYTA	15	JUNEL FE 1/20 (28)	59
HUMULIN 70/30 U-100		INREBIC	15	JUNEL FE 24	59
KWIKPEN	46	<i>insulin lispro</i>	46	JUXTAPID	36
HUMULIN N NPH INSULIN		<i>insulin syringe-needle u-100</i>	46	JYNARQUE	47
KWIKPEN	46	INTELENCE	9	KALETRA	9
HUMULIN N NPH U-100		INTRALIPID	68, 69	KALYDECO	65
INSULIN	46	INTRAROSA	59	KARIVA (28)	59
HUMULIN R REGULAR U-		INTRON A	54	KELNOR 1/35 (28)	59
100 INSULN	46	INTROVALE	59	KELNOR 1-50	60
HUMULIN R U-500 (CONC)		INVANZ	9	<i>ketoconazole</i>	9, 41
INSULIN	46	INVEGA SUSTENNA	25	<i>ketoprofen</i>	25
		INVEGA TRINZA	25	<i>ketorolac</i>	63

KEVZARA	57	<i>levocetirizine</i>	66	LYSODREN	16
KINERET	57	<i>levofloxacin</i>	9, 63	LYZA	60
KINRIX (PF)	54	<i>levofloxacin in d5w</i>	9	<i>magnesium sulfate</i>	69
KIONEX (WITH		LEVONEST (28)	60	<i>malathion</i>	41
SORBITOL)	43	<i>levonorgestrel-ethinyl estrad</i>	60	<i>maprotiline</i>	26
KISQALI	15	<i>levonorg-eth estrad triphasic</i>	60	MARLISSA (28)	60
KISQALI FEMARA CO-		LEVORA-28	60	MARPLAN	26
PACK	15	<i>levothyroxine</i>	47	MATULANE	16
KLOR-CON	69	LEVOXYL	47	MAVENCLAD (10 TABLET	
KLOR-CON 10	69	LEXIVA	9	PACK)	26
KLOR-CON 8	69	<i>lidocaine</i>	41	MAVENCLAD (4 TABLET	
KLOR-CON M10	69	<i>lidocaine hcl</i>	41	PACK)	26
KLOR-CON M15	69	LIDOCAINE VISCOUS	41	MAVENCLAD (5 TABLET	
KLOR-CON M20	69	<i>lidocaine-prilocaine</i>	41	PACK)	26
KLOR-CON SPRINKLE	69	<i>linezolid</i>	9	MAVENCLAD (6 TABLET	
KORLYM	47	<i>linezolid in dextrose 5%</i>	9	PACK)	26
KURVELO (28)	60	LINZESS	50	MAVENCLAD (7 TABLET	
KUVAN	47	<i>liothyronine</i>	47	PACK)	26
<i>l norgest/e.estradiol-e.estrad</i>	60	<i>lisinopril</i>	36	MAVENCLAD (8 TABLET	
<i>labetalol</i>	36	<i>lisinopril-hydrochlorothiazide</i>	36	PACK)	26
LACRISERT	63	<i>lithium carbonate</i>	26	MAVENCLAD (9 TABLET	
<i>lactulose</i>	50	<i>lithium citrate</i>	26	PACK)	26
<i>lamivudine</i>	9	LOKELMA	43	MAVYRET	9
<i>lamivudine-zidovudine</i>	9	LONSURF	15	MAYZENT	26
<i>lamotrigine</i>	25	<i>loperamide</i>	51	<i>meclizine</i>	51
LANTUS SOLOSTAR U-100		<i>lopinavir-ritonavir</i>	9	<i>medroxyprogesterone</i>	60
INSULIN	47	LOPREEZA	60	<i>mefloquine</i>	10
LANTUS U-100 INSULIN	47	<i>lorazepam</i>	26	<i>megestrol</i>	16
LARISSIA	60	LORBRENA	15	MEKINIST	16
LASTACAFT	63	LORCET		MEKTOVI	16
<i>latanoprost</i>	63	(HYDROCODONE)	26	MELODETTA 24 FE	60
LATUDA	25	LORCET HD	26	<i>meloxicam</i>	26
LAZANDA	25	LORCET PLUS	26	<i>memantine</i>	26
<i>ledipasvir-sofosbuvir</i>	9	LORYNA (28)	60	MENACTRA (PF)	54
<i>leflunomide</i>	57	<i>losartan</i>	36	MENVEO A-C-Y-W-135-DIP	
LENVIMA	15	<i>losartan-hydrochlorothiazide</i>	36	(PF)	54
LESSINA	60	<i>lovastatin</i>	36	<i>mercaptopurine</i>	16
LETAIRIS	65	LOW-OGESTREL (28)	60	<i>meropenem</i>	10
<i>letrozole</i>	15	<i>loxapine succinate</i>	26	<i>mesalamine</i>	51
<i>leucovorin calcium</i>	15	LUCEMYRA	26	MESNEX	16
LEUKERAN	15	LUMIGAN	63	MESTINON	26
LEUKINE	54	LUPRON DEPOT	15	METADATE ER	26
<i>leuprolide</i>	15	LUPRON DEPOT (3		<i>metformin</i>	47
<i>levalbuterol hcl</i>	66	MONTH)	15	<i>methadone</i>	27
<i>levalbuterol tartrate</i>	66	LUPRON DEPOT (4		<i>methazolamide</i>	63
LEVEMIR FLEXTOUCH U-		MONTH)	15	<i>methenamine hippurate</i>	10
100 INSULN	47	LUPRON DEPOT (6		<i>methimazole</i>	47
LEVEMIR U-100 INSULIN	47	MONTH)	15	<i>methotrexate sodium</i>	16
<i>levetiracetam</i>	25	LUTERA (28)	60	<i>methotrexate sodium (pf)</i>	16
<i>levobunolol</i>	63	LYNPARZA	15	<i>methoxsalen</i>	41
<i>levocarnitine</i>	43	LYRICA	26	<i>methylphenidate hcl</i>	27
<i>levocarnitine (with sugar)</i>	43	LYRICA CR	26	<i>methylprednisolone</i>	47

<i>metoclopramide hcl</i>	51	<i>naloxone</i>	28	NORMOSOL-M IN 5 %	
<i>metolazone</i>	36	<i>naltrexone</i>	28	DEXTROSE	69
<i>metoprolol succinate</i>	36	NAMENDA XR	28	NORMOSOL-R IN 5 %	
<i>metoprolol ta-hydrochlorothiaz.</i>	36	NAMZARIC	28	DEXTROSE	69
<i>metoprolol tartrate</i>	36	<i>naproxen</i>	28	NORMOSOL-R PH 7.4	69
<i>metronidazole</i>	10, 41, 60	<i>naproxen sodium</i>	28	NORTHERA	44
<i>metronidazole in nacl (iso-os)</i>	10	<i>naratriptan</i>	28	NORTREL 0.5/35 (28)	60
<i>mexiletine</i>	36	NARCAN	28	NORTREL 1/35 (21)	60
MIBELAS 24 FE	60	NATACYN	63	NORTREL 1/35 (28)	61
MICONAZOLE-3	60	<i>nateglinide</i>	47	NORTREL 7/7/7 (28)	61
MICROGESTIN 1.5/30 (21)	60	NATPARA	47	<i>nortriptyline</i>	28
MICROGESTIN 1/20 (21)	60	NEBUPENT	10	NORVIR	10
MICROGESTIN FE 1.5/30		NECON 0.5/35 (28)	60	NOURIANZ	28
(28)	60	<i>nefazodone</i>	28	NOVOLIN 70/30 U-100	
MICROGESTIN FE 1/20 (28) .	60	<i>neomycin</i>	10	INSULIN	47
<i>midodrine</i>	43	<i>neomycin-bacitracin-poly-hc</i>	63	NOVOLIN N NPH U-100	
MIGERGOT	27	<i>neomycin-bacitracin-polymyxin</i> ..	63	INSULIN	47
<i>miglustat</i>	47	<i>neomycin-polymyxin b-</i>		NOVOLIN R REGULAR U-	
MILI	60	<i>dexameth</i>	63	100 INSULN	47
<i>minocycline</i>	10	<i>neomycin-polymyxin-gramicidin</i>	63	NOVOLOG FLEXPEN U-100	
<i>minoxidil</i>	36	<i>neomycin-polymyxin-hc</i>	44, 63	INSULIN	47
<i>mirtazapine</i>	27	NEORAL	16	NOVOLOG MIX 70-30 U-100	
<i>misoprostol</i>	51	NEPHRAMINE 5.4 %	69	INSULN	47
MITIGARE	57	NERLYNX	16	NOVOLOG MIX 70-	
M-M-R II (PF)	54	NEUPRO	28	30FLEXPEN U-100	47
<i>modafinil</i>	27	<i>nevirapine</i>	10	NOVOLOG PENFILL U-100	
<i>moexipril</i>	36	NEXAVAR	16	INSULIN	47
<i>molindone</i>	27	<i>niacin</i>	36	NOVOLOG U-100 INSULIN	
<i>mometasone</i>	41, 66	NIACOR	36	ASPART	47
MONDOXYNE NL	10	<i>nicardipine</i>	36	NUBEQA	16
<i>montelukast</i>	66	NICOTROL	43	NUCALA	66
MORGIDOX	10	NICOTROL NS	43	NUEDEXTA	28
<i>morphine</i>	27, 28	<i>nifedipine</i>	36	NUPLAZID	28
<i>morphine concentrate</i>	27	<i>nilutamide</i>	16	NUTROPIN AQ NUSPIN	54
MOVANTIK	51	<i>nimodipine</i>	36	NUVARING	61
MOVIPREP	51	NINLARO	16	NUZYRA	10
MOXEZA	63	NITRO-BID	36	NUZYRA (7 DAY WITH	
<i>moxifloxacin</i>	63	NITRO-DUR	36	LOAD DOSE)	10
MULPLETA	36	<i>nitrofurantoin</i>	10	NUZYRA (7 DAY)	10
MULTAQ	36	<i>nitrofurantoin macrocrystal</i>	10	NYAMYC	41
<i>mupirocin</i>	41	<i>nitrofurantoin monohyd/m-cryst.</i>	10	NYMALIZE	37
<i>mupirocin calcium</i>	41	<i>nitroglycerin</i>	36, 37	<i>nystatin</i>	10, 41
MYALEPT	47	NITYR	44	NYSTOP	42
MYCAMINE	10	NIVESTYM	54	OALIVA	51
<i>mycophenolate mofetil</i>	16	NOLIX	41	OCTAGAM	54
<i>mycophenolate sodium</i>	16	NORDITROPIN FLEXPRO ...	54	<i>octreotide acetate</i>	16
MYORISAN	41	<i>noreth-ethinyl estradiol-iron</i>	60	ODEFSEY	10
MYRBETRIQ	68	<i>norethindrone (contraceptive)</i>	60	ODOMZO	16
MYTESI	51	<i>norethindrone acetate</i>	60	OFEV	66
<i>nabumetone</i>	28	<i>norethindrone ac-eth estradiol</i> ...	60	<i>ofloxacin</i>	10, 44, 63
<i>nadolol</i>	36	<i>norethindrone-e.estradiol-iron</i> ...	60	OGESTREL (28)	61
<i>nafacillin</i>	10	<i>norgestimate-ethinyl estradiol</i>	60	<i>olanzapine</i>	28

<i>olmesartan-amlodipin-hcthiazid</i>37	<i>peg-electrolyte soln</i>51	<i>potassium chloride-d5-0.9%nacl</i>70
<i>olopatadine</i>44, 63	<i>pen needle, diabetic</i>48	<i>potassium citrate</i>68
OLUMIANT57	<i>penicillamine</i>57	PRADAXA37
<i>omega-3 acid ethyl esters</i>37	<i>penicillin g pot in dextrose</i>11	PRALUENT PEN37
<i>omeprazole</i>51	<i>penicillin g potassium</i>11	<i>pramipexole</i>29
OMNARIS66	<i>penicillin g procaine</i>11	<i>prasugrel</i>37
OMNITROPE54	<i>penicillin v potassium</i>11	<i>pravastatin</i>37
<i>ondansetron</i>51	PENTAM11	<i>praziquantel</i>11
<i>ondansetron hcl</i>51	PENTASA51	<i>prazosin</i>37
ONFI28	<i>pentoxifylline</i>37	<i>prednisolone</i>48
OPSUMIT66	<i>perindopril erbumine</i>37	<i>prednisolone acetate</i>63
ORALAIR54	<i>permethrin</i>42	<i>prednisolone sodium phosphate</i>48, 63
ORENCIA57	<i>perphenazine</i>29	<i>prednisone</i>48
ORENCIA CLICKJECT57	PERSERIS29	PREDNISONE INTENSOL48
ORENITRAM37	PHENADOZ66	<i>pregabalin</i>29
ORFADIN44	<i>phenelzine</i>29	PREMARIN61
ORILISSA48	<i>phenobarbital</i>29	PREMASOL 10 %70
ORKAMBI66	PHENYTEK29	PREMASOL 6 %70
ORSYTHIA61	<i>phenytoin</i>29	PRENATAL VITAMIN PLUS LOW IRON70
<i>oseltamivir</i>10	<i>phenytoin sodium extended</i>29	PREVALITE37
OTEZLA57	PHOSPHOLINE IODIDE63	PREVIFEM61
OTEZLA STARTER57	PIFELTRO11	PREZCOBIX11
OTOVEL44	<i>pilocarpine hcl</i>44, 63	PREZISTA11
<i>oxacillin</i>10	<i>pimozide</i>29	PRIFTIN11
<i>oxacillin in dextrose(iso-osm)</i>10	PIMTREA (28)61	<i>primaquine</i>11
<i>oxandrolone</i>48	<i>pindolol</i>37	<i>primidone</i>29
<i>oxcarbazepine</i>28	<i>pioglitazone</i>48	PRIVIGEN55
OXERVATE63	<i>pioglitazone-metformin</i>48	PROAIR HFA66
<i>oxybutynin chloride</i>68	<i>piperacillin-tazobactam</i>11	PROAIR RESPICLICK66
<i>oxycodone</i>28	PIQRAY16	<i>probenecid</i>57
<i>oxycodone-acetaminophen</i>28	PIRMELLA61	<i>probenecid-colchicine</i>57
OZEMPIC48	<i>piroxicam</i>29	PROCALAMINE 3%70
PACERONE37	PLASMA-LYTE 14869	<i>prochlorperazine</i>51
<i>paliperidone</i>29	PLASMA-LYTE A69	<i>prochlorperazine maleate</i>51
PALYNZIQ48	PLENAMINE69	PROCRIT55
PANRETIN42	<i>podofilox</i>42	PROCTO-PAK51
<i>pantoprazole</i>51	<i>polymyxin b sulf-trimethoprim</i>63	PROCTOSOL HC51
PANZYGA54	POMALYST16	PROCTOZONE-HC51
<i>paricalcitol</i>48	PORTIA 2861	PROGLYCEM48
<i>paromomycin</i>10	<i>potassium chlorid-d5-0.45%nacl</i>69	PROGRAF16
<i>paroxetine hcl</i>29	<i>potassium chloride</i>69	PROLASTIN-C44
<i>paroxetine mesylate(menop.sym)</i>29	<i>potassium chloride in 0.9%nacl</i>69	PROLIA57
PASER10	<i>potassium chloride in 5 % dex</i>69	PROMACTA37
PAXIL29	<i>potassium chloride in lr-d5</i>69	<i>promethazine</i>66
PAZEO63	<i>potassium chloride in water</i>69	<i>promethazine-phenylephrine</i>66
PEDIARIX (PF)54	<i>potassium chloride-0.45 % nacl</i>69	PROMETHEGAN66
PEDVAX HIB (PF)54	<i>potassium chloride-d5-0.2%nacl</i>70	<i>propafenone</i>37
<i>peg 3350-electrolytes</i>51	<i>potassium chloride-d5-0.3%nacl</i>70	<i>propranolol</i>37
PEGANONE29		<i>propranolol-hydrochlorothiazid</i>37
PEGASYS55		
PEGASYS PROCLICK55		

<i>propylthiouracil</i>	48	RINVOQ ER	57	SIVEXTRO	11
PROQUAD (PF)	55	<i>risedronate</i>	44, 57, 58	SKYRIZI	42
PROSOL 20 %	70	RISPERDAL CONSTA	29	<i>sodium chloride</i>	44
<i>protriptyline</i>	29	<i>risperidone</i>	29, 30	<i>sodium chloride 0.45 %</i>	70
PULMOZYME	66	<i>ritonavir</i>	11	<i>sodium chloride 0.9 %</i>	44
PURIXAN	16	<i>rivastigmine</i>	30	<i>sodium chloride 3 %</i>	70
<i>pyrazinamide</i>	11	<i>rivastigmine tartrate</i>	30	<i>sodium chloride 5 %</i>	70
<i>pyridostigmine bromide</i>	29	RIVELSA	61	<i>sodium phenylbutyrate</i>	44
QBRELIS	37	<i>rizatriptan</i>	30	<i>sodium polystyrene sulfonate</i>	44
QUADRACEL (PF)	55	<i>ropinirole</i>	30	<i>sofosbuvir-velpatasvir</i>	12
<i>quetiapine</i>	29	<i>rosuvastatin</i>	38	<i>solifenacin</i>	68
<i>quinapril</i>	37	ROTARIX	55	SOLTAMOX	17
<i>quinapril-hydrochlorothiazide</i>	37	ROTATEQ VACCINE	55	SOMATULINE DEPOT	17
<i>quinidine gluconate</i>	38	ROWEEPRA	30	SOMAVERT	48
<i>quinidine sulfate</i>	38	ROWEEPRA XR	30	SORINE	38
<i>quinine sulfate</i>	11	ROZLYTREK	16	<i>sotalol</i>	38
QVAR REDHALER	66	RUBRACA	17	SOTALOL AF	38
RABAVERT (PF)	55	RUCONEST	66	SOVALDI	12
<i>rabeprazole</i>	51	RUZURGI	30	SPIRIVA RESPIMAT	67
<i>raloxifene</i>	57	RYDAPT	17	SPIRIVA WITH	
<i>ramelteon</i>	29	SABRIL	30	HANDHALER	67
<i>ramipril</i>	38	SAIZEN	55	<i>spironolactone</i>	38
<i>ranitidine hcl</i>	51	SAIZEN SAIZENPREP	55	<i>spironolacton-hydrochlorothiaz.</i>	38
<i>ranolazine</i>	38	SAMSCA	48	SPRINTEC (28)	61
RAPAFLO	68	SANDIMMUNE	17	SPRITAM	30
RAPAMUNE	16	SANTYL	42	SPRYCEL	17
<i>rasagiline</i>	29	SAPHRIS	30	SPS (WITH SORBITOL)	44
RAVICTI	44	SAVELLA	58	SRONYX	61
RECLIPSEN (28)	61	<i>scopolamine base</i>	51	SSD	42
RECOMBIVAX HB (PF)	55	<i>selegiline hcl</i>	30	<i>stavudine</i>	12
RECTIV	51	<i>selenium sulfide</i>	42	STELARA	42
REGRANEX	42	SELZENTRY	11	STIMATE	48
RELENZA DISKHALER	11	SENSIPAR	48	STIOLTO RESPIMAT	67
RELISTOR	51	SEREVENT DISKUS	66	STIVARGA	17
<i>repaglinide</i>	48	SEROSTIM	55	<i>streptomycin</i>	12
REPATHA PUSHTRONEX	38	<i>sertraline</i>	30	STRIBILD	12
REPATHA SURECLICK	38	SETLAKIN	61	STRIVERDI RESPIMAT	67
REPATHA SYRINGE	38	<i>sevelamer carbonate</i>	44	SUBSYS	30
RESCRIPTOR	11	<i>sevelamer hcl</i>	44	SUCRAID	51
RESTASIS	63	SHINGRIX (PF)	55	<i>sucralfate</i>	51
RETACRIT	55	SIGNIFOR	17	<i>sulfacetamide sodium</i>	63
REVATIO	66	SIKLOS	17	<i>sulfacetamide sodium (acne)</i>	42
REVLIMID	16	<i>sildenafil (pulm.hypertension)</i>	66, 67	<i>sulfacetamide-prednisolone</i>	63
REXULTI	29	SILENOR	30	<i>sulfadiazine</i>	12
REYATAZ	11	SILIQ	42	<i>sulfamethoxazole-trimethoprim.</i>	12
<i>ribavirin</i>	11	<i>silver sulfadiazine</i>	42	SULFAMYLON	42
RIDAURA	57	SIMBRINZA	63	<i>sulfasalazine</i>	51
<i>rifabutin</i>	11	SIMPONI	58	<i>sulindac</i>	30
<i>rifampin</i>	11	<i>simvastatin</i>	38	<i>sumatriptan</i>	30
RIFATER	11	<i>sirolimus</i>	17	<i>sumatriptan succinate</i>	30, 31
<i>riluzole</i>	44	SIRTURO	11	SUNOSI	31
<i>rimantadine</i>	11			SUPRAX	12

SUPREP BOWEL PREP KIT	51	<i>terbinafine hcl</i>	12	TRELEGY ELLIPTA	67
SUTENT	17	<i>terbutaline</i>	67	TRELSTAR	17
SYEDA	61	<i>terconazole</i>	61	TRESIBA FLEXTOUCH U-	
SYLATRON	55	<i>testosterone</i>	49	100	49
SYMBICORT	67	<i>testosterone cypionate</i>	49	TRESIBA FLEXTOUCH U-	
SYMDEKO	67	<i>testosterone enanthate</i>	49	200	49
SYMFI	12	<i>tetanus,diphtheria tox ped(pf)</i>	55	TRESIBA U-100 INSULIN	49
SYMFI LO	12	<i>tetrabenazine</i>	31	<i>tretinoin</i>	42
SYMLINPEN 120	48	<i>tetracycline</i>	12	<i>tretinoin (chemotherapy)</i>	18
SYMLINPEN 60	48	THALOMID	17	<i>tretinoin microspheres</i>	42
SYMPAZAN	31	THEO-24	67	<i>triamcinolone acetonide</i>	42, 44
SYMPROIC	51	<i>theophylline</i>	67	<i>triamterene-hydrochlorothiazid</i>	38
SYMTUZA	12	<i>thioridazine</i>	31	TRIDERM	42
SYNAREL	48	<i>thiothixene</i>	31	<i>trientine</i>	44
SYNJARDY	48	<i>tiagabine</i>	31	TRI-ESTARYLLA	61
SYNJARDY XR	49	TIBSOVO	17	<i>trifluoperazine</i>	32
SYNRIBO	17	<i>tigecycline</i>	12	<i>trifluridine</i>	64
SYNTHROID	49	TIGLUTIK	44	TRI-LEGEST FE	61
TABLOID	17	<i>timolol maleate</i>	38, 63	TRI-LO-ESTARYLLA	61
<i>tacrolimus</i>	17, 42	TIROSINT	49	TRI-LO-SPRINTEC	61
<i>tadalafil</i>	68	TIVICAY	12	TRILYTE WITH FLAVOR	
<i>tadalafil (pulm. hypertension)</i>	67	<i>tizanidine</i>	31	PACKETS	51
TAFINLAR	17	TOBI PODHALER	12	<i>trimethoprim</i>	12
TAGRISSO	17	TOBRADEX	64	TRI-MILI	61
TAKHZYRO	67	TOBRADEX ST	64	<i>trimipramine</i>	32
TALTZ AUTOINJECTOR	42	<i>tobramycin</i>	64	TRINTELLIX	32
TALTZ SYRINGE	42	<i>tobramycin in 0.225 % nacl</i>	12	TRI-PREVIFEM (28)	61
TALZENNA	17	<i>tobramycin sulfate</i>	12	TRI-SPRINTEC (28)	61
<i>tamoxifen</i>	17	<i>tobramycin-dexamethasone</i>	64	TRIUMEQ	12
<i>tamsulosin</i>	68	TOBREX	64	TRIVORA (28)	61
TARCEVA	17	<i>tolbutamide</i>	49	TRI-VYLIBRA	61
TARGRETIN	17	<i>tolcapone</i>	31	TRI-VYLIBRA LO	61
TARINA 24 FE	61	TOLSURA	12	TROPHAMINE 10 %	70
TASIGNA	17	<i>tolterodine</i>	68	<i>tropium</i>	68
TAVALISSE	38	<i>topiramate</i>	31	TRULICITY	49
<i>tazarotene</i>	42	<i>toremifene</i>	17	TRUMENBA	55
TAZICEF	12	<i>torse mide</i>	38	TRUVADA	12
TAZORAC	42	TOUJEO MAX U-300		TURALIO	18
TAZTIA XT	38	SOLOSTAR	49	TWINRIX (PF)	55
TDVAX	55	TOUJEO SOLOSTAR U-300		TYBOST	12
TECFIDERA	31	INSULIN	49	TYDEMY	61
TEFLARO	12	TRACLEER	67	TYGACIL	12
TEGRETOL	31	TRADJENTA	49	TYKERB	18
TEGRETOL XR	31	<i>tramadol</i>	31	TYMLOS	58
TEGSEDI	31	<i>tramadol-acetaminophen</i>	32	TYPHIM VI	55
<i>telmisartan</i>	38	<i>trandolapril</i>	38	UDENYCA	55
<i>telmisartan-amlodipine</i>	38	<i>tranexamic acid</i>	61	ULORIC	58
<i>telmisartan-hydrochlorothiazid</i>	38	<i>tranylcypromine</i>	32	UNITHROID	49
<i>temazepam</i>	31	TRAVASOL 10 %	70	UPTRAVI	38
TENIVAC (PF)	55	TRAVATAN Z	64	<i>ursodiol</i>	52
<i>tenofovir disoproxil fumarate</i>	12	<i>trazodone</i>	32	VABOMERE	12
<i>terazosin</i>	38	TRECATOR	12	<i>valacyclovir</i>	12

VALCHLOR	42	XARELTO	39
<i>valganciclovir</i>	12	XATMEP	18
<i>valproic acid</i>	32	XELJANZ	58
<i>valproic acid (as sodium salt)</i>	32	XELJANZ XR	58
<i>valsartan</i>	38	XERMELO	18
<i>valsartan-hydrochlorothiazide</i> ..	38	XGEVA	18
<i>vancomycin</i>	12, 13	XIFAXAN	13
VANDAZOLE	61	XIIDRA	64
VAQTA (PF)	55	XOFLUZA	13
VARIVAX (PF)	56	XOLAIR	67
VARIZIG	56	XOSPATA	18
VASCEPA	38	XPOVIO	18
VELIVET TRIPHASIC		XTANDI	18
REGIMEN (28)	61	XULTOPHY 100/3.6	49
VELTASSA	44	XURIDEN	44
VEMLIDY	13	XYREM	32
VENCLEXTA	18	YF-VAX (PF)	56
VENCLEXTA STARTING		YONSA	18
PACK	18	YOSPRALA	39
<i>venlafaxine</i>	32	YUPELRI	67
VENTAVIS	67	YUVAFEM	61
VENTOLIN HFA	67	<i>zafirlukast</i>	67
<i>verapamil</i>	38	<i>zaleplon</i>	32
VERSACLOZ	32	ZARAH	62
VERZENIO	18	ZARXIO	56
VIBERZI	52	ZAVESCA	49
VICTOZA 3-PAK	49	ZEJULA	18
VIDEX 2 GRAM		ZELBORAF	18
PEDIATRIC	13	ZEMAIRA	44
VIDEX EC	13	ZENPEP	52
VIEKIRA PAK	13	ZEPATIER	13
VIENVA	61	<i>zidovudine</i>	13
<i>vigabatrin</i>	32	<i>zileuton</i>	67
VIGADRONE	32	<i>ziprasidone hcl</i>	32
VIIBRYD	32	ZIRGAN	64
VIMPAT	32	ZOLINZA	18
VIRACEPT	13	<i>zolmitriptan</i>	32
VIREAD	13	<i>zolpidem</i>	32
VITRAKVI	18	ZOMACTON	56
VIVITROL	32	<i>zonisamide</i>	32
VIZIMPRO	18	ZONTIVITY	39
<i>voriconazole</i>	13	ZORBTIVE	56
VOSEVI	13	ZORTRESS	18
VOTRIENT	18	ZOSTAVAX (PF)	56
VRAYLAR	32	ZOVIA 1/35E (28)	62
VYFEMLA (28)	61	ZUBSOLV	32, 33
VYLIBRA	61	ZYDELIG	18
VYNDAQEL	38	ZYKADIA	18
<i>warfarin</i>	39	ZYLET	64
WELCHOL	39	ZYPREXA RELPREVV	33
WIXELA INHUB	67	ZYTIGA	18, 19
XALKORI	18		

acitretin

Products Affected

- *acitretin*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

actemra

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Kineret, Remicade, Humira, Orencia, Enbrel, Simponi, Cimzia
Required Medical Information	Documentation of diagnosis. For rheumatoid arthritis and polyarticular juvenile idiopathic arthritis, patients must have an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide). For giant cell arteritis, patients must have an adequate trial or intolerance to one systemic corticosteroid (e.g., prednisone). Documentation of systemic juvenile idiopathic arthritis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

acthar h.p.

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Covered for the following indications: 1. Infantile spasms (West syndrome) 2. Acute exacerbations of multiple sclerosis (MS) for patients receiving concurrent immunomodulator therapy (e.g., interferon beta, glatiramer acetate, dimethyl fumarate, fingolimod, teriflunomide) 3. Rheumatic disorders 4. Collagen diseases 5. Dermatologic diseases 6. Allergic states 7. Ophthalmic diseases 8. Respiratory diseases 9. Transfusion reaction due to serum protein reaction 10. Proteinuria in nephrotic syndrome and trial/failure or contraindication to two therapies from any of the following different classes: corticosteroids (e.g., cortisone or dexamethasone), calcineurin inhibitors (e.g., cyclosporine or tacrolimus, per DRUGDEX). 11. Diagnosis for adrenal insufficiency with trial/failure or contraindication to cosyntropin. 12. Gout and intolerance or contraindication to at least two first-line gout therapies (e.g., allopurinol, probenecid, colchicine). 13. Pediatric acquired epileptic aphasia. For covered indications 2 through 9, limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (i.e. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

actimmune

Products Affected

- ACTIMMUNE

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

ADHD Drugs

Products Affected

- *guanfacine oral tablet extended release 24 hr*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

afinitor

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of advanced renal cell carcinoma and trial/failure with 1 from each of the following (A and B) for clear cell histology. A) sunitinib, sorafenib, pazopanib, or axitinib. B) cabozantinib or nivolumab -OR- documentation of patients with progressive neuroendocrine tumors of pancreatic origin (PNET) that is unresectable, locally advanced or metastatic -OR- documentation of renal angiomyolipoma and tuberous sclerosis complex (TSC) -OR- documentation of use in postmenopausal advanced hormone receptor-positive, HER2-negative breast cancer in combination with exemestane after failure of treatment with letrozole or anastrozole -OR- documentation of SEGA associated with tuberous sclerosis for those not a candidate for surgical resection-OR- documentation of progressive, well-differentiated, non-functional, neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin with unresectable, locally advanced or metastatic disease -OR- Afinitor Disperz used as adjunct therapy for TSC- associated partial-onset seizures
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For renal cell carcinoma with clear cell histology additional trial/failure of cabozantinib or nivolumab per NCCN guidelines.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

aimovig

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. 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 (1-4). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in average monthly migraine days or number of migraine episodes following Aimovig administration is required.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

alecensa

Products Affected

- ALECENSA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

ALPHA1-PROTEINASE INHIBITORS

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of panacinar emphysema AND documentation of a decline in forced expiratory volume in 1 second (fev1) despite optimal medical therapy (bronchodilators, corticosteroids, oxygen if indicated) AND documentation of phenotype (pi*zz, pi*znull or pi*nullnull) associated with causing serum alpha 1-antitrypsin of less than 80 mg/dl AND documentation of an alpha 1-antitrypsin serum level below the value of 35% of normal (less than 80 mg/dl).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Covered under Part B when furnished incident to a physician service and is not self-administered.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

alunbrig

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

ampyra

Products Affected

- AMPYRA
- *dalfampridine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	History of seizure disorder, Cr Cl less than 50ml/min
Required Medical Information	Documentation of diagnosis -AND- documentation that the patient is ambulatory and has walking impairment as evidenced by one of the following. 1. Functional status score (EDSS score). 2. Timed 25-foot Walk Test (T25W).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	Doses greater than 20 mg/day will not be approved. For reauthorization, documentation supporting improvement in walking impairment from baseline is required.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

anabolic steroids

Products Affected

- **ANADROL-50**
- *oxandrolone*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

apokyn

Products Affected

- APOKYN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease -AND- for use in acute, intermittent treatment of hypomobility off-episodes -AND- documentation of concurrent medication for the treatment of Parkinson's disease (e.g. carbidopa/levodopa, pramipexole, ropinerole)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

arikayce

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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 a macrolide - AND- Arikayce will be used in conjunction with a background multidrug regimen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	18 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).

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

attr-cm drugs

Products Affected

- VYNDAQEL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) with amyloid deposits on cardiac biopsy or scintigraphy with heart contralateral greater than 1.5 (Grade III) -AND- Cardiac involvement supported by cardiac magnetic resonance, echocardiography or serum cardiac biomarker (e.g. B-type natriuretic peptide, cardiac troponin) - AND- Primary (light chain) amyloidosis has been ruled out by immunohistochemistry, mass spectrometry or scintigraphy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of improvement or delayed disease progression from baseline demonstrated by 6-minute walk test, cardiac function (e.g. LVEF, NYHA class), Kansas City Cardiomyopathy Questionnaire-Overall Summary, number of cardiovascular-related hospitalizations or serum cardiac biomarkers (e.g. B-type natriuretic peptide, cardiac troponin)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

atypical antipsychotics

Products Affected

- *aripiprazole*
- **REXULTI**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

aubagio

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Aubagio and other disease modifying agents such as fingolimod, interferons, Copaxone, Tysabri
Required Medical Information	Documentation of relapsing-remitting or relapsing secondary progressive multiple sclerosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Doses greater than 14 mg per day will not be approved

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

auryxia

Products Affected

- AURYXIA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

balversa

Products Affected

- BALVERSA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic urothelial carcinoma - AND- FGFR3 or FGFR2 mutation positive as detected by FDA approved test -AND- Disease progression during or following at least one prior platinum containing chemotherapy including within 12 months of neoadjuvant or adjuvant platinum containing chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

banzel

Products Affected

- BANZEL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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- an adequate trial or intolerance of a previous antiepileptic therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses greater than 3200mg per day will not be approved.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of active systemic lupus erythematosus (SLE) -AND- documentation of positive anti-nuclear antibody (ANA) titer (greater than or equal to 1:80) or anti-double-stranded DNA antibody (anti-dsDNA) greater than or equal to 30IU/mL -AND- trial, intolerance, or inadequate response to at least 2 of the following standard of care drug classes: 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate) -AND- member will continue to receive concomitant standard of care treatment with use of at least one of the following (alone or in combination): 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

berinert

Products Affected

- **BERINERT INTRAVENOUS KIT**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

bonjesta

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	9 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

bosulif

Products Affected

- BOSULIF

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

braftovi

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

butrans

Products Affected

- *buprenorphine*
- BUTRANS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of moderate to severe chronic pain -AND- trial and failure of at least two previous federal legend medications for pain, including NSAIDs, tramadol, or opioid analgesics. For concomitant use of an opiate agonist and substance abuse therapy, documentation that the member has an acute pain condition (e.g. acute traumatic injury) in which treatment with other agents would cause insufficient pain control or if the member requires treatment for pain related to a terminal illness. For concomitant use of an opiate agonist, benzodiazepine and a centrally acting skeletal muscle relaxant, documentation that the member has tried/failed at least 2 other skeletal muscle relaxant (e.g. methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients AND attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For concomitant use of an opiate agonist and other opiate potentiators (e.g. gabapentinoids, benzodiazepines) attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For long acting (e.g. extended release) opioid medications, the following apply (1-5). 1)Pain is severe enough to require daily, around-the-clock, long-term opioid treatment. 2)Patient is not long acting opioid naive. 3)Attestation that non-opiate alternative therapies have been explored (e.g. NSAIDs). 4)Attestation that controlled substance Rx history has been reviewed in the state Prescription Drug Monitoring Program. 5)Attestation of counseling on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.
Age Restrictions	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Buprenorphine topical patch should not be used concomitantly with substance abuse therapies.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

cablivi

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of acquired thrombocytopenic purpura (aTTP) -AND- Used in conjunction with plasma exchange and immunosuppressive therapy (i.e. systemic corticosteroids or rituximab)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	2 months initial authorization, 28 days reauthorization
Other Criteria	For reauthorization, attestation of remaining signs and symptoms of persistent disease (e.g. suppressed ADAMTS 13 activity level remain present)

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

cabometyx

Products Affected

- **CABOMETYX**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of advanced renal cell carcinoma (RCC) -OR- Documentation of hepatocellular carcinoma previously treated with sorafenib
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

calquence

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- the member has received at least one prior therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

caprelsa

Products Affected

- CAPRELSA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

carbaglu

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use as an adjunct therapy for acute hyperammonemia or maintenance therapy for chronic hyperammonemia due to hepatic enzyme N-acetylglutamate synthase (NAGS) deficiency
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

CERDELGA

Products Affected

- CERDELGA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

CF drugs

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis. For Bethkis: failure on, intolerance to, or contraindication to generic tobramycin inhalation solution
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Inhalation solutions covered under Part B when administered in the home setting using a covered nebulizer (i.e. DME).

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

cholbam

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of bile acid synthesis disorders due to single enzyme defects (SEDs) -OR- documentation of use as adjunctive therapy for peroxisomal disorders (PDs), including Zellweger spectrum disorders, in patients who exhibit manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

cialis

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of benign prostatic hyperplasia (BPH) and trial/failure of at least two alternative medications in the following classes (alpha-1 adrenergic blockers and/or 5-alpha reductase inhibitors)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

cimzia

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Orencia, Simponi, Actemra, Kineret
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For moderate to severe Crohn's disease, inadequate response or intolerance to at least two immunosuppressants (e.g. corticosteroids, azathioprine). For ankylosing spondylitis, inadequate response or intolerance to a nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For spinal or axial Psoriatic Arthritis (PsA), inadequate response or intolerance to one NSAID. For PsA without spinal or axial disease, inadequate response or intolerance to one nonbiological DMARD (e.g. methotrexate, leflunomide). For Enthesitis/dactylitis associated PsA, inadequate response or intolerance to one NSAID or local glucocorticoid injection. For non-radiographic axial spondyloarthritis, inadequate response or intolerance to two nonsteroidal anti-inflammatory drugs (NSAID).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Other Criteria	For Crohn's disease, patients must have an adequate trial or intolerance to one preferred biologic product, Humira or Stelara. For Rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra and Xeljanz/Xeljanz XR. For plaque psoriasis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Cosentyx, Otezla and Stelara. For ankylosing spondylitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel and Cosentyx. For Psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Cosentyx, Enbrel, Humira and Stelara. 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.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

cinryze

Products Affected

- CINRYZE

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

cometriq

Products Affected

- COMETRIQ

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

copiktra

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL) in patients who are no longer responding or intolerant to 2 prior therapies - OR- Documentation of Follicular Lymphoma (FL) in patients who are no longer responding or intolerant to 2 prior systemic therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

corlanor

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND all of the following: 1) Normal sinus rhythm. 2) Resting heart rate greater than or equal to 70 beats per minute. 3) Left ventricular ejection fraction less than or equal to 35 percent, when applicable. 4) In adult patients (greater than or equal to 18 years), trial/failure of maximum tolerated dose of one beta-blocker used for treatment of heart failure (e.g., bisoprolol, carvedilol, metoprolol succinate) OR contraindication to beta-blocker use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Cosentyx

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For ankylosing spondylitis, inadequate response or intolerance to a nonsteroidal anti-inflammatory drug (NSAID)
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.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

cotellic

Products Affected

- COTELLIC

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

crinone

Products Affected

- CRINONE

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

daurismo

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of newly diagnosed Acute Myeloid Leukemia -AND- Used in combination with cytarabine -AND- At least one comorbidity that preclude use of intensive induction chemotherapy defined as one of the following: 1) Age greater than or equal to 75 2) Severe cardiac or pulmonary comorbidity 3) Reduced renal function 4) Hepatic impairment 5.) Physician attests patient is not a candidate for intensive induction therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

doptelet

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of thrombocytopenia and chronic liver disease - AND- beneficiary is scheduled to undergo a procedure -OR- Documentation of chronic immune thrombocytopenia -AND- Trial, intolerance, or inadequate response to corticosteroid therapy, immunoglobulin therapy or splenectomy -AND- One of the following (1 or 2): 1) Platelet count less than or equal to $50 \times 10^9/L$ and has significant mucous member bleeding or at least one risk factor for bleeding (e.g. hypertension, peptic ulcer disease). 2) Platelets count of less than or equal to $30 \times 10^9/L$
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Platelet count is provided for applicable dosing.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

duobrii

Products Affected

- DUOBRII

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of plaque psoriasis -AND- therapeutic failure or intolerance to generic tazarotene cream -AND- therapeutic failure or intolerance to 1 high-potency topical corticosteroid (e.g. betamethasone dipropionate 0.05%, halobetasol propionate 0.05%)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

dupixent

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3): 1) moderate to severe atopic dermatitis 2) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- trial & failure, intolerance, or contraindication to at least one non-fluorinated topical corticosteroid for patients requesting treatment for atopic dermatitis of the face 3) trial & failure, intolerance, or contraindication to tacrolimus ointment, or pimecrolimus cream, or crisaborole ointment -OR- Documentation of the following (4-7): 4) moderate-to-severe asthma 5) documented FEV1 reversibility of at least 12% or 200 milliliters (mL) after albuterol (salbutamol) administration 6) Blood eosinophils greater than or equal to 150 cells/uL -OR- patient is currently taking daily or alternate-day oral corticosteroids 7) using a medium- or high-dose inhaled corticosteroid and a long acting beta agonist -OR- Documentation of the following (8-9): 8) chronic rhinosinusitis with nasal polyposis 9) trial & failure, intolerance or contraindication to intra-nasal corticosteroid and 14 day course of oral corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Other Criteria	For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. Reauthorization or continuation of therapy will be approved when documentation of improvement or response to therapy is provided.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

egfr tyrosine kinase inhibitors

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

egrifta

Products Affected

- **EGRIFTA SUBCUTANEOUS RECON
SOLN 1 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documented diagnosis of HIV and lipodystrophy, member must actively be receiving antiretroviral therapy including protease inhibitors, nucleoside reverse transcriptase inhibitors, or non-nucleoside reverse transcriptase inhibitors
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

emflaza

Products Affected

- EMFLAZA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of Duchenne muscular dystrophy (DMD) with mutation of dystrophin gene -AND- onset of weakness or history of DMD starting before age 2 -AND- One of the following (1 or 2). 1) Documented trial of prednisone has resulted in intolerable adverse events (e.g. diabetes, hypertension that is difficult to manage, Cushingoid features, truncal obesity, greater than or equal to 10 percent increase in body weight over a 6 month period). 2) Documented severe behavioral adverse event while on prednisone that warrants prednisone dose reduction impacting efficacy for management of DMD (i.e. abnormal behavior, aggression, irritability, disturbance in mood)
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

enbrel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Remicade, Cimzia, Humira, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of 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 nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunamide). For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

endari

Products Affected

- ENDARI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of Sickle Cell Disease with 2 or more sickle cell complications within the previous 12 months -AND-documentation of previous trial of antisickling treatment (e.g. hydroxyurea) and plans of continued therapy while taking Endari
Age Restrictions	Deny if less than 5 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

epclusa

Products Affected

- **EPCLUSA**
- *sofosbuvir-velpatasvir*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

epidiolex

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For Lennox-Gastuat syndrome, treatment is in combination with other conventional agents -AND- trial and failure or intolerance of at least two standard of care treatments (e.g. clonazepam, topiramate, lamotrigine, clobazam). For Dravet syndrome, treatment is in combination with other conventional agents.
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For reauthorization, attestation supporting reduction in seizure frequency

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

erivedge

Products Affected

- ERIVEDGE

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

erleada

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- 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	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

evenity

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- 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) Age 50 years or older with 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 50 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of trial/failure, intolerance, or contraindication to at least one oral bisphosphonate.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

farydak

Products Affected

- FARYDAK

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

fasenra

Products Affected

- FASENRA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of severe asthma -and- history of at least one asthma exacerbations requiring oral or systemic corticosteroid treatment in the past 12 months -and- documented reduced lung function [prebronchodilator FEV1 below 80% in adults, and below 90% in adolescents] despite regular treatment with (a. or b.): a) high dose inhaled corticosteroid and additional asthma controller medication or b.) a medium or high dose inhaled corticosteroid plus a long-acting beta agonist with or without oral corticosteroids and additional asthma controller medication
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Blood eosinophil count (in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection) greater than or equal to 150 cells/microliter within 6 weeks of initiation of therapy

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

firazyr

Products Affected

- **FIRAZYR**
- *icatibant*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

firdapse

Products Affected

- **FIRDAPSE**
- **RUZURGI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive clinical response to therapy.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

flector

Products Affected

- *diclofenac epolamine*
- **FLECTOR**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

forteo

Products Affected

- FORTEO

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

gabapentin

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. 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	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

galafold

Products Affected

- GALAFOLD

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

gattex

Products Affected

- **GATTEX 30-VIAL**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of short bowel syndrome (SBS) AND dependence on parenteral nutrition or intravenous nutritional support for at least 12 months AND requiring parenteral nutrition at least 3 times per week -OR- Documentation of SBS AND age 1 to 17 years of age AND Dependence on parenteral nutrition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

gilenya

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Gilenya and other disease modifying agents such as interferons, Copaxone, Tysabri
Required Medical Information	Members must have a documented diagnosis of relapsing-remitting, relapsing secondary progressive or progressive relapsing multiple sclerosis -AND- new starts to therapy have the following baseline information documented within 6 months of initiating therapy: ophthalmologic evaluation, liver transaminase and bilirubin, complete blood count, and electrocardiogram if using an antiarrhythmic agent or have second degree or greater AV block -AND- new starts to therapy do not have any of the following comorbid conditions or concomitant therapies: bradycardia, congestive heart failure, sick sinus syndrome, prolonged QT interval, ischemic cardiac disease, irregular heartbeat, current neutropenia, current chronic or acute infections, use of antineoplastics, immunosuppressive or immune modulating therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Doses greater than 0.5mg/day will not be approved

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

gleevec

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

growth hormone

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUEL
- HUMATROPE
- NORDITROPIN FLEXP
- NUTROPIN AQ NUSPIN
- OMNITROPE
- SAIZEN
- SAIZEN SAIZENPREP
- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG
- ZOMACTON
- ZORBTIVE

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

haegarda

Products Affected

- HAEGARDA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

HARVONI

Products Affected

- **HARVONI ORAL TABLET 90-400 MG**
- *ledipasvir-sofosbuvir*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Non-24 Sleep-Wake disorder -AND- patient is totally blind
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of increased total nighttime sleep or decreased daytime nap duration

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

high-risk meds

Products Affected

- amitriptyline
- benztropine oral
- clomipramine
- cyclobenzaprine oral tablet
- cyproheptadine
- **DIGITEK**
- **DIGOX**
- digoxin oral solution 50 mcg/ml (0.05 mg/ml)
- digoxin oral tablet
- doxepin oral
- glyburide
- glyburide micronized
- glyburide-metformin
- hydroxyzine hcl oral solution 10 mg/5 ml
- hydroxyzine hcl oral tablet
- imipramine hcl
- nitrofurantoin
- nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg
- nitrofurantoin monohyd/m-cryst
- promethazine oral syrup
- **SILENOR**
- trimipramine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	For all medications subject to this PA group, the following information (1 through 3) is required: 1. Documentation of diagnosis 2. Explanation of risk-benefit profile favoring use of the high-risk medication 3. Attestation of an intent to monitor and address treatment-related adverse events. In addition to requirements 1 through 3 above, for digoxin doses exceeding 0.125 mg daily, provider confirmation that a lower dose of digoxin has or would be ineffective in managing the member's condition is required. For the target high-risk medications glyburide, TCAs and nitrofurantoin, in addition to criteria 1 through 3 above, trial and failure or documentation of intolerance or contraindication to at least 2 non-high risk alternative drugs for the same indication, if available, is required. Non-high risk alternative medications for those target high-risk medications include the following: 1. Glyburide (non-high risk alternatives include glipizide and glimepiride) 2. TCAs (non-high risk alternatives include SSRIs and SNRIs) 3. Nitrofurantoin (non-high risk alternatives include Bactrim, Cipro, or cephalexin). If using one of the above 3 high-risk medications for a medically-accepted indication not shared by the safer alternatives listed, then no trial of alternatives is required for that target high-risk medication.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Age Restrictions	Automatic approval if less than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected class drugs. Digoxin doses less than or equal to 0.125 mg per day and doxepin doses less than or equal to 6 mg per day will receive automatic approval.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

homozygous fh

Products Affected

- JUXTAPID

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

humira

Products Affected

- HUMIRA
- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 40 MG/0.8 ML (6 PACK)
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UEVITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Remicade, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of 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 nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunamide). For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For moderate to severe Crohn's disease, inadequate response or intolerance to two immunosuppressants (e.g. corticosteroids, azathioprine) or monotherapy with infliximab. For moderate to severe ulcerative colitis, inadequate response or intolerance to two immunosuppressants (e.g. corticosteroids, azathioprine or 6-mercaptopurine).
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	For Crohn's disease in adults (18 years or older), trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine) or monotherapy with infliximab is required. For Crohn's disease in pediatrics, trial of 1 immunosuppressant (e.g. corticosteroids, azathioprine) or monotherapy with infliximab is required. For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis therapy without concomitant methotrexate, doses above plan quantity limit will be approved aligned with recommended weekly dosing regimen. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Ibrance

Products Affected

- IBRANCE

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

iclusig

Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

idhifa

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA approved test
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Required Medical Information	Documentation of diagnosis. For select diagnoses the following apply- 1) For Myasthenia Gravis Syndrome, documentation that the patient is refractory to other standard therapies (e.g., cholinesterase inhibitors, corticosteroids, azathioprine) given in therapeutic doses over at least 3 months OR is intolerant of/has a contraindication to those standard therapies. 2) For Multiple Sclerosis, patient is refractory to other standard therapies (e.g., interferons) given in therapeutic doses over at least 3 months, OR is intolerant of/has a contraindication to those standard therapies. 3) For Inflammatory Myopathies, the patient is refractory to corticosteroids given in therapeutic doses over at least 4 months, OR is intolerant of/has a contraindication to corticosteroids or immunosuppressants. 4) For CLL, IgG level less than 600mg/dL or evidence of a specific antibody deficiency or recurrent bacterial infections. 5) For Bone Marrow Transplant, when indicated within the first 100 days after transplantation. 6) For Dermatomyositis/Polymyositis, trial and failure, intolerance, or contraindication to standard first line therapy (i.e. corticosteroids or immunosuppressants). 7) For Pediatric HIV, the patient is less than 13 y.o. who have entry CD4 lymphocyte count greater than or equal to 200/mm3 and IgG less than 400 mg/dL OR a history of recurrent bacterial infections. 8) For Guillain-Barre syndrome, impaired function by objective assessment and/or objective findings on physical exam at the time of initial therapy and IVIG therapy must be initiated within 2 weeks of symptom onset. 9) For Autoimmune Mucocutaneous Blistering Diseases (e.g. Stevens-Johnson Syndrome), trial and failure, intolerance, or contraindication to conventional therapy (e.g. corticosteroids) or the patient has rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents.
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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

imbruvica

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

inbrija

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use for the treatment of intermittent off episodes of Parkinsons 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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

increlex

Products Affected

- INCRELEX

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

ingrezza

Products Affected

- **INGREZZA INITIATION PACK**
- **INGREZZA ORAL CAPSULE 40 MG, 80 MG**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

inlyta

Products Affected

- INLYTA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

inrebic

Products Affected

- INREBIC

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of intermediate-2 or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis -AND- If a new start, baseline platelet count of greater than $50 \times 10^9/L$
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

interferon alfa

Products Affected

- INTRON A INJECTION
 - PEGASYS
 - PEGASYS PROCLICK
 - SYLATRON
- SUBCUTANEOUS PEN INJECTOR 180

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

interleukin-1b blockers

Products Affected

- ARCALYST

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

intrarosa

Products Affected

- INTRAROSA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

IPF AGENTS

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of pirfenidone and nintedanib
Required Medical Information	Documentation of idiopathic pulmonary fibrosis -AND- baseline forced vital capacity (FVC) of at least 50% and a percent predicted diffusing capacity of the lungs of carbon monoxide (DLCO) of at least 30% -OR- For Ofev, 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%
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

iressa

Products Affected

- IRESSA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

itraconazole

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. If 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.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

jakafi

Products Affected

- **JAKAFI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis -OR- Documentation of steroid refractory acute graft-versus-host disease and prior therapy with at least one systemic corticosteroid
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. Platelet count to be provided.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

jynarque

Products Affected

- JYNARQUE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of rapidly progressing autosomal dominant polycystic kidney disease defined by one of the following : 1.) Historical decline in eGFR greater than or equal to 5mL/min/1.73 m*2. 2.) Decline in eGFR of greater than or equal to 2.5mL/min/1.73m*2 over a period of 5 years. 3.) 5% increase in total kidney volume per year by 3 repeat CT or MRI. 4.) Average kidney length greater than 16.5cm. 5.) Family history of end-stage renal disease before age 58. 6.) Mayo imaging classification of 1C, 1D, or 1E. 7.) Kidney bleeds.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

kalydeco

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Homozygous for the F508del mutation in the CFTR gene
Required Medical Information	Documentation of cystic fibrosis (CF) in patients who have one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to ivacaftor based on clinical and or in vitro assay (e.g. G551D, G1244E, G1349D)
Age Restrictions	Deny if less than 6 months of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	Doses greater than 300mg/day will not be approved. 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.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

kevozara

Products Affected

- KEVZARA SUBCUTANEOUS SYRINGE

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

kineret

Products Affected

- KINERET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Actemra, Remicade, Humira, Orencia, Enbrel, Simponi, Cimzia
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra and Xeljanz/Xeljanz XR.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

kisqali

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) Alternatives tried/failed. 2) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

korlym

Products Affected

- KORLYM

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

kuvan

Products Affected

- KUVAN ORAL TABLET,SOLUBLE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documented diagnosis of PKU -AND- documented baseline Phe level greater than 6 mL/dL -AND- clinical documentation of current weight
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	Doses greater than 20mg/kg/day will not be approved. For reauthorization, attestation supporting improvement in blood Phe levels from baseline - AND- clinical documentation of current weight is required

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

latuda

Products Affected

- **LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. 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	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

lenvima

Products Affected

- LENVIMA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

leukine

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of treatment for neutrophil recovery following induction chemotherapy of acute myelogenous leukemia in patients 55 years or older -OR- following peripheral blood cell transplantation -OR- in patients with Hodgkin's disease, ALL, or non-Hodgkin's lymphoma undergoing autologous bone marrow transplantation -OR- in patients that have undergone allogeneic bone marrow transplantation from an HLA-matched donor -OR- in patients that have undergone bone marrow transplantation and experienced delayed or failed engraftment
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

leukotriene modifiers

Products Affected

- *zileuton*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

lidoderm

Products Affected

- *lidocaine topical adhesive patch,medicated*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of postherpetic neuralgia (PHN) and trial and failure of 1 other agent used to treat PHN (e.g. gabapentin) -OR- documentation of diabetic neuropathy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

lokelma

Products Affected

- LOKELMA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of hyperkalemia as defined by serum potassium level between 5.1 and 7.4 mmol/L on at least two (2) screenings - AND- one of the following: 1) Modification of medications to reduce serum potassium levels were not successful, when applicable. 2) Diagnosis of chronic kidney disease and medications known to cause hyperkalemia (e.g. ACE inhibitors, ARBs) have been discontinued or reduced to the lowest effective dose.
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, documentation of diagnosis of a chronic condition that is contributing to persistent hyperkalemia and attestation of reduction in serum potassium levels following Lokelma administration is required.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

lonsurf

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic colorectal cancer in patients who have previously been treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy -OR- Documentation of metastatic gastric or gastroesophageal junction adenocarcinoma who have previously been treated with 2 of the following: 1) Fluoropyrimidine-containing chemotherapy 2) Platinum-containing chemotherapy 3) Taxane-containing chemotherapy 4) HER2/neu-targeted therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

lorbrena

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of ALK-positive metastatic non-small cell lung cancer (NSCLC) -AND- one of the following (1 or 2): 1. Disease progression on crizotinib and at least one other ALK inhibitor -OR- 2. Disease progression on alectinib or ceritinib as the first ALK therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For reauthorization, attestation of disease improvement or delayed disease progression.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

lynparza

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use as monotherapy in patients with deleterious or suspected deleterious germline BRCA mutated advanced ovarian cancer after trial of three or more prior lines of chemotherapy (e.g. carboplatin, cisplatin, paclitaxel, gemcitabine) -OR- documentation of use as maintenance treatment in patients with recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, who are in a complete or partial response to platinum-based chemotherapy -OR- documentation of use in patients with deleterious or suspected deleterious gBRCAm, HER2-negative metastatic breast cancer, who have been previously treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting and previously treated with or considered inappropriate for treatment with endocrine therapy if hormone receptor (HR) positive -OR- documentation of deleterious or suspected deleterious germline or somatic BRCA mutated advanced epithelial ovarian, fallopian tube or primary peritoneal cancer, who are in complete or partial response to first-line platinum-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

lyrica

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of DPN and trial/failure or intolerance to duloxetine-OR- PHN and trial/failure or intolerance to gabapentin -OR- seizures and trial/failure or intolerance to two AEDS -OR- neuropathic pain associated with spinal cord injury -OR- documentation to support a diagnosis of fibromyalgia and trial/failure or intolerance to duloxetine. 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	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

mavenclad

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Mavenclad and other disease modifying agents such as interferons, Copaxone, Tysabri. Treatment duration greater than 24 months. Documentation of pregnancy, malignancy, HIV infection, active chronic infection, hypersensitivity to cladribine, breastfeeding or reproductive age not planning to use effective contraception
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) -AND- new starts to therapy have the following baseline information documented within 6 months of initiating therapy: cancer screening, infection screening, liver function tests, and complete blood count.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Coverage beyond 24 months will not be approved.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

mavyret

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than three tablets per day will not be approved.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

mayzent

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 2 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Mayzent and other disease modifying agents such as interferons, Copaxone, Tysabri.
Required Medical Information	Documentation of diagnosis of a relapsing form of multiple sclerosis - AND- new starts to therapy have the following baseline information documented within 6 months of initiating therapy: ophthalmologic evaluation, liver function test, complete blood count, and cardiac evaluation (e.g. electrocardiogram) -AND- Testing for CYP2C9 variants has confirmed member does not have CYP2C9*3/*3 genotype -AND- new starts to therapy do not have any of the following: history of myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, Class III/IV heart failure, Mobitz type II second-degree, third-degree AV block and sick sinus syndrome unless patient has a functioning pacemaker..
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

megace

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

mekinist

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Patients with melanoma who have disease progression on prior BRAF inhibitor therapy
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

mektovi

Products Affected

- MEKTOVI

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

mulpleta

Products Affected

- **MULPLETA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of thrombocytopenia and chronic liver disease - AND- beneficiary is scheduled to undergo a procedure.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

myalept

Products Affected

- MYALEPT

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

namenda

Products Affected

- **NAMENDA XR ORAL
CAP,SPRINKLE,ER 24HR DOSE PACK**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

namzaric

Products Affected

- NAMZARIC

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

natpara

Products Affected

- NATPARA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

nerlynx

Products Affected

- NERLYNX

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

nexavar

Products Affected

- NEXAVAR

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

ninlaro

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of multiple myeloma AND previous treatment with at least 1 prior therapy AND used in combination with lenalidomide and dexamethasone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

NORTHERA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of neurogenic orthostatic hypotension caused by primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency or non-diabetic autonomic neuropathy -AND- Documentation of inadequate response, intolerance or contraindication to preferred generic alternative midodrine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

nourianz

Products Affected

- NOURIANZ

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease experiencing off episodes -AND- trial/failure, contraindication or intolerance to selegiline and entacapone - AND- Used as adjunct to levodopa/carbidopa.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

nubeqa

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of non-metastatic castration-resistant prostate cancer - 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	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

nucala

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of severe asthma evidenced by pretreatment forced expiratory volume in 1 second (FEV1) less than 80% predicted and FEV1 reversibility of at least 12% after albuterol administration -AND- 1.) A history of 2 or more exacerbations in the previous year or inadequate symptom control with inhaled corticosteroid in combination with 3 months of controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline), unless intolerant of or contraindication to all agents.-AND- 2 or 3. 2) Greater than or equal to 150 cells/uL screening within 6 weeks of dosing. 3) Greater than or equal to 300 cells/uL within 12 months of screening. -OR- Documentation of eosinophilic granulomatosis with polyangitis (EGPA) in patients who have a history of relapsing or refractory disease and will be receiving concomitant glucocorticoid treatment with or without immunosuppressive therapy
Age Restrictions	Deny if less than 6 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

nuedexta

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation supporting improvement in symptoms is required.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

nuplazid

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of hallucinations and delusions associated with Parkinson's disease psychosis
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

ocaliva

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of primary biliary cholangitis -AND- trial and failure, contraindication, or intolerance to ursodiol monotherapy -AND- will use concomitantly with ursodiol unless contraindicated or intolerant.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

odomzo

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced basal cell carcinoma (laBCC) that has recurred following surgery or radiation therapy or for use in patients who are not candidates for surgery or radiation therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

olumiant

Products Affected

- OLUMIANT ORAL TABLET 2 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orencia, Stelara, Actemra, azathioprine, cyclosporine
Required Medical Information	Documentation of rheumatoid arthritis and an inadequate response or intolerance to at least one non-biologic DMARD (e.g., methotrexate, leflunamide).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have an adequate trial or intolerance to two of the following preferred products Humira, Enbrel, Actemra, Xeljanz/Xejanz XR.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

onfi

Products Affected

- *clobazam*
- **ONFI ORAL SUSPENSION**
- **ONFI ORAL TABLET 10 MG, 20 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- adequate trial or intolerance of a previous antiepileptic therapy
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

oralair

Products Affected

- **ORALAIR SUBLINGUAL TABLET 300
INDX REACTIVITY**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
Required Medical Information	Documentation of allergic rhinitis and use for Sweet Vernal, Orchard, Perennial Rye, Timothy or Kentucky Blue Grass pollens -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
Age Restrictions	Deny if less than 10 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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

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
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Orenzia, Simponi, Kineret, Cimzia
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis or severe juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Cosentyx and Stelara. For juvenile idiopathic arthritis, patients must have an adequate trial or intolerance to 1 of the following preferred products Humira and Enbrel.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

orilissa

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Diagnosis of severe hepatic impairment or osteoporosis.
Required Medical Information	Documentation of female with diagnosis of endometriosis with moderate to severe pain -AND- For women of child bearing 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).
Age Restrictions	Deny if less than 18 years of age
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- patient is receiving a dose of 150mg once daily -AND- Total cumulative duration of therapy does not exceed 24 months.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

orkambi

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis and homozygous F508del mutation
Age Restrictions	Deny if less than 2 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.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

orkambi granules

Products Affected

- **ORKAMBI ORAL GRANULES IN PACKET**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis and homozygous F508del mutation - AND- Inability to swallow tablets.
Age Restrictions	Deny if less than 2 or greater than 5 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.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

OTEZLA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For psoriatic arthritis, patients must have an adequate trial or intolerance to 1 of the following preferred products Humira, Enbrel, Cosentyx and Stelara SC. Maintenance doses greater than 60 mg per day will not be approved.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

oxervate

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Treatment duration greater than 8 weeks per eye
Required Medical Information	Documentation of affected eye (e.g. right eye, both eyes).
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	8 weeks
Other Criteria	Coverage beyond 8 weeks per eye will not be approved

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

palynziq

Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of phenylketonuria. Member meets the following criteria 1.) Baseline Phe level greater than 600 micrometers/L -AND- 2.) Failure or intolerance to existing management (i.e. Kuvan therapy).
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 baseline pretreatment Phe levels -OR- blood Phe levels are within recommended target range.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

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
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of HR-positive, HER2-negative advanced or metastatic breast cancer in men and postmenopausal women with disease progression on or after endocrine-based therapy -AND- Used in combination with fulvestrant - AND- PI3K mutation positive as detected by an FDA approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new start only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

pomalyst

Products Affected

- POMALYST

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

praluent

Products Affected

- PRALUENT PEN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of the following: 1. HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FD (e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190 mg/dL prior to lipid lowering therapy (greater than or equal to 160 mg/dL if age less than 20) or LDL-C greater than or equal to 160 mg/dL after treatment with antihyperlipidemic agents but prior to Praluent therapy AND prior therapy with at least 2 trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. 2. Hypercholesterolemia ASCVD OR Primary Hyperlipidemia AND prior therapy with at least 2 trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has been ineffective in achieving LDL-C goal (LDL-C is still greater than or equal to 70 mg/dL) AND must be used concomitantly with a statin which is dosed at maximally tolerated dose OR documentation of statin intolerance. For HeFH and ASCVD, statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin 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
Age Restrictions	Deny if less than 18 years of age

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Praluent therapy from baseline must be provided.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

prescription drug combo

Products Affected

- acetaminophen-codeine oral solution 120-12 mg/5 ml
- acetaminophen-codeine oral tablet
- alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg
- **DURAMORPH (PF) INJECTION SOLUTION 0.5 MG/ML, 1 MG/ML**
- **ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG**
- fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr
- hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml
- hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg
- hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg
- hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml
- hydromorphone injection syringe 2 mg/ml
- hydromorphone oral liquid
- hydromorphone oral tablet
- **LORCET (HYDROCODONE)**
- **LORCET HD**
- **LORCET PLUS ORAL TABLET 7.5-325**
- **MG**
- methadone oral solution 10 mg/5 ml, 5 mg/5 ml
- methadone oral tablet 10 mg, 5 mg
- morphine concentrate oral solution
- morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg
- morphine oral capsule, extend. release pellets
- morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)
- morphine oral tablet
- morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg
- oxycodone oral capsule
- oxycodone oral concentrate
- oxycodone oral solution
- oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg
- oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg
- tramadol oral capsule, er biphasic 24 hr 25-75 100 mg, 200 mg
- tramadol oral tablet
- tramadol-acetaminophen

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

pristiq

Products Affected

- FETZIMA ORAL CAPSULE,EXT REL HR 120 MG, 20 MG, 40 MG, 80 MG
24HR DOSE PACK
- FETZIMA ORAL
CAPSULE,EXTENDED RELEASE 24

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder and trial and failure of two other antidepressants.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

prolia

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use to increase bone mass in 1.) Men at high risk for fracture receiving androgen deprivation therapy 2.) Women at high risk for fracture receiving adjuvant aromatase inhibitor therapy 3.) Use for treatment of osteoporosis and the prevention of fractures in postmenopausal women 4.) Glucocorticoid induced osteoporosis 5.) Osteoporosis in men -AND- For diagnoses 3-5, T score of less than -2.5 and a trial and failure or contraindication to at least one bisphosphonate -OR- use to prevent fractures in men and postmenopausal women with a low bone mass (T score between -1.0 and -2.5) and history of previous osteoporotic fracture and had a trial and failure or contraindication to at least one bisphosphonate -OR- those who are found to have a 10-year risk of major osteoporotic fracture greater than or equal to 20 percent or a risk of hip fracture greater than or equal to 3 percent and had a trial and failure or contraindication to at least one bisphosphonate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Other Criteria	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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

promethazine vc

Products Affected

- *promethazine-phenylephrine*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

provigil

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of 1 of the following. 1) Diagnosis of shift work sleep disorder (SWSD) as defined by a minimum of 5 night shifts per month with at least 3 of those nights occurring consecutively and the shift is 6 to 12 hours in duration occurring between 10pm and 8am. 2) Diagnosis of narcolepsy documented by MSLT less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) or other appropriate testing. 3) Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography. Diagnosis established in accordance with ICSD or DSM V criteria acceptable for all indications. 4) Documentation of fatigue associated with Multiple Sclerosis (MS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

pulmonary arterial hypertension

Products Affected

- **ADCIRCA**
- **ADEMPAS**
- **ALYQ**
- *ambrisentan*
- *bosentan*
- **LETAIRIS**
- **OPSUMIT**
- **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG**
- **REVATIO ORAL SUSPENSION FOR RECONSTITUTION**
- **REVATIO ORAL TABLET**
- *sildenafil (pulm.hypertension) oral suspension for reconstitution*
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*
- **TRACLEER ORAL TABLET**
- **TRACLEER ORAL TABLET FOR SUSPENSION**
- **UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**
- **UPTRAVI ORAL TABLETS,DOSE PACK**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization, defined as a mean pulmonary arterial pressure (mPAP) of greater than or equal to 25 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than 3 Wood units -AND- WHO Group -AND- other causes of pulmonary hypertension have been ruled out (e.g. left heart disease, chronic lung disease, venous thromboembolism). For Adempas, additional diagnosis of CTEPH as documented by right heart catheterization and V/Q scan substantiating mPAP greater than or equal to 25 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.
Age Restrictions	
Prescriber Restrictions	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

quinine

Products Affected

- *quinine sulfate*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

ravicti

Products Affected

- RAVICTI

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

regranex

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of lower-extremity diabetic neuropathic ulcer(s) that extends into the subcutaneous tissue or beyond and have an adequate blood supply -AND- being used as an adjunct to standard ulcer care practices (e.g. sharp debridement, non-weight bearing regimen, infection control) -AND- attestation of a wound care plan.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

relistor

Products Affected

- RELISTOR ORAL

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

repatha

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Required Medical Information	1.HoFH supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL(or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 yrs or 2. HeFH in both parents AND used with max tolerated statin unless all statins are contraindicated or not tolerated AND not used with lomitapide, mipomersen, or another PCSK9 inhibitor. HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FD(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190mg/dL prior to lipid lowering therapy (greater than or equal to 160mg/dL if age less than 20) or LDL-C greater than or equal to 160mg/dL after treatment with antihyperlipidemic agents but prior to Repatha therapy AND Prior therapy with at least 2 trials of different high-intensity statins(e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. 3. Hypercholesterolemia ASCVD OR Primary Hyperlipidemia AND Prior therapy with at least 2 trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal (LDL-C is still greater than or equal to 70 mg/dL) AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin 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
Age Restrictions	Deny if less than 18 years of age for HeFH, ASCVD and Primary Hyperlipidemia, or less than 13 years of age for HoFH .
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. For HoFH diagnosis, 3 syringes per month will be approved aligned with recommended dosing regimen for this indication.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

repatha pushtronex

Products Affected

- **REPATHA PUSHTRONEX**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Required Medical Information	1. HoFH supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL (or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 yrs or 2. HeFH in both parents AND used with max tolerated statin unless all statins are contraindicated or not tolerated AND not used with lomitapide, mipomersen, or another PCSK9 inhibitor. HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FH (e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190mg/dL prior to lipid lowering therapy (greater than or equal to 160mg/dL if age less than 20) or LDL-C greater than or equal to 160mg/dL after treatment with antihyperlipidemic agents but prior to Repatha therapy AND Prior therapy with at least 2 trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. 3. Hypercholesterolemia ASCVD OR Primary Hyperlipidemia AND Prior therapy with at least 2 trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal (LDL-C is still greater than or equal to 70 mg/dL) AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin 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
Age Restrictions	Deny if less than 18 years of age for HeFH, ASCVD and Primary Hyperlipidemia, or less than 13 years of age for HoFH.
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. Requests for greater than 1 Pushtronex System per month will not be approved.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

revlimid

Products Affected

- REVLIMID

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

rinvoq

Products Affected

- **RINVOQ ER**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orencia, Stelara, Actemra, azathioprine, cyclosporine
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, an inadequate response or intolerance to at least one immunosuppressant (e.g., azathioprine, corticosteroid, methotrexate).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

rozlytrek

Products Affected

- **ROZLYTREK ORAL CAPSULE 100 MG, 200 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. 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	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

rubraca

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) BRCA mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

ruconest

Products Affected

- RUCONEST

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

rydapt

Products Affected

- RYDAPT

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

sabril

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of refractory complex partial seizures -AND- documentation of adjunctive therapy -AND- an adequate trial 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 10 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	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

samsca

Products Affected

- SAMSCA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Patients with documentation of hypovolemic hyponatremia -OR- patients with the need to increase serum sodium acutely
Required Medical Information	Documentation of symptomatic hypervolemic or euvolemic hyponatremia evidenced by 1.) Serum Na less than 125 mEq/L -OR- 2.) Serum NA less than 135mEq/Ls with symptoms (e.g. nausea, malaise, lethargy, headache, seizures), and resistance to fluid restriction correction.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	Doses must be initiated in the hospital setting to closely monitor serum sodium

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

savella

Products Affected

- SAVELLA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation to support a diagnosis of fibromyalgia and trial/failure or intolerance to duloxetine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

signifor

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of Cushing's disease AND patient is not a candidate for pituitary surgery or surgery has not been curative
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

siliq

Products Affected

- SILIQ

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

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
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Actemra, Kineret, Remicade, Humira, Orencia, Enbrel, Cimzia
Required Medical Information	Documentation of diagnosis. 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 a nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe ulcerative colitis, inadequate response or intolerance to two immunosuppressants (e.g. azathioprine) -OR- use in those patients requiring continuous steroid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Other Criteria	For ulcerative colitis a trial and failure of preferred product Humira. For Rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Cosentyx and Stelara. For ankylosing spondylitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel and Cosentyx. For ulcerative colitis, patients must have an adequate trial or intolerance to 1 preferred product Humira. For ulcerative colitis indication therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

skyrizi

Products Affected

- SKYRIZI SUBCUTANEOUS SYRINGE KIT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

solaraze

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure, intolerance, or contraindication to topical fluorouracil
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

sovaldi

Products Affected

- SOVALDI ORAL TABLET 400 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than or less than 400 mg/day will not be approved.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

sprycel

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and failure of Gleevec therapy (failure of Gleevec is not necessary for the indication of newly diagnosed adults with chronic phase Ph+ CML or pediatric patients with Ph+ CML in chronic phase) - OR- Documentation of pediatric patient with newly diagnosed Ph+ acute lymphocytic leukemia in combination with chemotherapy -OR- Documentation of adult with Ph+ acute lymphocytic leukemia with resistance or intolerance to prior therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

stelara

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Simponi
Required Medical Information	Documentation of 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, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For Crohn's Disease, inadequate response or intolerance to an immunosuppressant (e.g. corticosteroids, azathioprine) -OR- intolerance or contraindication to a TNF inhibitor (e.g. Humira) due to demyelinating disease or heart failure - AND- attestation of clinical remission following IV administration of Stelara within 2 months of initiating therapy with Stelara SC.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Must follow recommended dosing guidelines based upon weight. Psoriasis: For patients weighing less than 100 kilograms (220 pounds), 45 mg dosing will be approved. For patients weighing more than 100 kilograms (220 pounds), 90 mg dosing will be approved. Psoriatic Arthritis: 45 mg dosing will be approved. For patients with co-existent moderate to severe plaque psoriasis weighing greater than 100 kilograms (220 pounds), 90 mg dosing will be approved.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

stivarga

Products Affected

- STIVARGA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

sunosi

Products Affected

- SUNOSI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
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. Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography as established in accordance with ICSD or DSM V criteria acceptable for all indications
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.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

sutent

Products Affected

- SUTENT

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

symdeko

Products Affected

- **SYMDEKO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis (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.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

sympazan

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- adequate trial 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	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

symproic

Products Affected

- SYMPROIC

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tagrisso

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) EGFR mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

takhzyro

Products Affected

- TAKHZYRO

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

taltz

Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Simponi, Stelara
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For ankylosing spondylitis, inadequate response or intolerance to a nonsteroidal anti-inflammatory drug (NSAID)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Cosentyx and Stelara. For plaque psoriasis patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Cosentyx, Otezla and Stelara. For ankylosing spondylitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel and Cosentyx. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

talzenna

Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of deleterious or suspected deleterious gBRCAm, HER2-negative metastatic breast cancer -AND- Previous treatment with chemotherapy in the neoadjuvant, adjuvant and/or metastatic setting.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For reauthorization, attestation of disease improvement or delayed disease progression.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

targretin

Products Affected

- *bexarotene*
- TARGRETIN TOPICAL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous manifestations of T-cell lymphoma -AND- trial and failure, intolerance, or contraindication to two systemic therapies (e.g. interferon-alpha, PUVA, single agent chemotherapy, combination chemotherapy)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tasigna

Products Affected

- **TASIGNA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tavalisse

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For diagnosis of ITP, the following criteria apply (1 and 2): 1) trial, intolerance, or inadequate response to a corticosteroid, immunoglobulin, or splenectomy. 2) One of the following (A or B): A) Platelet count less than or equal to $50 \times 10^9/L$ and has significant mucous membrane bleeding or at least one risk factor for bleeding (e.g. hypertension, peptic ulcer disease). B) Platelet count of less than or equal to $30 \times 10^9/L$.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tazorac

Products Affected

- *tazarotene*
- **TAZORAC TOPICAL CREAM 0.05 %**
- **TAZORAC TOPICAL GEL**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tecfidera

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use with other disease modifying agents such as interferons, Copaxone , Tysabri, Aubagio, Gilenya
Required Medical Information	Documentation of relapsing form of multiple sclerosis (relapsing-remitting, relapsing secondary progressive, or progressive relapsing multiple sclerosis)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Doses greater than 240 mg twice-daily will not be approved

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tegsedi

Products Affected

- TEGSEDI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of polyneuropathy associate with hereditary TTR amyloidosis (hATTR) 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- Is not being used for sensorimotor or autonomic neuropathy that is unrelated to hATTR amyloidosis -AND- Attestation of electrophysiologic test results indicative of polyneuropathy or biopsy results indicative of polyneuropathy of hereditary TTR amyloidosis -AND- Baseline functional ambulation performance stage of 1 or 2 -AND- Attestation of peripheral neuropathy impairment score (NIS) of 10 or greater or Polyneuropathy disability score of IIIb or lower -AND- Not simultaneously utilizing other gene targeted therapy for polyneuropathy of hATTR
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive clinical response

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

testosterone (androgens)

Products Affected

- **ANDRODERM**
- *testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of primary or secondary hypogonadism in males with testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, radiation or toxic damage -OR- documentation of primary or secondary hypogonadism in males with multiple symptoms of hypogonadism including at least one of the following specific symptoms: height loss due to vertebral fractures, low trauma fractures, low bone density, incomplete or delayed sexual development, breast discomfort, loss of axillar and/or pubic body hair, hot flushes -OR- documentation of HIV infection in men with weight loss -OR- documentation of chronic steroid treatment in men. In all previously noted indications, members must also have documented low testosterone level below the normal range for the laboratory -OR- a total testosterone level near the lower limit of the normal range with a low free testosterone level which is less than normal based upon the laboratory reference range. Additional approvable indications include vulvar dystrophies in women (topical ointment only) - AND- palliative treatment in female patients with metastatic breast cancer (testosterone enanthate only), primary or secondary hypogonadism in males with testicular failure due to double orchidectomy
Age Restrictions	Deny if less than recommended age per FDA product labeling
Prescriber Restrictions	
Coverage Duration	12 months

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

PA Criteria	Criteria Details
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

thalomid

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

thrombopoiesis stimulating agents

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tibsovo

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA approved test -OR- Documentation of newly-diagnosed acute myeloid leukemia with an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA approved test -AND- presence of one comorbidity that precludes use of intensive induction chemotherapy (i.e. age greater than or equal to 75 years, severe cardiac or pulmonary comorbidity, reduced renal function, and hepatic impairment, attestation not a candidate for intensive induction therapy).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For reauthorization, attestation of disease improvement or delayed disease progression.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tiglutik

Products Affected

- TIGLUTIK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of amyotrophic lateral sclerosis (ALS) -AND- Inability to swallow tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of stability or improvement in symptoms of ALS.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tolsura

Products Affected

- TOLSURA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Unable to tolerate generic itraconazole capsules -AND- Prescriber provides rationale for clinical need of SUBA technology
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation the member is still unable to tolerate generic itraconazole capsules

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

topical lidocaine

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

transmucosal fentanyl citrate

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of therapeutic use and the member is currently receiving and tolerant to long acting opioid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tretinoin

Products Affected

- *adapalene topical cream*
- *adapalene topical gel*
- *adapalene topical solution*
- *adapalene topical swab*
- **AVITA**
- *tretinoin*
- *tretinoin microspheres topical gel*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Cosmetic use
Required Medical Information	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two topical acne medications (e.g. clindamycin, sulfacetamide, erythromycin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

turalio

Products Affected

- TURALIO

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tykerb

Products Affected

- **TYKERB**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

tymlos

Products Affected

- TYMLOS

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

uloric

Products Affected

- *febuxostat*
- ULORIC

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

VALCHLOR

Products Affected

- VALCHLOR

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

veltassa

Products Affected

- VELTASSA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of hyperkalemia as defined by serum potassium level between 5.1 and 6.4 mmol/L on at least two (2) screenings -AND- one of the following: 1) Modification of medications to reduce serum potassium levels were not successful, when applicable. 2) Diagnosis of chronic kidney disease and medications known to cause hyperkalemia (e.g. ACE inhibitors, ARBs) have been discontinued or reduced to the lowest effective dose.
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, documentation of diagnosis of a chronic condition that is contributing to persistent hyperkalemia and attestation of reduction in serum potassium levels following Veltassa administration is required.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

venclexta

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of chronic lymphocytic leukemia (CLL) -OR- Documentation of small lymphocytic lymphoma -OR- Documentation of newly-diagnosed acute myeloid leukemia -AND- used in combination with either azacitidine, decitabine or cytarabine -AND- presence of one comorbidity that precludes use of intensive induction chemotherapy (i.e. age greater than or equal to 75 years, severe cardiac or pulmonary comorbidity, reduced renal function, and hepatic impairment).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

verzenio

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) Alternatives tried/failed. 2) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

viberzi

Products Affected

- VIBERZI

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

VIEKIRA PAK

Products Affected

- VIEKIRA PAK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than four tablets per day will not be approved.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

viibryd

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis major depressive disorder and trial and failure of one other antidepressant
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

vimpat

Products Affected

- VIMPAT ORAL SOLUTION
- VIMPAT ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- documentation of concomitant therapies, if applicable
Age Restrictions	Deny if less than 4 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

vitrakvi

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of 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	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

vizimpro

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer -AND- one of the following (1 or 2): 1. Epidermal growth factor (EGFR) exon 19 deletions - OR- 2. Epidermal growth factor receptor (EGFR) exon 21 L858R substitution mutations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For reauthorization, attestation of disease improvement or delayed disease progression.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

vosevi

Products Affected

- VOSEVI

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

votrient

Products Affected

- VOTRIENT

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

vraylar

Products Affected

- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE,DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial, intolerance, or contraindication to one other formulary generic atypical antipsychotic (e.g. quetiapine).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xalkori

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive -OR- that is ROS-1 positive
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xeljanz

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orencia, Stelara, Actemra, azathioprine, cyclosporine
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and an inadequate response or intolerance to methotrexate -OR- Documentation of psoriatic arthritis in combination with a nonbiologic DMARD and member has an inadequate response or intolerance to systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy -OR- For Xeljanz IR, documentation of ulcerative colitis and patients must have an inadequate response or intolerance to two immunosuppressants (e.g. azathioprine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses greater than 10 mg per day for Xeljanz and 11 mg per day for Xeljanz XR will not be approved for rheumatoid arthritis and psoriatic arthritis. Doses greater than 20mg per day for Xeljanz will not be approved for ulcerative colitis.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patients with comorbid depression should have controlled depression and are on an antidepressant medication. Doses above 50mg/day may be approved up to 100mg/day (FDA max) when documentation of adequate trial of 50mg/day had inadequate response and CYP2D6 genotype response demonstrating poor CYP metabolism.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xermelo

Products Affected

- XERMELO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of carcinoid syndrome diarrhea AND used in combination with a somatostatin analog AND trial and failure of somatostatin analog monotherapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of 1 or 2. 1) Diagnosis of hepatic encephalopathy AND trial/failure, intolerance, or contraindication to lactulose. 2) Diagnosis of Irritable Bowel Syndrome with Diarrhea (IBS-D) AND trial/failure, intolerance to two of the following medications for IBS-D or documentation of contraindication to all: loperamide, cholestyramine, Colestipol, dicyclomine, tricyclic antidepressants, selective serotonin reuptake inhibitors.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Hepatic encephalopathy: 1 year. IBS-D: 14 days.
Other Criteria	No more than three courses of rifaximin for the treatment of IBS-D will be approved per lifetime.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xolair

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of chronic idiopathic urticaria with trial/failure or intolerance of a second-generation non-sedating H1 antihistamine at the maximum recommended doses (e.g., cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine) -OR- Documentation of moderate to severe persistent asthma in patients with a positive skin test or in vitro reactivity to a perennial aeroallergen -AND- Baseline IgE titre greater than or equal to 30 IU/mL -AND- symptoms that are inadequately controlled despite a 3 month trial of both 1. and 2. 1) medium-dose inhaled corticosteroid or systemic steroid 2) a long-acting beta-agonist or leukotriene antagonist - AND- patient is currently on the optimal dose of a long-acting beta2-agonist, leukotriene modifier, or theophylline
Age Restrictions	Deny if less than 12 years of age in treatment for chronic idiopathic urticaria -OR- deny if less than 6 years of age for severe persistent asthma
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of improved asthma control while on Xolair in treatment of asthma -OR- improved symptoms in treatment of CIU must be provided for consideration of reauthorization

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xospata

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of relapse or refractory acute myeloid leukemia -AND- FLT3 mutation-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	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xpovio

Products Affected

- **XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 160 MG/WEEK (20 MG X 8), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4)**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use in combination with dexamethasone for relapse or refractory multiple myeloma with failure, intolerance or contraindication to 5 therapies (e.g. bortezomib, carfilzomib, lenalidomide, pomalidomide and daratumumab).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xtandi

Products Affected

- XTANDI

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xuriden

Products Affected

- XURIDEN

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

xyrem

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1, 2, and 3). 1)Diagnosis of narcolepsy documented by MSLT less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) or other appropriate testing - AND- 2)Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- One of the following (4 or 5). 4) Diagnosis of cataplexy documented by baseline number of cataplexy episodes -OR- 5)No diagnosis of cataplexy and trial and failure, intolerance, or contraindication to generic modafinil AND a generic CNS stimulant indicated for use in narcolepsy (e.g. methylphenidate, amphetamine salts).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation supporting improvement in symptoms of narcolepsy and cataplexy (if applicable) is required.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

yonsa

Products Affected

- YONSA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

yosprala

Products Affected

- YOSPRALA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

zavesca

Products Affected

- *miglustat*
- ZAVESCA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of mild to moderate type 1 Gaucher disease 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 one of the following (6 or 7): 6)Anemia with hemoglobin less than or equal to 11.5 g/dL for females or 12.5 g/dL for males -OR- 7)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). - AND- trial/failure or intolerance to at least one enzyme replacement therapy product including Cerezyme, Elelyso, or VPRIV
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation supporting improvement in reduction in liver volume, reduction in spleen volume, increase in hemoglobin levels, or increase in platelet counts is required.

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

zejula

Products Affected

- ZEJULA

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

zelboraf

Products Affected

- TAFINLAR
- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	Documentation of diagnosis -AND- both of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed and concomitant therapy, if applicable to diagnosis (e.g. diagnosis of V600K metastatic melanoma and drug regimen of Zelboraf + Cotellic)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

zepatier

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member is unable to utilize regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, paritaprevir/ombitasvir/ritonavir/dasabuvir and paritaprevir/ombitasvir/ritonavir.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than 1 tablet/day will not be approved

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

zolinza

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following 2 systemic therapies. Systemic therapies include bexarotene, interferon alpha, extracorporeal photochemotherapy, PUVA, single agent or combination chemotherapies (e.g. cyclophosphamide, vinblastine, romidepsin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

ZYDELIG

Products Affected

- ZYDELIG

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

zykadia

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) ALK mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

zytiga

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Index of Drugs

<i>abiraterone</i>	250	AURYXIA	18
ABSTRAL SUBLINGUAL TABLET		AVITA	212
100 MCG, 200 MCG, 300 MCG, 400		BALVERSA	19
MCG, 600 MCG, 800 MCG	211	BANZEL	20
<i>acetaminophen-codeine oral solution 120-</i>		BENLYSTA SUBCUTANEOUS	21
<i>12 mg/5 ml</i>	152	<i>benztropine oral</i>	76
<i>acetaminophen-codeine oral tablet</i>	152	BERINERT INTRAVENOUS KIT	22
<i>acitretin</i>	1	BETHKIS	34
ACTEMRA ACTPEN	2	<i>bexarotene</i>	197
ACTEMRA SUBCUTANEOUS	2	BONJESTA	23
ACTHAR	3	<i>bosentan</i>	159
ACTIMMUNE	4	BOSULIF	24
<i>adapalene topical cream</i>	212	BRAFTOVI ORAL CAPSULE 75 MG ...	25
<i>adapalene topical gel</i>	212	<i>buprenorphine</i>	26
<i>adapalene topical solution</i>	212	BUTRANS	26
<i>adapalene topical swab</i>	212	CABLIVI INJECTION KIT	28
ADCIRCA	159	CABOMETYX	29
ADEMPAS	159	CALQUENCE	30
AFINITOR	6	CAPRELSA	31
AFINITOR DISPERZ ORAL TABLET		CARBAGLU	32
FOR SUSPENSION 2 MG, 3 MG, 5 MG ...	6	CERDELGA	33
AIMOVIG AUTOINJECTOR		CHOLBAM	35
SUBCUTANEOUS AUTO-INJECTOR		CIALIS ORAL TABLET 2.5 MG, 5 MG ...	36
140 MG/ML, 70 MG/ML	7	CIMZIA	37
ALECENSA	8	CIMZIA POWDER FOR RECONST	37
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1</i>		CINRYZE	39
<i>mg, 2 mg</i>	152	<i>clobazam</i>	139
ALUNBRIG ORAL TABLET 180 MG,		<i>clomipramine</i>	76
30 MG, 90 MG	10	COMETRIQ	40
ALUNBRIG ORAL TABLETS,DOSE		COPIKTRA	41
PACK	10	CORLANOR ORAL SOLUTION	42
ALYQ	159	CORLANOR ORAL TABLET 5 MG,	
<i>ambrisentan</i>	159	7.5 MG	42
<i>amitriptyline</i>	76	COSENTYX (2 SYRINGES)	43
AMPYRA	11	COSENTYX PEN (2 PENS)	43
ANADROL-50	12	COTELLIC	44
ANDRODERM	203	CRINONE	45
APOKYN	13	<i>cyclobenzaprine oral tablet</i>	76
ARALAST NP INTRAVENOUS		<i>cyproheptadine</i>	76
RECON SOLN 1,000 MG	9	<i>dalfampridine</i>	11
ARCALYST	93	DAURISMO ORAL TABLET 100 MG,	
ARIKAYCE	14	25 MG	46
<i>aripiprazole</i>	16	<i>diclofenac epolamine</i>	65
<i>armodafinil</i>	158	<i>diclofenac sodium topical gel 3 %</i>	183
AUBAGIO	17	DIGITEK	76

DIGOX	76	<i>fentanyl citrate buccal tablet, effervescent</i>	
<i>digoxin oral solution 50 mcg/ml (0.05</i>		<i>100 mcg, 200 mcg, 400 mcg, 600 mcg, 800</i>	
<i>mg/ml)</i>	76	<i>mcg</i>	211
<i>digoxin oral tablet</i>	76	<i>fentanyl transdermal patch 72 hour 100</i>	
DOPTELET (10 TAB PACK)	47	<i>mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr,</i>	
DOPTELET (15 TAB PACK)	47	<i>75 mcg/hr</i>	152
DOPTELET (30 TAB PACK)	47	FENTORA BUCCAL TABLET,	
<i>doxepin oral</i>	76	EFFERVESCENT 100 MCG, 200 MCG,	
<i>doxylamine-pyridoxine (vit b6)</i>	23	400 MCG, 600 MCG, 800 MCG	211
DUOBRII	48	FETZIMA ORAL CAPSULE,EXT REL	
DUPIXENT SUBCUTANEOUS		24HR DOSE PACK	154
SYRINGE 200 MG/1.14 ML, 300 MG/2		FETZIMA ORAL	
ML	49	CAPSULE,EXTENDED RELEASE 24	
DURAMORPH (PF) INJECTION		HR 120 MG, 20 MG, 40 MG, 80 MG	154
SOLUTION 0.5 MG/ML, 1 MG/ML	152	FIRAZYR	63
EGRIFTA SUBCUTANEOUS RECON		FIRDAPSE	64
SOLN 1 MG	52	FLEBOGAMMA DIF INTRAVENOUS	
EMFLAZA	53	SOLUTION 10 %	84
ENBREL MINI	54	FLECTOR	65
ENBREL SUBCUTANEOUS RECON		FORTEO	66
SOLN	54	<i>gabapentin oral capsule</i>	67
ENBREL SUBCUTANEOUS SYRINGE		<i>gabapentin oral solution 250 mg/5 ml</i>	67
25 MG/0.5 ML (0.5), 50 MG/ML (1 ML) ..	54	<i>gabapentin oral tablet 600 mg, 800 mg</i>	67
ENBREL SURECLICK	54	GALAFOLD	68
ENDARI	55	GAMMAGARD LIQUID	84
ENDOCET ORAL TABLET 10-325		GAMMAGARD S-D (IGA < 1	
MG, 5-325 MG, 7.5-325 MG	152	MCG/ML)	84
EPCLUSA	56	GAMMAKED INJECTION	
EPIDIOLEX	57	SOLUTION 1 GRAM/10 ML (10 %)	84
ERIVEDGE	58	GAMMAPLEX	84
ERLEADA	59	GAMMAPLEX (WITH SORBITOL)	84
<i>erlotinib</i>	51	GAMUNEX-C INJECTION	
ESBRIET ORAL CAPSULE	95	SOLUTION 1 GRAM/10 ML (10 %)	84
ESBRIET ORAL TABLET 267 MG,		GATTEX 30-VIAL	69
801 MG	95	GENOTROPIN	72
EVENITY SUBCUTANEOUS		GENOTROPIN MINQUICK	72
SYRINGE 210MG/2.34ML (		GILENYA ORAL CAPSULE 0.5 MG	70
105MG/1.17MLX2)	60	GILOTRIF	51
FARYDAK	61	<i>glyburide</i>	76
FASENRA	62	<i>glyburide micronized</i>	76
<i>febuxostat</i>	216	<i>glyburide-metformin</i>	76
<i>fentanyl citrate buccal lozenge on a handle</i>		<i>guanfacine oral tablet extended release 24</i>	
<i>1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg,</i>		<i>hr</i>	5
<i>600 mcg, 800 mcg</i>	211	HAEGARDA	73
		HARVONI ORAL TABLET 90-400 MG ..	74
		HETLIOZ	75

HUMATROPE	72	INBRIJA INHALATION CAPSULE,	
HUMIRA	79	W/INHALATION DEVICE	87
HUMIRA PEDIATRIC CROHNS		INCRELEX	88
START SUBCUTANEOUS SYRINGE		INGREZZA INITIATION PACK	89
KIT 40 MG/0.8 ML, 40 MG/0.8 ML (6		INGREZZA ORAL CAPSULE 40 MG,	
PACK)	79	80 MG	89
HUMIRA PEN	79	INLYTA	90
HUMIRA PEN CROHNS-UC-HS		INREBIC	91
START	79	INTRAROSA	94
HUMIRA PEN PSOR-UVEITS-ADOL		INTRON A INJECTION	92
HS	79	IRESSA	96
HUMIRA(CF)	79	<i>itraconazole</i>	97
HUMIRA(CF) PEDI CROHNS		JAKAFI	98
STARTER SUBCUTANEOUS		JUXTAPID	78
SYRINGE KIT 80 MG/0.8 ML, 80		JYNARQUE	99
MG/0.8 ML-40 MG/0.4 ML	79	KALYDECO ORAL GRANULES IN	
HUMIRA(CF) PEN CROHNS-UC-HS	79	PACKET 25 MG, 50 MG, 75 MG	100
HUMIRA(CF) PEN PSOR-UV-ADOL		KALYDECO ORAL TABLET	100
HS	79	KEVZARA SUBCUTANEOUS	
HUMIRA(CF) PEN SUBCUTANEOUS		SYRINGE	101
PEN INJECTOR KIT 40 MG/0.4 ML	79	KINERET	102
<i>hydrocodone-acetaminophen oral solution</i>		KISQALI FEMARA CO-PACK ORAL	
<i>7.5-325 mg/15 ml</i>	152	TABLET 200 MG/DAY(200 MG X 1)-	
<i>hydrocodone-acetaminophen oral tablet</i>		2.5 MG, 400 MG/DAY(200 MG X 2)-2.5	
<i>10-325 mg, 5-325 mg, 7.5-325 mg</i>	152	MG, 600 MG/DAY(200 MG X 3)-2.5	
<i>hydrocodone-ibuprofen oral tablet 10-200</i>		MG	103
<i>mg, 5-200 mg, 7.5-200 mg</i>	152	KISQALI ORAL TABLET 200	
<i>hydromorphone (pf) injection solution 10</i>		MG/DAY (200 MG X 1), 400 MG/DAY	
<i>(mg/ml) (5 ml), 10 mg/ml</i>	152	(200 MG X 2), 600 MG/DAY (200 MG X	
<i>hydromorphone injection syringe 2 mg/ml</i>	152	3)	103
<i>hydromorphone oral liquid</i>	152	KORLYM	104
<i>hydromorphone oral tablet</i>	152	KUVAN ORAL TABLET,SOLUBLE	105
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	76	LATUDA ORAL TABLET 120 MG, 20	
<i>hydroxyzine hcl oral tablet</i>	76	MG, 40 MG, 60 MG, 80 MG	106
IBRANCE	81	LAZANDA NASAL SPRAY, NON-	
<i>icatibant</i>	63	AEROSOL 100 MCG/SPRAY, 300	
ICLUSIG ORAL TABLET 15 MG, 45		MCG/SPRAY, 400 MCG/SPRAY	211
MG	82	<i>ledipasvir-sofosbuvir</i>	74
IDHIFA ORAL TABLET 100 MG, 50		LENVIMA	107
MG	83	LETAIRIS	159
<i>imatinib oral tablet 100 mg, 400 mg</i>	71	LEUKINE INJECTION RECON SOLN	
IMBRUVICA ORAL CAPSULE 140			108
MG, 70 MG	86	<i>lidocaine hcl mucous membrane jelly</i>	210
IMBRUVICA ORAL TABLET	86	<i>lidocaine hcl mucous membrane solution 4</i>	
<i>imipramine hcl</i>	76	<i>% (40 mg/ml)</i>	210

<i>lidocaine topical adhesive patch,medicated</i>	110	<i>morphine oral tablet</i>	152
<i>lidocaine topical ointment</i>	210	<i>morphine oral tablet extended release 100</i>	
<i>lidocaine-prilocaine topical cream</i>	210	<i>mg, 15 mg, 200 mg, 30 mg, 60 mg</i>	152
LOKELMA	111	MULPLETA	122
LONSURF	112	MYALEPT	123
LORBRENA ORAL TABLET 100 MG,		NAMENDA XR ORAL	
25 MG	113	CAP,SPRINKLE,ER 24HR DOSE	
LORCET (HYDROCODONE)	152	PACK	124
LORCET HD	152	NAMZARIC	125
LORCET PLUS ORAL TABLET 7.5-		NATPARA	126
325 MG	152	NERLYNX	127
LYNPARZA ORAL TABLET	114	NEXAVAR	128
LYRICA CR	115	NINLARO	129
LYRICA ORAL CAPSULE 100 MG,		<i>nitrofurantoin</i>	76
150 MG, 200 MG, 225 MG, 25 MG, 300		<i>nitrofurantoin macrocrystal oral capsule</i>	
MG, 50 MG, 75 MG	115	<i>100 mg, 25 mg, 50 mg</i>	76
LYRICA ORAL SOLUTION	115	<i>nitrofurantoin monohyd/m-cryst</i>	76
MAVENCLAD (10 TABLET PACK)	116	NORDITROPIN FLEXPOR	72
MAVENCLAD (4 TABLET PACK)	116	NORTHERA	130
MAVENCLAD (5 TABLET PACK)	116	NOURIANZ	131
MAVENCLAD (6 TABLET PACK)	116	NUBEQA	132
MAVENCLAD (7 TABLET PACK)	116	NUCALA	133
MAVENCLAD (8 TABLET PACK)	116	NUEDEXTA	134
MAVENCLAD (9 TABLET PACK)	116	NUPLAZID ORAL CAPSULE	135
MAVYRET	117	NUPLAZID ORAL TABLET 10 MG	135
MAYZENT ORAL TABLET 0.25 MG,		NUTROPIN AQ NUSPIN	72
2 MG	118	OALIVA	136
<i>megestrol oral suspension 400 mg/10 ml</i>		OCTAGAM	84
<i>(40 mg/ml), 625 mg/5 ml</i>	119	ODOMZO	137
<i>megestrol oral tablet</i>	119	OFEV	95
MEKINIST	120	OLUMIANT ORAL TABLET 2 MG	138
MEKTOVI	121	OMNITROPE	72
<i>methadone oral solution 10 mg/5 ml, 5</i>		ONFI ORAL SUSPENSION	139
<i>mg/5 ml</i>	152	ONFI ORAL TABLET 10 MG, 20 MG ..	139
<i>methadone oral tablet 10 mg, 5 mg</i>	152	OPSUMIT	159
<i>miglustat</i>	243	ORALAIR SUBLINGUAL TABLET	
<i>modafinil</i>	158	300 INDX REACTIVITY	140
<i>morphine concentrate oral solution</i>	152	ORENCIA CLICKJECT	141
<i>morphine oral capsule, er multiphase 24 hr</i>		ORENCIA SUBCUTANEOUS	
<i>120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90</i>		SYRINGE 125 MG/ML, 50 MG/0.4 ML,	
<i>mg</i>	152	87.5 MG/0.7 ML	141
<i>morphine oral capsule,extend.release</i>		ORENITRAM ORAL TABLET	
<i>pellets</i>	152	EXTENDED RELEASE 0.125 MG, 0.25	
<i>morphine oral solution 10 mg/5 ml, 20</i>		MG, 1 MG, 2.5 MG, 5 MG	159
<i>mg/5 ml (4 mg/ml)</i>	152	ORILISSA ORAL TABLET 150 MG,	
		200 MG	142

ORKAMBI ORAL GRANULES IN PACKET	144	REGRANEX	163
ORKAMBI ORAL TABLET	143	RELISTOR ORAL	164
OTEZLA	145	REPATHA PUSHTRONEX	167
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	145	REPATHA SURECLICK	165
<i>oxandrolone</i>	12	REPATHA SYRINGE	165
OXERVATE	146	REVATIO ORAL SUSPENSION FOR RECONSTITUTION	159
<i>oxycodone oral capsule</i>	152	REVATIO ORAL TABLET	159
<i>oxycodone oral concentrate</i>	152	REVLIMID	169
<i>oxycodone oral solution</i>	152	REXULTI	16
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	152	RINVOQ ER	170
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	152	ROZLYTREK ORAL CAPSULE 100 MG, 200 MG	171
PALYNZIQ	147	RUBRACA	172
PANZYGA	84	RUCONEST	173
PEGASYS	92	RUZURGI	64
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML	92	RYDAPT	174
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)	148	SABRIL	175
POMALYST	149	SAIZEN	72
PRALUENT PEN	150	SAIZEN SAIZENPREP	72
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	115	SAMSCA	176
<i>pregabalin oral solution</i>	115	SAVELLA	177
PRIVIGEN	84	SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	72
PROLASTIN-C INTRAVENOUS	9	SIGNIFOR	178
RECON SOLN	9	<i>sildenafil (pulm.hypertension) oral suspension for reconstitution</i>	159
PROLIA	155	<i>sildenafil (pulm.hypertension) oral tablet..</i>	159
PROMACTA ORAL POWDER IN PACKET	206	SILENOR	76
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG	206	SILIQ	179
<i>promethazine oral syrup</i>	76	SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML	180
<i>promethazine-phenylephrine</i>	157	SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML	180
PULMOZYME	34	SKYRIZI SUBCUTANEOUS SYRINGE KIT	182
<i>quinine sulfate</i>	161	<i>sofosbuvir-velpatasvir</i>	56
RAVICTI	162	SOVALDI ORAL TABLET 400 MG	184
		SPRYCEL	185
		STELARA SUBCUTANEOUS SOLUTION	186
		STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML ..	186
		STIVARGA	187

SUBSYS SUBLINGUAL SPRAY, NON- AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY	211	<i>tobramycin in 0.225 % nacl</i>	34
SUNOSI	188	TOLSURA	209
SUTENT	189	TRACLEER ORAL TABLET	159
SYLATRON	92	TRACLEER ORAL TABLET FOR SUSPENSION	159
SYMDEKO	190	<i>tramadol oral capsule, er biphasic 24 hr 25- 75 100 mg, 200 mg</i>	152
SYMPAZAN	191	<i>tramadol oral tablet</i>	152
SYMPROIC	192	<i>tramadol-acetaminophen</i>	152
<i>tadalafil (pulm. hypertension)</i>	159	<i>tretinoin</i>	212
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	36	<i>tretinoin microspheres topical gel</i>	212
TAFINLAR	245	<i>trimipramine</i>	76
TAGRISSE	193	TRINTELLIX	223
TAKHZYRO	194	TURALIO	213
TALTZ AUTOINJECTOR	195	TYKERB	214
TALTZ SYRINGE	195	TYMLOS	215
TALZENNA ORAL CAPSULE 0.25 MG, 1 MG	196	ULORIC	216
TARCEVA	51	UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	159
TARGRETIN TOPICAL	197	UPTRAVI ORAL TABLETS, DOSE PACK	159
TASIGNA	198	VALCHLOR	217
TAVALISSE	199	VELTASSA	218
<i>tazarotene</i>	200	VENCLEXTA	219
TAZORAC TOPICAL CREAM 0.05 %	200	VENCLEXTA STARTING PACK	219
TAZORAC TOPICAL GEL	200	VERZENIO	220
TECFIDERA ORAL CAPSULE, DELAYED RELEASE (DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG	201	VIBERZI	221
TEGSEDI	202	VIEKIRA PAK	222
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	203	<i>vigabatrin</i>	175
<i>testosterone enanthate</i>	203	VIGADRONE	175
<i>testosterone transdermal gel in metered- dose pump 20.25 mg/1.25 gram (1.62 %)</i>	203	VIIBRYD ORAL TABLET	223
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)</i>	203	VIIBRYD ORAL TABLETS, DOSE PACK 10 MG (7)- 20 MG (23)	223
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	232	VIMPAT ORAL SOLUTION	224
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	205	VIMPAT ORAL TABLET	224
TIBSOVO	207	VITRAKVI ORAL CAPSULE 100 MG, 25 MG	225
TIGLUTIK	208	VITRAKVI ORAL SOLUTION	225
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	34	VIZIMPRO	226
		VOSEVI	227
		VOTRIENT	228
		VRAYLAR ORAL CAPSULE	229
		VRAYLAR ORAL CAPSULE, DOSE PACK	229

VYNDAQEL	15
XALKORI	230
XELJANZ	231
XELJANZ XR	231
XERMELO	233
XIFAXAN ORAL TABLET 550 MG	234
XOLAIR	235
XOSPATA	236
XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 160 MG/WEEK (20 MG X 8), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4)	237
XTANDI	238
XURIDEN	239
XYREM	240
YONSA	241
YOSPRALA	242
ZAVESCA	243
ZEJULA	244
ZELBORAF	245
ZEMAIRA	9
ZEPATIER	246
<i>zileuton</i>	109
ZOLINZA	247
ZOMACTON	72
ZORBTIVE	72
ZYDELIG	248
ZYKADIA	249
ZYTIGA ORAL TABLET 250 MG, 500 MG	250

bunavail

Products Affected

- **BUNAVAIL 2.1 MG-0.3 MG BUCCAL FILM**
- **BUNAVAIL 4.2 MG-0.7 MG BUCCAL FILM**
- **BUNAVAIL 6.3 MG-1 MG BUCCAL FILM**

Details

Criteria	Require a 1 month trial of Zubsolv (Step 1 drug) in the last 90 days
-----------------	--

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

suboxone

Products Affected

- *buprenorphine 12 mg-naloxone 3 mg sublingual film*
- *buprenorphine 2 mg-naloxone 0.5 mg sublingual film*
- *buprenorphine 4 mg-naloxone 1 mg sublingual film*
- *buprenorphine 8 mg-naloxone 2 mg sublingual film*

Details

Criteria	Require a 1 month trial of Zubsolv (Step 1 drug) in the last 90 days
----------	--

You can find information on what the symbols and abbreviations on this table mean by going to page 3 of this booklet.

Index of Drugs

BUNAVAIL 2.1 MG-0.3 MG BUCCAL FILM.....	1
BUNAVAIL 4.2 MG-0.7 MG BUCCAL FILM.....	1
BUNAVAIL 6.3 MG-1 MG BUCCAL FILM.....	1
<i>buprenorphine 12 mg-naloxone 3 mg sublingual film.....</i>	<i>2</i>
<i>buprenorphine 2 mg-naloxone 0.5 mg sublingual film.....</i>	<i>2</i>
<i>buprenorphine 4 mg-naloxone 1 mg sublingual film.....</i>	<i>2</i>
<i>buprenorphine 8 mg-naloxone 2 mg sublingual film.....</i>	<i>2</i>

Do changes to your drug coverage affect you right away?

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

A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug)

We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions. We may not tell you in advance before we make that change—even if you are currently taking the brand name drug.

You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

This formulary was updated on 12/2019. For more recent information or other questions, please contact Freedom Blue PPO (PA) Customer Service at 1-800-550-8722, Freedom Blue PPO (WV) Customer Service at 1-888-459-4020 Security Blue HMO-POS Customer Service at 1-800-935-2583, Community Blue Medicare HMO Customer Service at 1-888-234-5397, Community Blue Medicare PPO Customer Service at 1-888-757-2946, or Community Blue Medicare Plus PPO Customer Service at 1-888-757-2946 or, for TTY users, 711 National Relay Service, Monday through Sunday, 8:00 a.m. to 8:00 p.m., or visit www.highmarkblueshield.com/medicare.

The Formulary may change at any time. You will receive notice when necessary.

Highmark Choice Company, Highmark Senior Health Company, and Highmark Senior Solutions Company are Medicare Advantage plans with a Medicare contract. HM Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Highmark Choice Company, Highmark Senior Health Company, Highmark Senior Solutions Company, and HM Health Company depends on contract renewal.

Highmark Blue Shield, Highmark Choice Company, Highmark Senior Health Company, Highmark Senior Solutions Company, and HM Health Insurance Company are independent licensees of the Blue Cross and Blue Shield Association.