

Medicare Part D: 5 Tier Closed Choice Formulary

Please click here.

For Medicare Part D: Prior Authorization Criteria

Please click here.

For Medicare Part D: Step Therapy Criteria

Please click here.

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List of Abbreviations

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

T2: Cost-Sharing Tier 2 includes generic drugs.

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

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

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

Brand Ref: Brand Reference Drug

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 for 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

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	
ALBENZA	T4	
ALINIA	T4	
<i>amantadine hcl oral capsule</i>	T2	QL (124 EA per 31 days)
<i>amantadine hcl oral solution</i>	T2	QL (1240 ML per 31 days)
<i>amantadine hcl oral tablet</i>	T2	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>	T2	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	
<i>atazanavir</i>	T3	
<i>atovaquone</i>	T5	
<i>atovaquone-proguanil</i>	T3	
ATRIPLA	T5	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	T4	
AVYCAZ	T5	
AZACTAM INJECTION RECON SOLN 2 GRAM	T4	
<i>azithromycin</i>	T2	
<i>aztreonam injection recon soln 1 gram</i>	T3	

Drug Name	Drug Tier	Requirements/Limits
BACIIM	T2	
<i>bacitracin intramuscular</i>	T2	
BARACLUDE ORAL SOLUTION	T4	
BETHKIS	T4	PA
BICILLIN C-R	T3	
BICILLIN L-A	T3	
BIKTARVY	T5	QL (31 EA per 31 days)
BILTRICIDE	T3	
CANCIDAS INTRAVENOUS RECON SOLN 50 MG	T5	
CANCIDAS INTRAVENOUS RECON SOLN 70 MG	T4	
CAPASTAT	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</i>	T4	
<i>cefixime</i>	T4	
<i>cefotaxime injection recon soln 1 gram, 2 gram, 500 mg</i>	T2	
<i>cefotetan injection</i>	T4	
<i>cefoxitin</i>	T4	
<i>cefpodoxime</i>	T2	
<i>cefprozil</i>	T3	
<i>ceftazidime injection recon soln 1 gram, 2 gram</i>	T4	
<i>ceftazidime injection recon soln 6 gram</i>	T3	
<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	

Drug Name	Drug Tier	Requirements/Limits
<i>cefuroxime sodium intravenous</i>	T3	
<i>cephalexin</i>	T2	
<i>chloramphenicol sod succinate</i>	T2	
<i>chloroquine phosphate</i>	T3	
CIMDUO	T5	QL (31 EA per 31 days)
<i>ciprofloxacin</i>	T2	
<i>ciprofloxacin (mixture)</i>	T2	
<i>ciprofloxacin hcl oral</i>	T1	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	T2	
<i>clarithromycin</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	
CRESEMBA	T5	
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	T4	
CUBICIN	T5	
DAKLINZA	T5	PA; QL (28 EA per 28 days)
DALVANCE	T5	
<i>dapsone oral</i>	T3	
<i>daptomycin intravenous recon soln 500 mg</i>	T5	
DARAPRIM	T5	
<i>demeclocycline</i>	T4	
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)
<i>doripenem intravenous recon soln 500 mg</i>	T4	
DOXY-100	T2	
<i>doxycycline hyclate oral capsule</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg</i>	T2	
<i>doxycycline hyclate oral tablet, delayed release (dr/ec)</i>	T2	
<i>doxycycline monohydrate oral capsule</i>	T2	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	T2	
<i>doxycycline monohydrate oral tablet</i>	T2	
E.E.S. 400 ORAL TABLET	T4	
EDURANT	T5	
<i>efavirenz</i>	T3	
EMTRIVA	T3	
EMVERM	T4	
<i>entecavir</i>	T4	
EPCLUSA	T5	PA; QL (28 EA per 28 days)
EPIVIR HBV ORAL SOLUTION	T4	
EPZICOM	T5	
ERAXIS(WATER DILUENT)	T4	
ERYPED 200	T4	
ERYPED 400	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>	T4	
<i>erythromycin oral capsule, delayed release(dr/ec)</i>	T2	
<i>erythromycin oral tablet</i>	T2	
<i>ethambutol</i>	T2	
EVOTAZ	T4	
<i>famciclovir</i>	T3	
<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>ganciclovir sodium intravenous recon soln</i>	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	T2	
<i>gentamicin injection solution 40 mg/ml</i>	T1	
GENVOYA	T5	
<i>griseofulvin microsize</i>	T2	
<i>griseofulvin ultramicrosize</i>	T2	
HARVONI	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 CAPSULE	T4	
INVIRASE ORAL TABLET	T5	
ISENTRESS HD	T5	
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 injection</i>	T2	
<i>isoniazid oral solution</i>	T2	
<i>isoniazid oral tablet</i>	T1	
<i>itraconazole oral capsule</i>	T4	PA
<i>ivermectin</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>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	
LINCOCIN	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>lincomycin</i>	T2	
<i>linezolid</i>	T5	
<i>linezolid in dextrose 5%</i>	T4	
<i>lopinavir-ritonavir</i>	T5	
MAVYRET	T5	PA; QL (84 EA per 28 days)
<i>mefloquine</i>	T2	
<i>meropenem</i>	T4	
<i>methenamine hippurate</i>	T4	
<i>metronidazole in nacl (iso-os)</i>	T2	
<i>metronidazole oral</i>	T2	
<i>minocycline</i>	T2	
MODERIBA	T2	
MODERIBA DOSE PACK ORAL TABLETS,DOSE PACK 400-400 MG (28)-MG (28), 600-600 MG (28)-MG (28)	T2	
MONUROL	T4	
MORGIDOX ORAL CAPSULE 50 MG	T3	
<i>moxifloxacin oral</i>	T3	
MYCAMINE	T5	
<i>nafcillin injection recon soln 1 gram, 10 gram</i>	T4	
NEBUPENT	T4	PA-BvD
<i>neomycin</i>	T2	
<i>nevirapine oral tablet</i>	T2	
<i>nevirapine oral tablet extended release 24 hr</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 CAPSULE	T3	
NORVIR ORAL POWDER IN PACKET	T3	
NORVIR ORAL SOLUTION	T3	
<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)

Drug Name	Drug Tier	Requirements/Limits
<i>oxacillin in dextrose(iso-osm)</i>	T4	
<i>oxacillin injection recon soln 1 gram, 2 gram</i>	T2	
<i>oxacillin injection recon soln 10 gram</i>	T4	
<i>paromomycin</i>	T4	
PASER	T4	
<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 g sodium</i>	T4	
<i>penicillin v potassium</i>	T1	
PENTAM	T4	
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	T4	
<i>polymyxin b sulfate</i>	T2	
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>	T2	
<i>quinine sulfate</i>	T3	PA
REBETOL ORAL SOLUTION	T4	
RELENZA DISKHALER	T3	
RESCRIPTOR	T4	
RETROVIR INTRAVENOUS	T4	
REYATAZ ORAL POWDER IN PACKET	T4	
RIBASPHERE ORAL CAPSULE	T2	
RIBASPHERE ORAL TABLET 200 MG, 400 MG	T2	
RIBASPHERE ORAL TABLET 600 MG	T5	
RIBASPHERE RIBAPAK ORAL TABLETS,DOSE PACK 200 MG (7)- 400 MG (7)	T2	
RIBASPHERE RIBAPAK ORAL TABLETS,DOSE PACK 600-400 MG (28)- MG (28), 600-600 MG (28)-MG (28)	T5	

Drug Name	Drug Tier	Requirements/Limits
<i>ribavirin oral capsule</i>	T3	
<i>ribavirin oral tablet 200 mg</i>	T3	
<i>rifabutin</i>	T4	
<i>rifampin</i>	T2	
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)
SOVALDI	T5	PA; QL (28 EA per 28 days)
SPORANOX ORAL SOLUTION	T5	PA
<i>stavudine oral capsule</i>	T4	
<i>streptomycin</i>	T4	
STRIBILD	T5	
<i>sulfadiazine</i>	T4	
<i>sulfamethoxazole-trimethoprim</i>	T1	
SUPRAX ORAL CAPSULE	T3	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	T3	
SUSTIVA ORAL TABLET	T3	
SYMFI	T5	QL (31 EA per 31 days)
SYMFI LO	T5	QL (31 EA per 31 days)
SYNAGIS	T5	
SYNERCID	T4	
TAZICEF INJECTION	T4	
TECHNIVIE	T5	PA; QL (56 EA per 28 days)
TEFLARO	T4	
<i>tenofovir disoproxil fumarate</i>	T3	
<i>terbinafine hcl oral</i>	T2	QL (90 EA per 180 days)
<i>tetracycline</i>	T2	
<i>tigecycline</i>	T4	
<i>tinidazole</i>	T2	
TIVICAY ORAL TABLET 10 MG	T4	
TIVICAY ORAL TABLET 25 MG, 50 MG	T5	

Drug Name	Drug Tier	Requirements/Limits
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>	T2	
TRECTOR	T4	
<i>trimethoprim</i>	T2	
TRIUMEQ	T5	
TRUVADA	T5	
TYBOST	T3	
TYGACIL	T5	
VABOMERE	T4	
<i>valacyclovir</i>	T2	
<i>valganciclovir oral recon soln</i>	T4	
<i>valganciclovir oral tablet</i>	T5	
<i>vancomycin intravenous recon soln 1,000 mg, 500 mg</i>	T2	
<i>vancomycin intravenous recon soln 10 gram</i>	T3	
<i>vancomycin oral capsule 125 mg</i>	T4	
<i>vancomycin oral capsule 250 mg</i>	T5	
VEMLIDY	T5	QL (31 EA per 31 days)
VIDEX 4 GRAM PEDIATRIC	T4	
VIDEX EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 125 MG	T4	
VIEKIRA PAK	T5	PA; QL (112 EA per 28 days)
VIEKIRA XR	T5	PA; QL (84 EA per 28 days)
VIRACEPT ORAL TABLET	T5	
VIRAMUNE ORAL SUSPENSION	T4	
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)
ZEPATIER	T5	PA; QL (28 EA per 28 days)
ZERBAXA	T5	
ZERIT ORAL RECON SOLN	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>zidovudine</i>	T2	
Antineoplastic / Immunosuppressant Drugs		
ABRAXANE	T4	
ADRIAMYCIN INTRAVENOUS SOLUTION 20 MG/10 ML	T4	PA-BvD
ADRUCIL INTRAVENOUS SOLUTION 500 MG/10 ML	T2	PA-BvD
AFINITOR	T5	PA-NS; QL (31 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 5 MG	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG	T5	PA-NS; QL (93 EA per 31 days)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALIMTA	T4	
ALIQOPA	T5	
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	
ARRANON	T4	
ASTAGRAF XL	T4	PA-BvD
AVASTIN	T5	
<i>azacitidine</i>	T5	
AZASAN	T4	PA-BvD
<i>azathioprine</i>	T2	PA-BvD
<i>azathioprine sodium</i>	T3	PA-BvD
BAVENCIO	T5	PA-NS
BELEODAQ	T5	PA-NS
<i>bexarotene</i>	T5	PA-NS
<i>bicalutamide</i>	T3	
BICNU	T4	
<i>bleomycin injection recon soln 30 unit</i>	T3	PA-BvD
<i>bortezomib</i>	T5	
BOSULIF	T5	PA-NS
<i>busulfan</i>	T4	
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CALQUENCE	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA	T5	PA-NS

Drug Name	Drug Tier	Requirements/Limits
<i>carboplatin intravenous solution</i>	T4	
CELLCEPT INTRAVENOUS	T4	PA-BvD
<i>cisplatin</i>	T2	
<i>cladribine</i>	T2	PA-BvD
<i>clofarabine</i>	T4	
COMETRIQ	T5	PA-NS
COTELLIC	T5	PA-NS
<i>cyclophosphamide oral capsule</i>	T4	PA-BvD
<i>cyclosporine intravenous</i>	T2	PA-BvD
<i>cyclosporine modified</i>	T2	PA-BvD
<i>cyclosporine oral capsule</i>	T2	PA-BvD
<i>cytarabine</i>	T2	PA-BvD
<i>cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)</i>	T2	PA-BvD
<i>dacarbazine intravenous recon soln 200 mg</i>	T2	
<i>dactinomycin</i>	T5	
DARZALEX	T5	PA-NS
<i>daunorubicin intravenous solution</i>	T2	
<i>dexrazoxane hcl intravenous recon soln 250 mg</i>	T3	
<i>docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 80 mg/4 ml (20 mg/ml)</i>	T3	
<i>doxorubicin intravenous solution 50 mg/25 ml</i>	T2	PA-BvD
<i>doxorubicin, peg-liposomal</i>	T3	PA-BvD
DROXIA	T4	
ELIGARD	T4	
ELIGARD (3 MONTH)	T4	
ELIGARD (4 MONTH)	T4	
ELIGARD (6 MONTH)	T4	
ELITEK	T5	
EMCYT	T4	
ENVARUSUS XR	T4	PA-BvD
<i>epirubicin intravenous solution 200 mg/100 ml</i>	T4	
ERIVEDGE	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA	T5	PA-NS; QL (124 EA per 31 days)
<i>etoposide intravenous</i>	T2	
<i>exemestane</i>	T4	
FARESTON	T4	
FARYDAK	T5	PA-NS
FASLODEX	T5	

Drug Name	Drug Tier	Requirements/Limits
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	T5	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	T4	
<i>fludarabine intravenous recon soln</i>	T2	
<i>fluorouracil intravenous solution 5 gram/100 ml</i>	T2	PA-BvD
<i>flutamide</i>	T2	
FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)	T5	
FUSILEV	T4	
<i>gemcitabine intravenous recon soln 1 gram</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	
HALAVEN	T5	
HERCEPTIN	T5	
HEXALEN	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)
<i>idarubicin</i>	T2	
IDHIFA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 50 MG	T5	PA-NS; QL (62 EA per 31 days)
<i>ifosfamide intravenous recon soln 1 gram</i>	T2	
<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)
IMFINZI	T5	PA-NS
INLYTA	T5	PA-NS; QL (124 EA per 31 days)
IRESSA	T5	PA-NS
<i>irinotecan intravenous solution 100 mg/5 ml</i>	T4	
ISTODAX	T5	
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
KADCYLA	T5	
KEYTRUDA INTRAVENOUS SOLUTION	T5	PA-NS
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	T5	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	T5	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	T5	PA-NS; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
KYPROLIS INTRAVENOUS RECON SOLN 30 MG, 60 MG	T5	
LARTRUVO	T5	
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 8 MG/DAY (4 MG X 2)	T5	PA-NS
<i>letrozole</i>	T2	
<i>leucovorin calcium injection recon soln 100 mg, 350 mg</i>	T2	
<i>leucovorin calcium oral</i>	T2	
LEUKERAN	T4	
<i>leuprolide subcutaneous kit</i>	T3	
<i>levoleucovorin intravenous recon soln 50 mg</i>	T4	
<i>levoleucovorin intravenous solution</i>	T4	
LONSURF	T5	PA-NS
LUPRON DEPOT (3 MONTH)	T5	
LUPRON DEPOT (4 MONTH)	T5	
LUPRON DEPOT (6 MONTH)	T5	
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	T4	
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG	T5	
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 30 MG	T5	
LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG	T5	

Drug Name	Drug Tier	Requirements/Limits
LYNPARZA ORAL CAPSULE	T5	PA-NS
LYNPARZA ORAL TABLET	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T3	
MATULANE	T5	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml</i>	T2	PA
<i>megestrol oral tablet</i>	T2	PA-NS
MEKINIST	T5	PA-NS
<i>melphalan hcl</i>	T5	
<i>mercaptopurine</i>	T2	
<i>mesna</i>	T2	
MESNEX ORAL	T4	
<i>methotrexate sodium (pf)</i>	T2	PA-BvD
<i>methotrexate sodium injection</i>	T2	PA-BvD
<i>methotrexate sodium oral</i>	T1	PA-BvD
<i>mitomycin intravenous</i>	T2	
<i>mitoxantrone</i>	T3	
MUSTARGEN	T4	
<i>mycophenolate mofetil hcl</i>	T3	PA-BvD
<i>mycophenolate mofetil oral capsule</i>	T2	PA-BvD
<i>mycophenolate mofetil oral suspension for reconstitution</i>	T3	PA-BvD
<i>mycophenolate mofetil oral tablet</i>	T2	PA-BvD
<i>mycophenolate sodium</i>	T3	PA-BvD
MYLOTARG	T5	
NEORAL	T3	PA-BvD
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
NEXAVAR	T5	PA-NS; QL (124 EA per 31 days)
NILANDRON	T5	
<i>nilutamide</i>	T5	
NINLARO	T5	PA-NS
NIPENT	T4	
NULOJIX	T5	PA-BvD
<i>octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 50 mcg/ml</i>	T3	
<i>octreotide acetate injection solution 200 mcg/ml, 500 mcg/ml</i>	T5	
ODOMZO	T5	PA-NS

Drug Name	Drug Tier	Requirements/Limits
OPDIVO INTRAVENOUS SOLUTION 100 MG/10 ML, 40 MG/4 ML	T5	PA-NS
<i>oxaliplatin intravenous recon soln 100 mg</i>	T4	
<i>oxaliplatin intravenous solution 100 mg/20 ml</i>	T4	
<i>paclitaxel</i>	T4	
POMALYST	T5	PA-NS; QL (21 EA per 28 days)
PROGRAF INTRAVENOUS	T4	PA-BvD
PURIXAN	T4	
RAPAMUNE ORAL SOLUTION	T5	PA-BvD
REVLIMID	T5	PA-NS; QL (21 EA per 28 days)
RITUXAN	T5	
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
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON	T5	
SIGNIFOR	T5	PA
SIMULECT INTRAVENOUS RECON SOLN 20 MG	T4	PA-BvD
<i>sirolimus oral tablet 0.5 mg, 2 mg</i>	T4	PA-BvD
<i>sirolimus oral tablet 1 mg</i>	T5	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
SYLVANT	T5	PA-NS
SYNRIBO	T5	
TABLOID	T4	
<i>tacrolimus oral</i>	T2	PA-BvD
TAFINLAR	T5	PA-NS
TAGRISSO	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)
TECENTRIQ	T5	PA-NS

Drug Name	Drug Tier	Requirements/Limits
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)
<i>thiotepa</i>	T5	
TOPOSAR	T2	
<i>topotecan intravenous recon soln</i>	T2	
TREANDA INTRAVENOUS RECON SOLN	T4	
TRELSTAR INTRAMUSCULAR SYRINGE	T3	
<i>tretinoin (chemotherapy)</i>	T5	
TREXALL	T4	PA-BvD
TRISENOX INTRAVENOUS SOLUTION 2 MG/ML	T4	
TYKERB	T5	PA-NS
VELCADE	T5	
VENCLEXTA ORAL TABLET 10 MG, 50 MG	T4	PA-NS
VENCLEXTA ORAL TABLET 100 MG	T5	PA-NS
VENCLEXTA STARTING PACK	T5	PA-NS
VERZENIO	T5	PA-NS; QL (62 EA per 31 days)
<i>vinblastine intravenous solution</i>	T3	PA-BvD
VINCASAR PFS INTRAVENOUS SOLUTION 1 MG/ML	T2	PA-BvD
<i>vincristine intravenous solution 1 mg/ml</i>	T2	PA-BvD
<i>vinorelbine intravenous solution 50 mg/5 ml</i>	T3	
VOTRIENT	T5	PA-NS; QL (124 EA per 31 days)
VYXEOS	T5	PA-NS
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	
XTANDI	T5	PA-NS; QL (124 EA per 31 days)
YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)	T5	
YONDELIS	T5	
YONSA	T5	PA-NS; QL (124 EA per 31 days)
ZANOSAR	T4	
ZEJULA	T5	PA-NS; QL (93 EA per 31 days)
ZELBORAF	T5	PA-NS
ZINECARD (AS HCL) INTRAVENOUS RECON SOLN 250 MG	T4	

Drug Name	Drug Tier	Requirements/Limits
ZOLINZA	T5	PA-NS
ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG	T4	PA-BvD
ZORTRESS ORAL TABLET 0.75 MG	T5	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)
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 (2 PACK)	T4	PA; QL (2 ML per 28 days)
ALLZITAL	T4	QL (372 EA per 31 days)
<i>almotriptan malate oral tablet 12.5 mg</i>	T4	QL (8 EA per 31 days)
<i>almotriptan malate oral tablet 6.25 mg</i>	T4	QL (16 EA per 31 days)
ALPRAZOLAM INTENSOL	T2	PA
<i>alprazolam oral tablet 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg</i>	T2	PA; QL (31 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 3 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet,disintegrating 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>amitriptyline</i>	T2	PA-NS

Drug Name	Drug Tier	Requirements/Limits
<i>amitriptyline-chlordiazepoxide</i>	T2	PA-NS
<i>amoxapine</i>	T2	
AMPYRA	T5	PA; QL (62 EA per 31 days)
APLENZIN	T4	
APOKYN	T5	PA
APTENSIO XR	T4	
APTIOM	T4	
<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
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 1,064 MG/3.9 ML, 441 MG/1.6 ML	T4	
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 662 MG/2.4 ML, 882 MG/3.2 ML	T5	
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
<i>atomoxetine oral capsule 10 mg, 25 mg, 40 mg</i>	T4	PA; QL (62 EA per 31 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	T4	PA; QL (31 EA per 31 days)
<i>atomoxetine oral capsule 18 mg</i>	T4	PA; QL (124 EA per 31 days)
AUBAGIO	T5	PA; QL (31 EA per 31 days)
AZILECT	T3	
<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</i>	T2	
BRIVIACT	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 hcl injection</i>	T4	QL (267 ML per 30 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 transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour</i>	T4	PA; QL (4 EA per 28 days)
<i>buprenorphine-naloxone sublingual tablet</i>	T4	ST; QL (93 EA per 31 days)
<i>bupropion hcl oral tablet</i>	T3	

Drug Name	Drug Tier	Requirements/Limits
<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 sustained-release 12 hr</i>	T3	QL (62 EA per 31 days)
<i>bupirone</i>	T2	
BUTALBITAL COMPOUND W/CODEINE	T2	PA; QL (372 EA per 31 days)
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg</i>	T2	PA; QL (403 EA per 31 days)
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>butalbital-acetaminophen oral tablet 50-300 mg</i>	T2	QL (403 EA per 31 days)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	T2	QL (372 EA per 31 days)
<i>butalbital-acetaminophen-caff oral capsule 50-300-40 mg</i>	T2	QL (403 EA per 31 days)
<i>butalbital-acetaminophen-caff oral capsule 50-325-40 mg</i>	T2	QL (372 EA per 31 days)
<i>butalbital-acetaminophen-caff oral tablet 50-325-40 mg</i>	T2	QL (372 EA per 31 days)
<i>butalbital-aspirin-caffeine oral capsule</i>	T2	
<i>butorphanol tartrate injection solution 1 mg/ml</i>	T4	QL (720 ML per 30 days)
<i>butorphanol tartrate injection solution 2 mg/ml</i>	T4	QL (360 ML per 30 days)
<i>butorphanol tartrate nasal</i>	T4	QL (5 ML per 28 days)
BUTRANS	T4	PA; QL (4 EA per 28 days)
CAMBIA	T4	
<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	
<i>carbidopa</i>	T4	
<i>carbidopa-levodopa</i>	T2	
<i>carbidopa-levodopa-entacapone</i>	T2	
<i>carisoprodol-asa-codeine</i>	T2	PA; QL (2582 EA per 31 days)
<i>celecoxib</i>	T2	QL (62 EA per 31 days)
CELONTIN ORAL CAPSULE 300 MG	T4	
<i>chlorpromazine</i>	T4	
<i>citalopram</i>	T1	
<i>clomipramine</i>	T4	PA-NS
<i>clonazepam oral tablet 0.5 mg</i>	T2	QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<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>clonidine hcl oral tablet extended release 12 hr</i>	T4	PA
<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 100 mg, 12.5 mg, 25 mg</i>	T2	
<i>clozapine oral tablet, disintegrating 150 mg, 200 mg</i>	T4	
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	T5	QL (31 ML per 31 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	T5	QL (12 ML per 28 days)
<i>cyclobenzaprine oral tablet</i>	T2	PA
<i>dantrolene</i>	T2	
DAYTRANA	T4	
<i>desipramine</i>	T2	
<i>desvenlafaxine oral tablet extended release 24 hr</i>	T4	
<i>desvenlafaxine succinate</i>	T4	QL (31 EA per 31 days)
<i>dexmethylphenidate</i>	T2	
<i>dextroamphetamine oral capsule, extended release</i>	T2	
<i>dextroamphetamine oral tablet</i>	T2	
<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)
<i>diclofenac potassium</i>	T2	
<i>diclofenac sodium oral</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>diclofenac sodium topical drops</i>	T2	
<i>diclofenac sodium topical gel 1 %</i>	T3	
<i>diclofenac-misoprostol</i>	T2	
<i>diflunisal</i>	T2	
<i>dihydroergotamine injection</i>	T2	
<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-BvD; QL (4000 ML per 30 days)
DURAMORPH (PF) INJECTION SOLUTION 1 MG/ML	T3	PA-BvD; QL (2000 ML per 30 days)
<i>eletriptan oral tablet 20 mg</i>	T4	QL (12 EA per 31 days)
<i>eletriptan oral tablet 40 mg</i>	T4	QL (6 EA per 31 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	
EPITOL	T1	
EQUETRO	T4	
<i>ergoloid</i>	T4	
<i>ergotamine-caffeine</i>	T2	
<i>escitalopram oxalate oral solution</i>	T4	QL (620 ML per 31 days)
<i>escitalopram oxalate oral tablet</i>	T4	QL (31 EA per 31 days)
<i>eszopiclone</i>	T2	
<i>ethosuximide</i>	T2	
<i>etodolac</i>	T2	
EXONDYS 51	T5	PA

Drug Name	Drug Tier	Requirements/Limits
FANAPT	T4	
<i>felbamate</i>	T4	
<i>fenoprofen oral tablet</i>	T2	
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg</i>	T5	PA; QL (40 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 1,600 mcg</i>	T5	PA; QL (30 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	T4	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 400 mcg</i>	T4	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr</i>	T4	PA; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr</i>	T4	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 25 mcg/hr</i>	T2	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 50 mcg/hr</i>	T2	PA; QL (17 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 75 mcg/hr</i>	T4	PA; QL (12 EA per 30 days)
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)
FLECTOR	T4	PA; QL (62 EA per 31 days)
<i>fluoxetine oral capsule</i>	T1	
<i>fluoxetine oral capsule,delayed release(dr/ec)</i>	T2	
<i>fluoxetine oral solution</i>	T1	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	T1	
<i>fluoxetine oral tablet 60 mg</i>	T4	
<i>fluphenazine decanoate</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>fluphenazine hcl</i>	T2	
<i>flurbiprofen</i>	T2	
<i>fluvoxamine</i>	T2	
<i>fosphenytoin injection solution 100 mg pe/2 ml</i>	T2	
<i>frovatriptan</i>	T4	QL (12 EA per 31 days)
FYCOMPA ORAL SUSPENSION	T4	
FYCOMPA ORAL TABLET	T4	
<i>gabapentin oral capsule</i>	T2	
<i>gabapentin oral solution 250 mg/5 ml</i>	T2	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	T2	
<i>galantamine</i>	T2	
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)
GRALISE	T4	PA-NS
GRALISE 30-DAY STARTER PACK	T4	PA-NS
<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
HORIZANT	T4	PA-NS
<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, 2.5-325 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)
<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	

Drug Name	Drug Tier	Requirements/Limits
<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
<i>imipramine pamoate</i>	T2	
INDOCIN ORAL	T4	
<i>indomethacin oral</i>	T2	
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	T5	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	T5	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	T5	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T4	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	T5	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.875 ML	T5	QL (0.875 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.315 ML	T5	QL (1.315 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	T5	QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.625 ML	T5	QL (2.625 ML per 84 days)
<i>ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg</i>	T3	
<i>ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)</i>	T2	
<i>ketorolac intramuscular cartridge</i>	T2	
<i>ketorolac oral</i>	T2	
<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 tablet,disintegrating</i>	T4	
<i>lamotrigine oral tablets,dose pack</i>	T2	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	T5	QL (31 EA per 31 days)
LATUDA ORAL TABLET 80 MG	T5	QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
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 in nacl (iso-os)</i>	T4	
<i>levetiracetam intravenous</i>	T2	
<i>levetiracetam oral solution 100 mg/ml</i>	T2	
<i>levetiracetam oral tablet</i>	T2	
<i>levetiracetam oral tablet extended release 24 hr</i>	T2	
LIORESAL INTRATHECAL SOLUTION 2,000 MCG/ML, 500 MCG/ML	T4	PA-BvD
<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-NS; 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	
<i>meclofenamate</i>	T2	
<i>mefenamic acid</i>	T2	
<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	

Drug Name	Drug Tier	Requirements/Limits
<i>memantine oral tablets,dose pack</i>	T4	
MESTINON ORAL SYRUP	T5	
METADATE ER	T2	QL (93 EA per 31 days)
METAXALL	T2	
<i>metaxalone</i>	T2	
<i>methadone injection solution</i>	T2	PA-BvD; QL (160 ML per 30 days)
<i>methadone oral solution 10 mg/5 ml</i>	T2	PA; QL (1033 ML per 31 days)
<i>methadone oral solution 5 mg/5 ml</i>	T2	PA; QL (2066 ML per 31 days)
<i>methadone oral tablet 10 mg</i>	T2	PA; QL (206 EA per 31 days)
<i>methadone oral tablet 5 mg</i>	T2	PA; QL (248 EA per 31 days)
<i>methamphetamine</i>	T5	PA
<i>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>	T2	PA; QL (31 EA per 31 days)
<i>morphine concentrate oral solution</i>	T2	PA; QL (310 ML per 31 days)
<i>morphine injection syringe 5 mg/ml</i>	T2	PA; QL (400 ML per 30 days)
<i>morphine intravenous syringe 10 mg/ml</i>	T4	PA; QL (200 ML per 30 days)
<i>morphine intravenous syringe 2 mg/ml</i>	T2	PA; QL (1000 ML per 30 days)
<i>morphine intravenous syringe 4 mg/ml</i>	T2	PA; QL (500 ML per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>morphine intravenous syringe 8 mg/ml</i>	T4	PA; QL (250 ML per 30 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 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</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)
<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>nalbuphine injection solution 10 mg/ml</i>	T2	QL (200 ML per 30 days)
<i>nalbuphine injection solution 20 mg/ml</i>	T2	QL (100 ML per 30 days)
<i>naloxone</i>	T2	
<i>naltrexone</i>	T2	
NAMENDA TITRATION PAK	T4	PA
NAMENDA XR	T4	PA
NAMZARIC	T4	PA
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 750 MG	T4	
<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>	T2	
<i>naproxen sodium oral tablet, er multiphase 24 hr</i>	T2	
<i>naratriptan oral tablet 1 mg</i>	T2	QL (20 EA per 31 days)
<i>naratriptan oral tablet 2.5 mg</i>	T2	QL (8 EA per 31 days)
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION	T4	
<i>nefazodone</i>	T2	
NEUPRO	T4	
<i>nortriptyline</i>	T2	
NUCYNTA	T4	QL (186 EA per 31 days)
NUEDEXTA	T3	
NUPLAZID ORAL TABLET 17 MG	T5	PA-NS
<i>olanzapine intramuscular</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 7.5 mg</i>	T2	QL (31 EA per 31 days)
<i>olanzapine oral tablet 5 mg</i>	T3	QL (31 EA per 31 days)
<i>olanzapine oral tablet,disintegrating</i>	T2	QL (31 EA per 31 days)
<i>olanzapine-fluoxetine</i>	T4	
ONFI ORAL SUSPENSION	T4	PA-NS
ONFI ORAL TABLET 10 MG, 20 MG	T5	PA-NS
ONZETRA XSAIL	T4	QL (16 EA per 31 days)
<i>oxaprozin</i>	T2	
<i>oxcarbazepine</i>	T2	
OXTELLAR XR	T4	
<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)
<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)
PANLOR(ACETAM-CAFF-DIHYDROCOD)	T2	PA; QL (372 EA per 31 days)
<i>paroxetine hcl oral tablet</i>	T1	
<i>paroxetine hcl oral tablet extended release 24 hr</i>	T2	
<i>paroxetine mesylate(menop.sym)</i>	T4	
PAXIL ORAL SUSPENSION	T4	
PEGANONE	T4	
<i>perphenazine</i>	T2	
<i>perphenazine-amitriptyline</i>	T2	PA-NS
<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>phenytoin sodium intravenous solution</i>	T2	
<i>pimozide</i>	T2	
<i>piroxicam</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>pramipexole oral tablet</i>	T2	
<i>pramipexole oral tablet extended release 24 hr</i>	T4	
<i>primidone</i>	T2	
PRIMLEV	T4	PA; QL (403 EA per 31 days)
PROCENTRA	T2	
<i>protriptyline</i>	T3	
<i>pyridostigmine bromide</i>	T3	
<i>quetiapine oral tablet</i>	T2	QL (62 EA per 31 days)
QUILLIVANT XR	T4	
RADICAVA	T5	PA
<i>rasagiline</i>	T3	
REXULTI	T5	PA-NS; QL (31 EA per 31 days)
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML	T4	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 50 MG/2 ML	T5	QL (2 EA per 28 days)
<i>risperidone oral solution</i>	T2	QL (496 ML per 31 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T2	QL (31 EA per 31 days)
<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>	T2	QL (31 EA per 31 days)
<i>risperidone oral tablet,disintegrating 3 mg</i>	T2	QL (93 EA per 31 days)
<i>risperidone oral tablet,disintegrating 4 mg</i>	T2	QL (124 EA per 31 days)
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG	T4	QL (186 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 31 days)
<i>rizatriptan oral tablet 5 mg</i>	T3	QL (24 EA per 31 days)
<i>rizatriptan oral tablet,disintegrating 10 mg</i>	T3	QL (12 EA per 31 days)
<i>rizatriptan oral tablet,disintegrating 5 mg</i>	T3	QL (24 EA per 31 days)
<i>ropinirole</i>	T2	
ROWEEPRA	T2	
ROWEEPRA XR	T2	
ROZEREM	T4	
SABRIL	T5	PA-NS
SAPHRIS	T4	QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>selegiline hcl</i>	T2	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR	T3	QL (62 EA per 31 days)
<i>sertraline</i>	T1	
SILENOR	T4	PA-NS
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 31 days)
<i>sumatriptan nasal spray, non-aerosol 5 mg/actuation</i>	T2	QL (32 EA per 31 days)
<i>sumatriptan succinate oral tablet 100 mg</i>	T2	QL (9 EA per 31 days)
<i>sumatriptan succinate oral tablet 25 mg</i>	T2	QL (36 EA per 31 days)
<i>sumatriptan succinate oral tablet 50 mg</i>	T2	QL (18 EA per 31 days)
<i>sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml</i>	T2	QL (6 ML per 31 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	T2	QL (4 ML per 31 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	T2	QL (6 ML per 31 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	T2	QL (4 ML per 31 days)
<i>sumatriptan succinate subcutaneous solution</i>	T2	QL (4 ML per 31 days)
<i>sumatriptan-naproxen</i>	T4	QL (9 EA per 31 days)
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	
<i>temazepam</i>	T2	QL (31 EA per 31 days)
TENCON ORAL TABLET 50-325 MG	T2	QL (372 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>tetrabenazine oral tablet 12.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>tetrabenazine oral tablet 25 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>thioridazine</i>	T2	
<i>thiothixene</i>	T2	
<i>tiagabine oral tablet 12 mg, 16 mg</i>	T4	
<i>tiagabine oral tablet 2 mg, 4 mg</i>	T3	
<i>tizanidine</i>	T2	
<i>tolcapone</i>	T5	
<i>tolmetin oral capsule</i>	T2	
<i>tolmetin oral tablet 600 mg</i>	T2	
<i>topiramate oral capsule, sprinkle</i>	T2	
<i>topiramate oral capsule, sprinkle, er 24hr</i>	T4	
<i>topiramate oral tablet</i>	T2	
<i>tramadol oral capsule, er biphase 24 hr 25-75 100 mg, 200 mg</i>	T4	QL (30 EA per 30 days)
<i>tramadol oral tablet</i>	T2	QL (240 EA per 30 days)
<i>tramadol-acetaminophen</i>	T2	QL (372 EA per 31 days)
<i>tranylcypromine</i>	T4	
<i>trazodone oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>trazodone oral tablet 300 mg</i>	T2	
TREXIMET ORAL TABLET 10-60 MG	T4	QL (10 EA per 31 days)
TREXIMET ORAL TABLET 85-500 MG	T4	QL (9 EA per 31 days)
<i>trifluoperazine</i>	T2	
<i>trihexyphenidyl</i>	T2	
<i>trimipramine</i>	T3	PA-NS
TRINTELLIX	T4	PA-NS
TROKENDI XR	T4	
TYSABRI	T5	PA; QL (15 ML per 28 days)
<i>valproate sodium</i>	T2	
<i>valproic acid</i>	T2	
<i>valproic acid (as sodium salt) oral solution 500 mg/10 ml (10 ml)</i>	T2	
<i>venlafaxine oral capsule, extended release 24hr</i>	T2	QL (31 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
VIIBRYD ORAL TABLET	T4	PA-NS; QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)	T4	PA-NS; QL (60 EA per 365 days)
VIMOVO	T5	PA; QL (62 EA per 31 days)
VIMPAT INTRAVENOUS	T4	
VIMPAT ORAL SOLUTION	T4	
VIMPAT ORAL TABLET	T4	
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)
VYVANSE ORAL CAPSULE	T4	QL (31 EA per 31 days)
XYREM	T5	PA; QL (540 ML per 30 days)
<i>zaleplon</i>	T2	
ZELAPAR	T5	
ZEMBRACE SYMTOUCH	T4	QL (8 ML per 31 days)
ZENZEDI ORAL TABLET 10 MG, 5 MG	T2	
ZENZEDI ORAL TABLET 2.5 MG, 30 MG	T4	
<i>ziprasidone hcl</i>	T3	QL (62 EA per 31 days)
<i>zolmitriptan oral tablet 2.5 mg</i>	T2	QL (16 EA per 31 days)
<i>zolmitriptan oral tablet 5 mg</i>	T2	QL (8 EA per 31 days)
<i>zolmitriptan oral tablet,disintegrating 2.5 mg</i>	T2	QL (16 EA per 31 days)
<i>zolmitriptan oral tablet,disintegrating 5 mg</i>	T2	QL (8 EA per 31 days)
<i>zolpidem oral tablet</i>	T2	
<i>zolpidem oral tablet,ext release multiphase</i>	T3	
<i>zolpidem sublingual</i>	T3	
ZOMIG NASAL SPRAY,NON-AEROSOL 2.5 MG	T4	QL (16 EA per 31 days)
ZOMIG NASAL SPRAY,NON-AEROSOL 5 MG	T4	QL (8 EA per 31 days)
<i>zonisamide</i>	T2	
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG, 2.9-0.71 MG	T3	QL (93 EA per 31 days)
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>	T1	

Drug Name	Drug Tier	Requirements/Limits
AFEDITAB CR	T2	
ALTOPREV	T4	
<i>amiloride</i>	T2	
<i>amiloride-hydrochlorothiazide</i>	T2	
<i>amiodarone intravenous solution</i>	T2	
<i>amiodarone oral</i>	T2	
<i>amlodipine</i>	T1	
<i>amlodipine-atorvastatin</i>	T2	
<i>amlodipine-benazepril</i>	T1	
<i>amlodipine-olmesartan</i>	T4	QL (31 EA per 31 days)
<i>amlodipine-valsartan</i>	T2	
<i>amlodipine-valsartan-hcthiazyd</i>	T2	
ANTARA ORAL CAPSULE 30 MG, 90 MG	T4	
<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>betaxolol oral</i>	T2	
BIDIL	T4	
<i>bisoprolol fumarate</i>	T2	
<i>bisoprolol-hydrochlorothiazide</i>	T1	
BRILINTA	T3	
<i>bumetanide</i>	T2	
BYSTOLIC	T4	
<i>candesartan</i>	T1	
<i>candesartan-hydrochlorothiazid</i>	T1	
<i>captopril</i>	T1	
<i>captopril-hydrochlorothiazide</i>	T1	
CARDENE IV IN SODIUM CHLORIDE INTRAVENOUS PIGGYBACK 40 MG/200 ML	T4	
CARTIA XT	T1	
<i>carvedilol</i>	T1	
<i>carvedilol phosphate</i>	T4	
<i>chlorothiazide</i>	T2	
<i>chlorothiazide sodium</i>	T2	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>cholestyramine (with sugar) oral powder in packet</i>	T2	
CHOLESTYRAMINE LIGHT ORAL POWDER	T2	
<i>cilostazol</i>	T2	
<i>clonidine</i>	T2	
<i>clonidine hcl oral tablet</i>	T1	
<i>clopidogrel oral tablet 75 mg</i>	T2	
<i>colesevelam oral tablet</i>	T3	
<i>colestipol oral packet</i>	T2	
<i>colestipol oral tablet</i>	T2	
CORLANOR ORAL TABLET 5 MG	T4	PA; QL (93 EA per 31 days)
CORLANOR ORAL TABLET 7.5 MG	T4	PA; QL (62 EA per 31 days)
COUMADIN ORAL	T4	
DEMSER	T3	
DIGITEK ORAL TABLET 125 MCG	T1	PA
DIGITEK ORAL TABLET 250 MCG	T2	PA
DIGOX ORAL TABLET 125 MCG	T1	PA
DIGOX ORAL TABLET 250 MCG	T2	PA
<i>digoxin injection solution</i>	T2	PA
<i>digoxin oral solution 50 mcg/ml</i>	T2	PA
<i>digoxin oral tablet 125 mcg</i>	T1	PA
<i>digoxin oral tablet 250 mcg</i>	T2	PA
<i>diltiazem hcl intravenous</i>	T1	
<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	T5	PA
<i>doxazosin</i>	T1	
DYRENIUM	T4	
EDARBYCLOR	T4	
EFFIENT	T3	
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
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 solution</i>	T4	
<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	PA; QL (62 EA per 31 days)
<i>eplerenone</i>	T2	
<i>eprosartan</i>	T1	
<i>ethacrynic acid</i>	T2	
<i>ezetimibe</i>	T2	
<i>ezetimibe-simvastatin</i>	T3	
<i>felodipine</i>	T2	
<i>fenofibrate micronized</i>	T2	
<i>fenofibrate nanocrystallized oral tablet 145 mg</i>	T3	
<i>fenofibrate nanocrystallized oral tablet 48 mg</i>	T2	
<i>fenofibrate oral tablet 120 mg</i>	T5	
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	T2	
<i>fenofibrate oral tablet 40 mg</i>	T4	
<i>fenofibric acid (choline)</i>	T3	
<i>fenofibric acid oral tablet 105 mg</i>	T3	
<i>fenofibric acid oral tablet 35 mg</i>	T2	
<i>flecainide</i>	T2	
<i>fluvastatin oral capsule</i>	T2	
<i>fluvastatin oral tablet extended release 24 hr</i>	T3	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	T5	
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	T4	
<i>fosinopril</i>	T1	
<i>fosinopril-hydrochlorothiazide</i>	T1	
FRAGMIN SUBCUTANEOUS SOLUTION	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 18,000 ANTI-XA UNIT/0.72 ML	T5	

Drug Name	Drug Tier	Requirements/Limits
FRAGMIN SUBCUTANEOUS SYRINGE 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI- XA UNIT/0.6 ML, 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML, 7,500 ANTI-XA UNIT/0.3 ML	T3	
<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	
GONITRO	T4	
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml), 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)</i>	T2	
<i>heparin (porcine) injection solution</i>	T2	
<i>hydralazine</i>	T2	
<i>hydrochlorothiazide</i>	T1	
<i>indapamide</i>	T2	
INNOPRAN XL	T4	
<i>irbesartan</i>	T1	QL (31 EA per 31 days)
<i>irbesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
ISORDIL	T4	
<i>isosorbide dinitrate oral</i>	T2	
<i>isosorbide mononitrate</i>	T2	
<i>isradipine</i>	T2	
JANTOVEN	T2	
JUXTAPID	T5	PA
KYNAMRO	T5	PA
<i>labetalol intravenous solution</i>	T1	
<i>labetalol oral</i>	T1	
LANOXIN ORAL TABLET 62.5 MCG	T4	PA
LIPOFEN	T4	
<i>lisinopril</i>	T1	
<i>lisinopril-hydrochlorothiazide</i>	T1	
LIVALO	T4	
<i>losartan oral tablet 100 mg</i>	T1	QL (31 EA per 31 days)
<i>losartan oral tablet 25 mg</i>	T1	QL (93 EA per 31 days)
<i>losartan oral tablet 50 mg</i>	T1	QL (62 EA per 31 days)
<i>losartan-hydrochlorothiazide</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
<i>lovastatin</i>	T1	
MATZIM LA	T2	
<i>methyclothiazide</i>	T2	
<i>methyldopa-hydrochlorothiazide</i>	T2	
<i>metolazone</i>	T2	
<i>metoprolol succinate</i>	T1	
<i>metoprolol ta-hydrochlorothiaz</i>	T1	
<i>metoprolol tartrate intravenous</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>mexiletine</i>	T2	
<i>minoxidil oral</i>	T2	
<i>moexipril</i>	T1	
<i>moexipril-hydrochlorothiazide</i>	T1	
MULTAQ	T4	
<i>nadolol</i>	T2	
<i>nadolol-bendroflumethiazide</i>	T2	
<i>niacin oral tablet extended release 24 hr 1,000 mg, 750 mg</i>	T3	
<i>niacin oral tablet extended release 24 hr 500 mg</i>	T3	QL (31 EA per 31 days)
NIACOR	T4	
<i>nicardipine intravenous solution</i>	T2	
<i>nicardipine oral</i>	T2	
<i>nifedipine oral tablet extended release</i>	T2	
<i>nifedipine oral tablet extended release 24hr</i>	T2	
<i>nimodipine</i>	T5	
<i>nisoldipine</i>	T4	
NITRO-BID	T2	
NITRO-DUR	T4	
<i>nitroglycerin intravenous</i>	T2	
<i>nitroglycerin sublingual</i>	T2	
<i>nitroglycerin transdermal patch 24 hour</i>	T2	
<i>nitroglycerin translingual spray,non-aerosol</i>	T2	
NITROSTAT	T4	
NYMALIZE ORAL SOLUTION 30 MG/10 ML	T4	
<i>olmesartan oral tablet 20 mg, 40 mg</i>	T4	QL (31 EA per 31 days)
<i>olmesartan oral tablet 5 mg</i>	T4	QL (93 EA per 31 days)
<i>olmesartan-amlodipin-hcthiazyd</i>	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>olmesartan-hydrochlorothiazide</i>	T4	QL (31 EA per 31 days)
<i>omega-3 acid ethyl esters</i>	T3	
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	T4	PA; QL (93 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG	T5	PA; QL (186 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG	T5	PA; QL (521 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG	T5	PA; QL (261 EA per 31 days)
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	T2	
<i>pentoxifylline</i>	T2	
<i>perindopril erbumine</i>	T1	
<i>phenoxybenzamine</i>	T5	
<i>pindolol</i>	T2	
PRADAXA	T4	QL (62 EA per 31 days)
PRALUENT PEN	T5	PA; QL (2 ML per 28 days)
<i>pravastatin</i>	T1	
<i>prazosin</i>	T2	
PREVALITE ORAL POWDER IN PACKET	T2	
<i>procainamide injection</i>	T2	
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</i>	T2	
<i>propranolol</i>	T2	
<i>propranolol-hydrochlorothiazid</i>	T2	
QBRELIS	T4	
<i>quinapril</i>	T1	
<i>quinapril-hydrochlorothiazide</i>	T1	
<i>quinidine gluconate</i>	T2	
<i>quinidine sulfate oral tablet</i>	T2	
<i>ramipril</i>	T1	
RANEXA	T3	QL (62 EA per 31 days)
REMODULIN	T5	PA-BvD
REPATHA PUSHTRONEX	T5	PA; QL (3.5 ML per 28 days)
REPATHA SURECLICK	T5	PA; QL (2 ML per 28 days)
REPATHA SYRINGE	T5	PA; QL (2 ML per 28 days)
<i>rosuvastatin</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>simvastatin</i>	T1	
SORINE	T1	
SOTALOL AF ORAL TABLET 120 MG	T1	
<i>sotalol oral tablet 160 mg, 240 mg, 80 mg</i>	T1	
<i>spironolactone</i>	T1	
<i>spironolacton-hydrochlorothiaz</i>	T2	
TAVALISSE	T5	PA; QL (62 EA per 31 days)
TAZTIA XT	T2	
TEKTURNA	T4	
TEKTURNA HCT	T4	
<i>telmisartan</i>	T1	
<i>telmisartan-amlodipine</i>	T2	
<i>telmisartan-hydrochlorothiazid</i>	T1	
<i>terazosin</i>	T1	
<i>timolol maleate oral</i>	T1	
<i>torseamide oral</i>	T2	
<i>trandolapril</i>	T1	
<i>trandolapril-verapamil</i>	T2	
<i>tranexamic acid intravenous</i>	T3	
<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 intravenous solution</i>	T2	
<i>verapamil oral</i>	T2	
<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 TABLETS,DOSE PACK	T3	QL (51 EA per 30 days)
YOSPRALA	T4	PA; QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
ZONTIVITY	T4	
Dermatologicals/Topical Therapy		
ACANYA TOPICAL GEL WITH PUMP	T4	
<i>acitretin</i>	T5	
<i>acyclovir topical</i>	T3	
<i>adapalene topical cream</i>	T4	PA
<i>adapalene topical gel</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>	T2	
<i>amcinonide</i>	T3	
<i>ammonium lactate</i>	T2	
AMNESTEEM	T4	
APEXICON E	T4	
AVITA TOPICAL CREAM	T2	PA
AVITA TOPICAL GEL	T4	PA
AZELEX	T4	
<i>betamethasone dipropionate</i>	T2	
<i>betamethasone valerate</i>	T2	
<i>betamethasone, augmented</i>	T2	
<i>calcipotriene</i>	T4	
<i>calcipotriene-betamethasone</i>	T4	
<i>calcitriol topical</i>	T2	
CAPEX	T4	
CARAC	T5	ST
<i>ciclopirox</i>	T2	
CLARAVIS ORAL CAPSULE 10 MG	T4	
CLINDACIN P	T4	
<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-benzoyl peroxide topical gel</i>	T2	
<i>clindamycin-tretinoin</i>	T2	
<i>clobetasol</i>	T3	
CLODERM	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>clotrimazole topical</i>	T3	
<i>clotrimazole-betamethasone</i>	T2	
CONDYLOX TOPICAL GEL	T4	
CORDRAN TAPE LARGE ROLL	T4	
CORTISPORIN TOPICAL	T4	
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	
DESONATE	T4	
<i>desonide</i>	T3	
<i>desoximetasone topical cream</i>	T4	
<i>desoximetasone topical gel</i>	T4	
<i>desoximetasone topical ointment</i>	T4	
<i>diclofenac sodium topical gel 3 %</i>	T5	PA
DIFFERIN TOPICAL LOTION	T4	
<i>diflorasone</i>	T4	
<i>doxepin topical</i>	T2	
DUPIXENT	T5	PA; QL (4 ML per 28 days)
<i>econazole</i>	T3	
ELIDEL	T4	
EPIDUO FORTE	T4	
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	
EXELDERM	T4	
FINACEA	T4	
<i>fluocinolone and shower cap</i>	T2	
<i>fluocinolone topical cream</i>	T2	
<i>fluocinolone topical ointment</i>	T2	
<i>fluocinolone topical solution</i>	T2	
<i>fluocinonide topical cream 0.1 %</i>	T4	
<i>fluocinonide topical gel</i>	T2	
<i>fluocinonide topical ointment</i>	T2	
<i>fluocinonide topical solution</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
FLUOCINONIDE-E	T2	
<i>fluorouracil topical cream 0.5 %</i>	T5	
<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 topical</i>	T2	
<i>gentamicin topical</i>	T2	
<i>halobetasol propionate</i>	T4	
HALOG	T4	
<i>hydrocortisone butyrate topical cream</i>	T2	
<i>hydrocortisone butyrate topical ointment</i>	T2	
<i>hydrocortisone butyrate topical solution</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 (pf) injection solution 10 mg/ml (1 %), 5 mg/ml (0.5 %)</i>	T2	
<i>lidocaine hcl injection solution 20 mg/ml (2 %)</i>	T2	
<i>lidocaine hcl mucous membrane jelly</i>	T2	
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	T2	
<i>lidocaine topical adhesive patch,medicated</i>	T2	PA; QL (124 EA per 31 days)
<i>lidocaine topical ointment</i>	T2	
LIDOCAINE VISCOUS	T2	
<i>lidocaine-prilocaine topical cream</i>	T2	
LIDODERM	T4	PA; QL (124 EA per 31 days)
<i>lindane topical shampoo</i>	T3	
<i>malathion</i>	T4	
MENTAX	T4	
<i>methoxsalen</i>	T2	
<i>metronidazole topical cream</i>	T3	
<i>metronidazole topical gel 0.75 %</i>	T3	
<i>metronidazole topical gel 1 %</i>	T2	
<i>metronidazole topical lotion</i>	T3	

Drug Name	Drug Tier	Requirements/Limits
<i>mometasone topical</i>	T2	
<i>mupirocin</i>	T2	
<i>mupirocin calcium</i>	T2	
MYORISAN	T4	
<i>naftifine</i>	T4	
NAFTIN TOPICAL GEL	T4	
NEO-SYNALAR	T4	
NEUAC	T2	
NOLIX	T3	
NORITATE	T5	
NYAMYC	T2	
<i>nystatin topical</i>	T2	
<i>nystatin-triamcinolone</i>	T3	
NYSTOP	T2	
<i>oxiconazole</i>	T4	
OXISTAT TOPICAL LOTION	T4	
PANRETIN	T5	
<i>permethrin topical cream</i>	T2	
PICATO	T5	
<i>podofilox</i>	T2	
<i>prednicarbate</i>	T3	
PRUDOXIN	T4	
REGRANEX	T5	PA
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %	T4	PA
SANTYL	T4	
<i>selenium sulfide topical lotion</i>	T2	
SILIQ	T5	PA; QL (6 ML per 28 days)
<i>silver sulfadiazine</i>	T2	
SSD	T2	
STELARA INTRAVENOUS	T5	PA; QL (104 ML per 180 days)
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	
TACLONEX TOPICAL SUSPENSION	T5	

Drug Name	Drug Tier	Requirements/Limits
<i>tacrolimus topical</i>	T2	
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
TOLAK	T4	
<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	
TRIANEX	T4	
TRIDERM TOPICAL CREAM 0.1 %	T2	
VALCHLOR	T4	PA-NS
VEREGEN	T5	
ZENATANE ORAL CAPSULE 30 MG	T2	
ZOVIRAX TOPICAL CREAM	T4	
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP	T5	
Diagnostics / Miscellaneous Agents		
<i>acamprosate</i>	T2	
ADAGEN	T5	
<i>alendronate oral tablet 40 mg</i>	T1	
<i>anagrelide</i>	T2	
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	
CHANTIX CONTINUING MONTH BOX	T4	
CHANTIX STARTING MONTH BOX	T4	
CHEMET	T4	
CLINIMIX 4.25%/D5W SULFIT FREE	T4	PA-BvD
CLINIMIX E 2.75%/D10W SUL FREE	T4	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
CLINIMIX E 2.75%/D5W SULF 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>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 %-lactated ringers</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>	T2	
ENDARI	T4	PA; QL (180 EA per 30 days)
<i>etidronate disodium oral tablet 200 mg</i>	T2	
<i>etidronate disodium oral tablet 400 mg</i>	T4	
EXJADE	T5	
FERRIPROX	T5	
FOSRENOL ORAL POWDER IN PACKET	T5	
FOSRENOL ORAL TABLET,CHEWABLE 1,000 MG, 500 MG	T5	
FOSRENOL ORAL TABLET,CHEWABLE 750 MG	T4	
GLASSIA	T5	PA
INCRELEX	T5	PA
KIONEX (WITH SORBITOL)	T4	
<i>lactated ringers irrigation</i>	T1	
<i>levocarnitine (with sugar)</i>	T2	PA-BvD
<i>levocarnitine oral tablet</i>	T2	PA-BvD
<i>midodrine</i>	T2	
<i>neomycin-polymyxin b gu</i>	T2	
NICOTROL	T4	
NICOTROL NS	T3	
NORTHERA	T5	PA
NUTRESTORE	T4	
ORFADIN	T5	
<i>pilocarpine hcl oral</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
PROLASTIN-C INTRAVENOUS RECON SOLN	T5	PA
RAVICTI	T5	PA
RENAGEL ORAL TABLET 800 MG	T4	
REVELA ORAL TABLET	T3	
<i>riluzole</i>	T4	
<i>ringer's irrigation</i>	T1	
<i>risedronate oral tablet 30 mg</i>	T2	
<i>sevelamer carbonate oral powder in packet</i>	T3	
<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>	T2	
SPS (WITH SORBITOL) ORAL	T2	
SYPRINE	T4	
THIOLA	T5	
<i>trientine</i>	T4	
VELPHORO	T5	
VELTASSA	T4	PA; QL (30 EA per 30 days)
<i>water for irrigation, sterile</i>	T2	
XURIDEN	T5	PA
ZEMAIRA	T5	PA
<i>zoledronic acid-mannitol-water</i>	T4	
Ear, Nose / Throat Medications		
<i>acetic acid otic (ear)</i>	T2	
<i>azelastine nasal</i>	T2	
BACTROBAN NASAL	T4	
<i>chlorhexidine gluconate mucous membrane</i>	T1	
CIPRO HC	T4	
CIPRODEX	T3	
<i>ciprofloxacin hcl otic (ear)</i>	T2	
COLY-MYCIN S	T4	
<i>fluocinolone acetonide oil</i>	T2	
<i>hydrocortisone-acetic acid</i>	T2	
<i>ipratropium bromide nasal</i>	T1	
<i>neomycin-polymyxin-hc otic (ear)</i>	T2	
<i>ofloxacin otic (ear)</i>	T2	
<i>olopatadine nasal</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
OTOVEL	T4	
PERIOGARD	T2	
<i>triamcinolone acetonide dental</i>	T2	
Endocrine/Diabetes		
<i>acarbose</i>	T2	QL (93 EA per 31 days)
ACTHAR H.P.	T5	PA
ACTOPLUS MET XR ORAL TABLET, ER MULTIPHASE 24 HR 15-1,000 MG	T4	QL (62 EA per 31 days)
ACTOPLUS MET XR ORAL TABLET, ER MULTIPHASE 24 HR 30-1,000 MG	T4	QL (31 EA per 31 days)
ALCOHOL PADS	T4	
ALDURAZYME	T5	
<i>alogliptin</i>	T4	QL (31 EA per 31 days)
<i>alogliptin-metformin</i>	T4	QL (62 EA per 31 days)
<i>alogliptin-pioglitazone</i>	T4	QL (31 EA per 31 days)
ANADROL-50	T4	PA
ANDRODERM	T3	PA
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	T3	PA
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)	T3	PA
APIDRA SOLOSTAR U-100 INSULIN	T4	
APIDRA U-100 INSULIN	T4	
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	
AVANDIA ORAL TABLET 2 MG, 4 MG	T4	
BASAGLAR KWIKPEN U-100 INSULIN	T3	
<i>cabergoline</i>	T2	
<i>calcitonin (salmon)</i>	T3	
<i>calcitriol intravenous solution 1 mcg/ml</i>	T2	PA-BvD
<i>calcitriol oral</i>	T2	PA-BvD
CERDELGA	T5	PA
CEREZYME INTRAVENOUS RECON SOLN 400 UNIT	T5	
<i>chorionic gonadotropin, human</i>	T4	PA-BvD
<i>cortisone</i>	T2	
CYCLOSET	T4	
<i>danazol</i>	T4	

Drug Name	Drug Tier	Requirements/Limits
DDAVP NASAL SOLUTION	T4	
DEPO-MEDROL	T4	
<i>desmopressin injection</i>	T2	
<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 sodium phosphate injection solution</i>	T2	
DEXPAK 13 DAY	T4	
<i>doxercalciferol intravenous</i>	T2	PA-BvD
<i>doxercalciferol oral capsule 0.5 mcg</i>	T2	PA-BvD
<i>doxercalciferol oral capsule 1 mcg, 2.5 mcg</i>	T5	PA-BvD
EMFLAZA	T5	PA
FABRAZYME	T5	PA
FARXIGA	T3	
FIASP FLEXTOUCH U-100 INSULIN	T3	
FIASP U-100 INSULIN	T3	
<i>fludrocortisone</i>	T2	
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T3	
<i>glimepiride</i>	T1	
<i>glipizide</i>	T1	
<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	

Drug Name	Drug Tier	Requirements/Limits
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 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)
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
KOMBIGLYZE XR	T4	
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	

Drug Name	Drug Tier	Requirements/Limits
<i>liothyronine</i>	T2	
LUMIZYME	T5	
MEDROL ORAL TABLET 2 MG	T4	
<i>metformin oral tablet</i>	T1	
<i>metformin oral tablet extended release 24 hr</i>	T1	Brand Ref (GLUCOPHAGE XR)
<i>metformin oral tablet extended release 24hr</i>	T4	PA; Brand Ref (FORTAMET)
<i>metformin oral tablet,er gast.retention 24 hr</i>	NF	Brand Ref (GLUMETZA)
<i>methimazole oral tablet 10 mg, 5 mg</i>	T2	
<i>methylprednisolone</i>	T2	
<i>methylprednisolone acetate</i>	T2	
<i>methylprednisolone sodium succ injection recon soln 125 mg, 40 mg</i>	T2	
<i>methylprednisolone sodium succ intravenous</i>	T2	
<i>methyltestosterone oral capsule</i>	T5	PA
MIACALCIN INJECTION	T4	PA-BvD
<i>miglitol</i>	T3	
<i>miglustat</i>	T5	PA
MILLIPRED ORAL TABLET	T4	
MYALEPT	T5	PA
NAGLAZYME	T5	
<i>nateglinide</i>	T1	QL (93 EA per 31 days)
NATPARA	T5	PA
NESINA	T4	QL (31 EA per 31 days)
NOVAREL	T4	PA-BvD
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	
ONGLYZA	T4	QL (31 EA per 31 days)
OSENI	T4	QL (31 EA per 31 days)
<i>oxandrolone oral tablet 10 mg</i>	T5	PA
<i>oxandrolone oral tablet 2.5 mg</i>	T3	PA
OZEMPIC	T3	QL (3 ML per 28 days)
PALYNZIQ	T5	PA

Drug Name	Drug Tier	Requirements/Limits
<i>pamidronate intravenous solution</i>	T2	PA-BvD
<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-glimepiride</i>	T2	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	
<i>prednisolone sodium phosphate oral tablet, disintegrating</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	
PREGNYL	T4	PA-BvD
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)
<i>repaglinide-metformin</i>	T2	QL (155 EA per 31 days)
RIOMET	T4	PA; QL (791 ML 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)
SOLU-CORTEF (PF) INJECTION RECON SOLN 100 MG/2 ML, 250 MG/2 ML	T4	
SOLU-MEDROL (PF)	T4	
SOLU-MEDROL INTRAVENOUS RECON SOLN 2 GRAM	T4	
SOMAVERT	T5	
STIMATE	T3	
STRENSIQ	T5	PA
SYMLINPEN 120	T3	QL (10.8 ML per 28 days)
SYMLINPEN 60	T3	QL (6 ML per 28 days)
SYNAREL	T5	
SYNJARDY	T3	
SYNJARDY XR	T3	

Drug Name	Drug Tier	Requirements/Limits
SYNTHROID	T4	
TAPERDEX	T4	
<i>testosterone cypionate</i>	T3	PA
<i>testosterone enanthate</i>	T3	PA
TIROSINT	T4	
<i>tolazamide</i>	T2	
<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	
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)
VPRIV	T5	
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 5-1,000 MG, 5-500 MG	T3	
XULTOPHY 100/3.6	T3	
ZAVESCA	T5	PA
<i>zoledronic acid intravenous solution</i>	T2	
Gastroenterology		
<i>alosetron</i>	T5	
ALOXI	T4	
AMITIZA	T3	QL (62 EA per 31 days)
<i>amoxicil-clarithromy-lansopraz</i>	T4	
ANZEMET ORAL	T4	PA-BvD
<i>aprepitant</i>	T4	PA-BvD
ASACOL HD	T3	
<i>atropine injection syringe 0.05 mg/ml</i>	T2	
<i>balsalazide</i>	T2	
BONJESTA	T4	PA; QL (62 EA per 31 days)
<i>budesonide oral</i>	T4	
CANASA	T3	
CARAFATE ORAL SUSPENSION	T3	

Drug Name	Drug Tier	Requirements/Limits
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	T3	
COLOCORT	T2	
COMPRO	T2	
CONSTULOSE	T2	
CREON	T3	
<i>cromolyn oral</i>	T5	
CUVPOSA	T4	
CYSTADANE	T4	
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)	T3	
<i>dicyclomine intramuscular</i>	T2	
<i>dicyclomine oral capsule</i>	T2	
<i>dicyclomine oral solution</i>	T2	
<i>dicyclomine oral tablet</i>	T2	
<i>diphenoxylate-atropine</i>	T2	
<i>dronabinol oral capsule 10 mg</i>	T5	PA-BvD
<i>dronabinol oral capsule 2.5 mg, 5 mg</i>	T4	PA-BvD
ENULOSE	T2	
<i>esomeprazole magnesium</i>	T4	QL (31 EA per 31 days)
<i>esomeprazole sodium</i>	T4	
<i>famotidine (pf)</i>	T1	
<i>famotidine (pf)-nacl (iso-os)</i>	T2	
<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 injection</i>	T2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T2	
GOLYTELY ORAL POWDER IN PACKET	T4	
<i>granisetron (pf) intravenous solution 100 mcg/ml</i>	T3	
<i>granisetron hcl intravenous</i>	T3	
<i>granisetron hcl oral</i>	T3	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
<i>hydrocortisone rectal</i>	T1	
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	T2	
INFLECTRA	T5	PA; QL (8 EA per 28 days)
<i>lactulose oral solution 10 gram/15 ml</i>	T2	
<i>lansoprazole oral capsule, delayed release(dr/ec) 15 mg</i>	T3	QL (31 EA per 31 days)
<i>lansoprazole oral capsule, delayed release(dr/ec) 30 mg</i>	T3	QL (62 EA per 31 days)
LIALDA	T3	
LINZESS	T3	QL (31 EA per 31 days)
<i>loperamide oral capsule</i>	T2	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	T2	
<i>mesalamine oral tablet, delayed release (dr/ec) 800 mg</i>	T4	
<i>mesalamine rectal</i>	T4	
<i>methscopolamine</i>	T2	
<i>metoclopramide hcl injection solution</i>	T2	
<i>metoclopramide hcl oral</i>	T2	
<i>misoprostol</i>	T2	
MOVANTI	T3	QL (31 EA per 31 days)
MOVIPREP	T4	
MYTESI	T4	QL (62 EA per 31 days)
OCALIVA	T5	PA; QL (31 EA per 31 days)
<i>omeprazole oral capsule, delayed release(dr/ec)</i>	T1	
<i>omeprazole-sodium bicarbonate</i>	T4	
<i>ondansetron</i>	T2	PA-BvD
<i>ondansetron hcl (pf)</i>	T2	
<i>ondansetron hcl oral</i>	T2	PA-BvD
OSMOPREP	T4	
<i>pantoprazole</i>	T2	
<i>peg 3350-electrolytes</i>	T2	
<i>peg-electrolyte soln</i>	T2	
PENTASA	T3	
<i>polyethylene glycol 3350 oral powder</i>	T2	
PREPOPIK	T4	
<i>prochlorperazine</i>	T2	
<i>prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)</i>	T2	
<i>prochlorperazine maleate</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
PROCTO-PAK	T2	
PROCTOSOL HC TOPICAL	T2	
PROCTOZONE-HC	T2	
<i>propantheline</i>	T2	
PYLERA	T4	
<i>rabeprazole</i>	T2	QL (62 EA per 31 days)
<i>ranitidine hcl injection solution 50 mg/2 ml (25 mg/ml)</i>	T4	
<i>ranitidine hcl oral capsule</i>	T2	
<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)
RELISTOR SUBCUTANEOUS SOLUTION	T4	QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	T5	QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	T5	QL (12.4 ML per 31 days)
REMICADE	T5	PA; QL (8 EA per 28 days)
RENFLEXIS	T5	PA; QL (8 EA per 28 days)
SANCUSO	T5	
<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	
<i>trimethobenzamide oral</i>	T2	PA
<i>ursodiol oral capsule</i>	T4	
<i>ursodiol oral tablet</i>	T3	
VARUBI ORAL	T4	PA-BvD
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	

Drug Name	Drug Tier	Requirements/Limits
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 25,000-79,000- 105,000 UNIT, 40,000-126,000- 168,000 UNIT	T5	
ZUPLENZ ORAL FILM 4 MG	T5	PA-BvD
ZUPLENZ ORAL FILM 8 MG	T4	PA-BvD
Immunology, Vaccines / Biotechnology		
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA-NS
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	T4	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 200 MCG/ML, 300 MCG/ML	T5	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML, 60 MCG/0.3 ML	T4	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML	T5	PA-BvD
ARCALYST	T5	PA
AVONEX (WITH ALBUMIN)	T5	QL (1 EA per 28 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	QL (4 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	QL (4 EA per 28 days)
<i>bcg vaccine, live (pf)</i>	T4	
BETASERON SUBCUTANEOUS KIT	T5	QL (15 EA per 31 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T4	
BOTOX	T4	PA
CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM	T5	PA
DAPTACEL (DTAP PEDIATRIC) (PF)	T4	
DYSPORT	T4	PA
EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG	T5	PA-NS

Drug Name	Drug Tier	Requirements/Limits
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
EXTAVIA SUBCUTANEOUS KIT	T5	QL (15 EA per 31 days)
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	T5	PA
<i>fomepizole</i>	T2	
GAMASTAN S/D	T4	PA
GAMMAGARD LIQUID	T5	PA
GAMMAGARD S-D (IGA < 1 MCG/ML)	T5	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GAMMAPLEX	T5	PA
GAMMAPLEX (WITH SORBITOL)	T5	PA
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	T5	
HAVRIX (PF)	T3	
HIBERIX (PF)	T4	
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT)	T5	PA
HUMATROPE INJECTION CARTRIDGE 6 MG (18 UNIT)	T4	PA
HUMATROPE INJECTION RECON SOLN	T5	PA
HYPERRAB S/D (PF)	T4	PA-BvD
ILARIS (PF) SUBCUTANEOUS SOLUTION	T5	PA
IMOGAM RABIES-HT (PF)	T4	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
IMOVAX RABIES VACCINE (PF)	T4	PA-BvD
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)	T4	
KINRIX (PF)	T4	
LEUKINE INJECTION RECON SOLN	T5	PA
MENACTRA (PF) INTRAMUSCULAR SOLUTION	T3	
MENVEO A-C-Y-W-135-DIP (PF)	T4	
MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML	T4	PA-BvD
M-M-R II (PF)	T4	
MOZOBIL	T5	PA
NEULASTA SUBCUTANEOUS SYRINGE	T5	
NEUPOGEN INJECTION SOLUTION 300 MCG/ML	T4	
NEUPOGEN INJECTION SYRINGE	T5	
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML)	T5	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
NUTROPIN AQ NUSPIN	T5	PA
OCTAGAM	T5	PA
OMNITROPE	T5	PA
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	T4	PA
PEDIARIX (PF)	T4	PA-BvD
PEDVAX HIB (PF)	T4	

Drug Name	Drug Tier	Requirements/Limits
PEGASYS	T5	PA
PEGASYS PROCLICK	T5	PA
PLEGRIDY	T5	QL (1 ML per 28 days)
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	T5	PA-BvD
PROLEUKIN	T5	
PROQUAD (PF)	T3	
QUADRACEL (PF)	T4	
RABAVERT (PF)	T4	PA-BvD
REBIF (WITH ALBUMIN)	T5	QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	T5	QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	T5	QL (4.2 ML per 365 days)
REBIF TITRATION PACK	T5	QL (8.4 ML per 365 days)
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	T4	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	T4	PA-BvD
ROTARIX	T4	
ROTATEQ VACCINE	T3	
SAIZEN	T5	PA
SAIZEN SAIZENPREP	T5	PA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	T5	PA
SHINGRIX (PF)	T3	
SYLATRON	T5	PA-NS
TENIVAC (PF) INTRAMUSCULAR SYRINGE	T4	
<i>tetanus,diphtheria tox ped(pf)</i>	T4	
<i>tetanus-diphtheria toxoids-td</i>	T3	
TRUMENBA	T3	
TWINRIX (PF) INTRAMUSCULAR SYRINGE	T3	
TYPHIM VI INTRAMUSCULAR SOLUTION	T3	

Drug Name	Drug Tier	Requirements/Limits
TYPHIM VI INTRAMUSCULAR SYRINGE	T4	
VAQTA (PF)	T3	
VARIVAX (PF)	T3	
VARIZIG INTRAMUSCULAR SOLUTION	T4	
XEOMIN INTRAMUSCULAR RECON SOLN 50 UNIT	T4	PA
YF-VAX (PF)	T3	
ZARXIO	T5	
ZINPLAVA	T5	PA
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG	T5	PA
ZOMACTON SUBCUTANEOUS RECON SOLN 5 MG	T4	PA
ZORBTIVE	T5	PA
ZOSTAVAX (PF)	T3	
Musculoskeletal / Rheumatology		
ACTEMRA INTRAVENOUS	T5	PA; QL (40 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
<i>alendronate oral solution</i>	T2	
<i>alendronate oral tablet 10 mg</i>	T2	
<i>alendronate oral tablet 35 mg, 5 mg, 70 mg</i>	T1	
<i>allopurinol</i>	T1	
<i>allopurinol sodium</i>	T5	
ALOPRIM	T2	
BENLYSTA INTRAVENOUS RECON SOLN 120 MG	T4	
BENLYSTA INTRAVENOUS RECON SOLN 400 MG	T5	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
<i>colchicine oral tablet</i>	T4	
CUPRIMINE	T5	
DEPEN TITRATABS	T5	
ENBREL SUBCUTANEOUS RECON SOLN	T5	PA; QL (8 EA per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51)	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (0.98 ML)	T5	PA; QL (7.84 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (7.84 ML per 28 days)
FORTEO	T5	PA; QL (2.4 ML per 28 days)
HUMIRA	T5	PA; QL (2 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (6 PACK)	T5	PA; QL (6 EA per 28 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 80 MG/0.8 ML	T5	PA; QL (3 EA per 28 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA PEN CROHN'S-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN CROHN'S-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	T5	PA; QL (3 EA per 28 days)
HUMIRA PEN PSORIASIS-UVEITIS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	T5	PA; QL (4 EA per 28 days)
HUMIRA PEN PSORIASIS-UVEITIS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML	T5	PA; QL (3 EA per 28 days)
<i>ibandronate intravenous solution</i>	T2	PA-BvD
<i>ibandronate oral</i>	T2	
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	T5	PA; QL (31 EA per 31 days)
ORENCIA (WITH MALTOSE)	T5	PA; QL (8 EA per 28 days)
ORENCIA CLICKJECT	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	T5	PA; QL (2.8 ML per 28 days)
OTEZLA	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (55 EA per 28 days)
<i>probenecid</i>	T2	
<i>probenecid-colchicine</i>	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)

Drug Name	Drug Tier	Requirements/Limits
<i>raloxifene</i>	T3	
RIDAURA	T4	
<i>risedronate</i>	T2	
SAVELLA	T4	PA
SIMPONI ARIA	T5	PA; QL (16 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 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	
XELJANZ	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
ZURAMPIC	T4	
Obstetrics / Gynecology		
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
AMABELZ	T2	
AMETHIA	T2	
AMETHIA LO	T2	
ANGELIQ ORAL TABLET 0.5-1 MG	T4	
APRI	T2	
ARANELLE (28)	T2	
ASHLYNA	T2	
AVC VAGINAL	T4	
AVIANE	T2	
BALZIVA (28)	T2	
BEKYREE (28)	T2	
BLISOVI 24 FE	T2	
BLISOVI FE 1.5/30 (28)	T2	
BLISOVI FE 1/20 (28)	T2	
BRIELLYN	T2	
CAMILA	T2	
CAMRESE LO	T2	
CAZIANZ (28)	T2	

Drug Name	Drug Tier	Requirements/Limits
CLEOCIN VAGINAL SUPPOSITORY	T4	
CLIMARA PRO	T4	
<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	
DEPO-ESTRADIOL	T4	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	T4	
<i>desogestrel-ethinyl estradiol</i>	T2	
DIVIGEL TRANSDERMAL GEL IN PACKET 1 MG/GRAM (0.1 %)	T4	
<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	
ESTRACE VAGINAL	T4	
<i>estradiol oral</i>	T2	
<i>estradiol transdermal</i>	T2	
<i>estradiol vaginal</i>	T4	
<i>estradiol valerate intramuscular oil 20 mg/ml</i>	T2	
<i>estradiol-norethindrone acet</i>	T2	
ESTRING	T4	
<i>estropipate oral tablet 0.75 mg</i>	T2	
<i>ethynodiol diac-eth estradiol</i>	T2	
EVAMIST	T4	
FAYOSIM	T2	
FEMRING	T4	
FEMYNOR	T2	
FYAVOLV	T2	
GYNAZOLE-1	T4	
<i>hydroxyprogesterone caproate</i>	T5	
INCASSIA	T2	

Drug Name	Drug Tier	Requirements/Limits
INTRAROSA	T4	PA
INTROVALE	T2	
ISIBLOOM	T2	
JINTELI	T2	
JOLIVETTE	T2	
JULEBER	T2	
JUNEL 1.5/30 (21)	T2	
JUNEL 1/20 (21)	T2	
JUNEL FE 1.5/30 (28)	T2	
JUNEL FE 1/20 (28)	T2	
JUNEL FE 24	T2	
KAITLIB FE	T2	
KARIVA (28)	T2	
KELNOR 1/35 (28)	T2	
KELNOR 1-50	T2	
KIMIDESS (28)	T2	
KURVELO	T2	
<i>l norgest/e.estradiol-e.estrad</i>	T2	
LARISSIA	T2	
LAYOLIS FE	T2	
LESSINA	T2	
LEVONEST (28)	T2	
<i>levonorgestrel-ethinyl estrad</i>	T2	
<i>levonorg-eth estrad triphasic</i>	T2	
LEVORA-28	T2	
LO LOESTRIN FE	T4	
LORYNA (28)	T2	
LOW-OGESTREL (28)	T2	
LUTERA (28)	T2	
LYZA	T2	
MAKENA (PF)	T5	
MAKENA INTRAMUSCULAR OIL 250 MG/ML (1 ML)	T5	
MARLISSA	T2	
<i>medroxyprogesterone</i>	T2	
MELODETTA 24 FE	T2	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	T4	
<i>metronidazole vaginal</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
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	
MONONESSA (28)	T2	
NECON 0.5/35 (28)	T2	
NECON 7/7/7 (28)	T2	
<i>noreth-ethinyl estradiol-iron</i>	T2	
<i>norethindrone (contraceptive)</i>	T2	
<i>norethindrone acetate</i>	T2	
<i>norethindrone ac-eth estradiol</i>	T2	
<i>norethindrone-e.estradiol-iron oral tablet,chewable</i>	T2	
<i>norgestimate-ethinyl estradiol</i>	T2	
NORTREL 0.5/35 (28)	T2	
NORTREL 1/35 (21)	T2	
NORTREL 1/35 (28)	T2	
NORTREL 7/7/7 (28)	T2	
NUVARING	T3	
OGESTREL (28)	T2	
ORSYTHIA	T2	
OSPHENA	T4	PA
PIMTREA (28)	T2	
PIRMELLA ORAL TABLET 1-35 MG-MCG	T2	
PORTIA	T2	
PREFEST	T4	
PREMARIN VAGINAL	T3	
PREVIFEM	T2	
<i>progesterone micronized</i>	T2	
QUASENSE	T2	
RECLIPSEN (28)	T2	
RIVELSA	T2	
SETLAKIN	T2	
SPRINTEC (28)	T2	
SRONYX	T2	

Drug Name	Drug Tier	Requirements/Limits
SYEDA	T2	
<i>terconazole</i>	T2	
<i>tranexamic acid oral</i>	T3	
TRI-LEGEST FE	T2	
TRI-LO-ESTARYLLA	T2	
TRI-LO-SPRINTEC	T2	
TRI-MILI	T2	
TRINESSA (28)	T2	
TRI-PREVIFEM (28)	T2	
TRI-SPRINTEC (28)	T2	
TRIVORA (28)	T2	
TRI-VYLIBRA	T2	
TYDEMY	T2	
VAGIFEM	T4	
VANDAZOLE	T2	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VIENVA	T2	
VYFEMLA (28)	T2	
VYLIBRA	T2	
YUVAFEM	T4	
ZARAH	T2	
ZOVIA 1/35E (28)	T2	
Ophthalmology		
<i>acetazolamide</i>	T2	
<i>acetazolamide sodium</i>	T2	
ACUVAIL (PF)	T4	
ALOCRIAL	T4	
ALOMIDE	T3	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
<i>apraclonidine</i>	T2	
<i>atropine ophthalmic (eye) drops</i>	T2	
AZASITE	T4	
<i>azelastine ophthalmic (eye)</i>	T2	
AZOPT	T3	
<i>bacitracin ophthalmic (eye)</i>	T2	
<i>bacitracin-polymyxin b ophthalmic (eye)</i>	T2	
BESIVANCE	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>betaxolol ophthalmic (eye)</i>	T2	
BETIMOL	T4	
BETOPTIC S	T4	
<i>bimatoprost ophthalmic (eye)</i>	T2	
BLEPH-10	T4	
BLEPHAMIDE	T4	
BLEPHAMIDE S.O.P.	T4	
<i>brimonidine</i>	T2	
<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>epinastine</i>	T2	
<i>erythromycin ophthalmic (eye)</i>	T2	
<i>fluorometholone</i>	T2	
<i>flurbiprofen sodium</i>	T2	
<i>gatifloxacin</i>	T2	
GENTAK OPHTHALMIC (EYE) OINTMENT	T2	
<i>gentamicin ophthalmic (eye) drops</i>	T2	
ILEVRO	T3	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	T3	
ISTALOL	T4	
<i>ketorolac ophthalmic (eye)</i>	T2	
LACRISERT	T4	
LASTACAFT	T4	
<i>latanoprost</i>	T2	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	T1	
<i>levofloxacin ophthalmic (eye)</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
<i>methazolamide</i>	T4	
<i>metipranolol</i>	T2	
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>	T2	
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	T2	
NEVANAC	T4	
<i>ofloxacin ophthalmic (eye)</i>	T2	
<i>olopatadine ophthalmic (eye)</i>	T3	
PAZEO	T3	
PHOSPHOLINE IODIDE	T4	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T2	
<i>polymyxin b sulf-trimethoprim</i>	T2	
PRED-G	T4	
PRED-G S.O.P.	T4	
<i>prednisolone acetate</i>	T3	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	T2	
RESTASIS	T3	
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	
TIMOPTIC OCUDOSE (PF)	T4	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
TOBRADEX ST	T3	
<i>tobramycin</i>	T2	
<i>tobramycin-dexamethasone</i>	T2	
TOBREX OPHTHALMIC (EYE) OINTMENT	T4	

Drug Name	Drug Tier	Requirements/Limits
TRAVATAN Z	T3	
<i>trifluridine</i>	T2	
XIIDRA	T4	
ZIOPTAN (PF)	T4	
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)
ADRENALIN INJECTION SOLUTION 1 MG/ML (1 ML)	T2	
ADVAIR DISKUS	T4	QL (60 EA per 30 days)
ADVAIR HFA	T4	QL (12 GM per 30 days)
<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>	T2	
<i>albuterol sulfate oral tablet extended release 12 hr</i>	T2	
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
ASMANEX HFA	T3	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 220 MCG (120 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES)	T3	QL (1 EA per 30 days)
ATROVENT HFA	T3	QL (25.8 GM per 30 days)
BECONASE AQ	T4	
BERINERT INTRAVENOUS KIT	T5	PA
BEVESPI AEROSPHERE	T3	QL (10.7 GM per 30 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BROVANA	T4	PA-BvD
<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)
CLARINEX-D 12 HOUR	T4	
COMBIVENT RESPIMAT	T4	QL (4 GM per 30 days)
<i>cromolyn inhalation</i>	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
<i>cyproheptadine oral syrup</i>	T4	
<i>cyproheptadine oral tablet</i>	T2	
DALIRESP	T4	QL (31 EA per 31 days)
<i>desloratadine</i>	T2	
<i>diphenhydramine hcl injection solution 50 mg/ml</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 nasal</i>	T2	
<i>fluticasone-salmeterol</i>	T3	QL (1 EA per 30 days)
HAEGARDA	T5	PA
<i>hydroxyzine hcl intramuscular</i>	T2	PA
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	T2	PA
<i>hydroxyzine hcl oral tablet</i>	T2	PA
<i>ipratropium bromide inhalation</i>	T2	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
LETAIRIS	T5	PA; QL (31 EA per 31 days)
<i>levalbuterol hcl</i>	T2	PA-BvD
<i>levalbuterol tartrate</i>	T4	QL (30 GM per 30 days)
<i>levocetirizine</i>	T2	
<i>metaproterenol</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 TABLET	T5	PA; QL (124 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
PERFOROMIST	T4	PA-BvD
PHENADOZ RECTAL SUPPOSITORY 12.5 MG	T2	
PROAIR HFA	T3	QL (17 GM per 30 days)
PROAIR RESPICLICK	T3	QL (2 EA per 30 days)
<i>promethazine injection solution</i>	T2	
<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	
PROMETHAZINE VC	T2	
PROMETHEGAN RECTAL SUPPOSITORY 25 MG, 50 MG	T3	
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 INTRAVENOUS	T5	PA
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	T5	PA; QL (224 ML per 31 days)
REVATIO ORAL TABLET	T5	PA; QL (93 EA per 31 days)
RUCONEST	T5	PA
SEMPREX-D	T4	
SEREVENT DISKUS	T4	QL (60 EA per 30 days)
<i>sildenafil (antihypertensive) intravenous</i>	T5	PA
<i>sildenafil (antihypertensive) oral</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>terbutaline oral</i>	T4	
<i>terbutaline subcutaneous</i>	T5	
THEO-24	T4	
<i>theophylline oral solution</i>	T2	
<i>theophylline oral tablet extended release 12 hr 100 mg, 200 mg, 300 mg</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<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)
<i>triamcinolone acetonide nasal</i>	T3	
VENTAVIS	T5	PA-BvD
VENTOLIN HFA	T3	QL (36 GM per 30 days)
XOLAIR	T5	PA
<i>zafirlukast</i>	T2	
<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>	T4	
<i>dutasteride</i>	T3	QL (31 EA per 31 days)
<i>dutasteride-tamsulosin</i>	T3	QL (31 EA per 31 days)
ELMIRON	T4	
<i>finasteride oral tablet 5 mg</i>	T2	
<i>flavoxate</i>	T2	
GELNIQUE TRANSDERMAL GEL IN PACKET	T4	QL (30 GM per 30 days)
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)
OXYTROL	T4	QL (8 EA per 28 days)
<i>potassium citrate</i>	T2	
PROCYSBI	T5	PA
RAPAFLO	T3	
<i>tamsulosin</i>	T2	
<i>tolterodine oral capsule, extended release 24hr</i>	T4	QL (31 EA per 31 days)
<i>tolterodine oral tablet 1 mg</i>	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>tolterodine oral tablet 2 mg</i>	T4	QL (62 EA per 31 days)
TOVIAZ	T4	QL (31 EA per 31 days)
<i>tropium oral capsule,extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>tropium oral tablet</i>	T2	QL (93 EA per 31 days)
VESICARE	T4	QL (31 EA per 31 days)
Vitamins, Hematinics / Electrolytes		
AMINOSYN 7 % WITH ELECTROLYTES	T4	PA-BvD
AMINOSYN 8.5 %-ELECTROLYTES	T4	PA-BvD
AMINOSYN II 10 %	T4	PA-BvD
AMINOSYN II 15 %	T4	PA-BvD
AMINOSYN II 8.5 %	T4	PA-BvD
AMINOSYN II 8.5 %-ELECTROLYTES	T4	PA-BvD
AMINOSYN-HBC 7%	T4	PA-BvD
AMINOSYN-PF 10 %	T4	PA-BvD
AMINOSYN-PF 7 % (SULFITE-FREE)	T4	PA-BvD
AMINOSYN-RF 5.2 %	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 2.75%/D5W SULFIT FREE	T4	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T4	PA-BvD
CLINIMIX 4.25%-D20W SULF-FREE	T4	PA-BvD
CLINIMIX 4.25%-D25W SULF-FREE	T4	PA-BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	T4	PA-BvD
CLINIMIX E 4.25%/D10W SUL FREE	T4	PA-BvD
CLINIMIX E 4.25%/D25W SUL FREE	T4	PA-BvD
CLINIMIX E 4.25%/D5W SULF FREE	T4	PA-BvD
CLINIMIX E 5%/D15W SULFIT FREE	T4	PA-BvD
CLINIMIX E 5%/D20W SULFIT FREE	T4	PA-BvD
CLINIMIX E 5%/D25W SULFIT FREE	T4	PA-BvD
CLINISOL SF 15 %	T4	PA-BvD
<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
INTRALIPID INTRAVENOUS EMULSION 30 %	T4	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
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	T2	
K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ, 20 MEQ	T4	
K-TAB ORAL TABLET EXTENDED RELEASE 8 MEQ	T2	
<i>lactated ringers intravenous</i>	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
NUTRILIPID	T4	PA-BvD
PHOSLYRA	T4	
PLASMA-LYTE 148	T4	PA-BvD
PLASMA-LYTE A	T4	PA-BvD
PLENAMINE	T3	PA-BvD
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<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 solution</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	

Drug Name	Drug Tier	Requirements/Limits
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<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
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PROCALAMINE 3%	T4	PA-BvD
PROSOL 20 %	T4	PA-BvD
<i>ringer's intravenous</i>	T2	
<i>sodium chloride 0.45 % intravenous parenteral solution</i>	T2	
<i>sodium chloride 3 %</i>	T2	
<i>sodium chloride 5 %</i>	T2	
<i>sodium chloride intravenous parenteral solution 2.5 meq/ml</i>	T2	
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CAYSTON	6	CINRYZE	73	CLINIMIX E 5%/D20W	
CAZIENT (28)	66	CIPRO HC	50	SULFIT FREE	77
<i>cefaclor</i>	6	CIPRODEX	50	CLINIMIX E 5%/D25W	
<i>cefadroxil</i>	6	<i>ciprofloxacin</i>	7	SULFIT FREE	77
<i>cefazolin</i>	6	<i>ciprofloxacin (mixture)</i>	7	CLINISOL SF 15 %	77
<i>cefdinir</i>	6	<i>ciprofloxacin hcl</i>	7, 50, 71	<i>clobetasol</i>	44
<i>cefepime</i>	6	<i>ciprofloxacin in 5 % dextrose</i>	7	CLODERM	44
<i>cefixime</i>	6	<i>cisplatin</i>	15	<i>clofarabine</i>	15
<i>cefotaxime</i>	6	<i>citalopram</i>	23	<i>clomipramine</i>	23
<i>cefotetan</i>	6	<i>cladribine</i>	15	<i>clonazepam</i>	23, 24
<i>cefoxitin</i>	6	CLARAVIS	44	<i>clonidine</i>	38
<i>cefpodoxime</i>	6	CLARINEX-D 12 HOUR	73	<i>clonidine hcl</i>	24, 38
<i>cefprozil</i>	6	<i>clarithromycin</i>	7	<i>clopidogrel</i>	38
<i>ceftazidime</i>	6	CLENPIQ	57	<i>clorazepate dipotassium</i>	24
<i>ceftriaxone</i>	6	CLEOCIN	67	<i>clotrimazole</i>	7, 45
<i>cefuroxime axetil</i>	6	CLIMARA PRO	67	<i>clotrimazole-betamethasone</i>	45
<i>cefuroxime sodium</i>	6, 7	CLINDACIN P	44	<i>clozapine</i>	24
<i>celecoxib</i>	23	<i>clindamycin hcl</i>	7	COARTEM	7
CELLCEPT INTRAVENOUS	15	<i>clindamycin in 5 % dextrose</i>	7	<i>colchicine</i>	64
CELONTIN	23	<i>clindamycin palmitate hcl</i>	7	<i>colesevelam</i>	38
<i>cephalexin</i>	7	<i>clindamycin phosphate</i>	7, 44, 67	<i>colestipol</i>	38
CERDELGA	51	<i>clindamycin-benzoyl peroxide</i>	44	<i>colistin (colistimethate na)</i>	7
CEREZYME	51	<i>clindamycin-tretinoin</i>	44	COLOCORT	57
<i>cetirizine</i>	73	CLINDESSE	67	COLY-MYCIN S	50
<i>cevimeline</i>	48	CLINIMIX 5%/D15W		COMBIGAN	71
CHANTIX	48	SULFITE FREE	77	COMBIVENT RESPIMAT	73
CHANTIX CONTINUING		CLINIMIX 5%/D25W		COMETRIQ	15
MONTH BOX	48	SULFITE-FREE	77	COMPLERA	7
CHANTIX STARTING		CLINIMIX 2.75%/D5W		COMPRO	57
MONTH BOX	48	SULFIT FREE	77	CONDYLOX	45
CHEMET	48	CLINIMIX 4.25%/D10W		CONSTULOSE	57
<i>chloramphenicol sod succinate</i>	7	SULF FREE	77	COPAXONE	24
<i>chlorhexidine gluconate</i>	50	CLINIMIX 4.25%/D5W		CORDRAN TAPE LARGE	
<i>chloroquine phosphate</i>	7	SULFIT FREE	48	ROLL	45
<i>chlorothiazide</i>	37	CLINIMIX 4.25%-D20W		CORLANOR	38
<i>chlorothiazide sodium</i>	37	SULF-FREE	77	<i>cortisone</i>	51
<i>chlorpromazine</i>	23	CLINIMIX 4.25%-D25W		CORTISPORIN	45
<i>chlorthalidone</i>	37	SULF-FREE	77	COSENTYX (2 SYRINGES) ...	45
CHOLBAM	57	CLINIMIX 5%-		COSENTYX PEN (2 PENS)	45
<i>cholestyramine (with sugar)</i>	38	D20W(SULFITE-FREE)	77	COTELLIC	15
CHOLESTYRAMINE		CLINIMIX E 2.75%/D10W		COUMADIN	38
LIGHT	38	SUL FREE	48	CREON	57
<i>chorionic gonadotropin, human</i> . 51		CLINIMIX E 2.75%/D5W		CRESEMBA	7
CIALIS	76	SULF FREE	49	CRINONE	67
<i>ciclopirox</i>	44	CLINIMIX E 4.25%/D10W		CRIXIVAN	7
<i>cilostazol</i>	38	SUL FREE	77	<i>cromolyn</i>	57, 71, 73
CILOXAN	71	CLINIMIX E 4.25%/D25W		CRYSELLE (28)	67
CIMDUO	7	SUL FREE	77	CUBICIN	7
CIMZIA	57	CLINIMIX E 4.25%/D5W		CUPRIMINE	64
		SULF FREE	77	CUVPOSA	57

CYCLAFEM 1/35 (28)	67	<i>desvenlafaxine succinate</i>	24	<i>doripenem</i>	7
CYCLAFEM 7/7/7 (28)	67	<i>dexamethasone</i>	52	<i>dorzolamide</i>	71
<i>cyclobenzaprine</i>	24	DEXAMETHASONE		<i>dorzolamide-timolol</i>	71
<i>cyclophosphamide</i>	15	INTENSOL	52	<i>doxazosin</i>	38
CYCLOSET	51	<i>dexamethasone sodium</i>		<i>doxepin</i>	25, 45
<i>cyclosporine</i>	15	<i>phosphate</i>	52, 71	<i>doxercalciferol</i>	52
<i>cyclosporine modified</i>	15	<i>dexmethylphenidate</i>	24	<i>doxorubicin</i>	15
<i>cyproheptadine</i>	74	DEXPAK 13 DAY	52	<i>doxorubicin, peg-liposomal</i>	15
CYSTADANE	57	<i>dexrazoxane hcl</i>	15	DOXY-100	7
CYSTAGON	76	<i>dextroamphetamine</i>	24	<i>doxycycline hyclate</i>	7, 8
CYSTARAN	71	<i>dextroamphetamine-</i>		<i>doxycycline monohydrate</i>	8
<i>cytarabine</i>	15	<i>amphetamine</i>	24	<i>dronabinol</i>	57
<i>cytarabine (pf)</i>	15	<i>dextrose 10 % and 0.2 % nacl</i> ...	49	<i>drospirenone-e.estradiol-lm.fa</i> ...	67
<i>d10 %-0.45 % sodium chloride</i> ...	49	<i>dextrose 10 % in water (d10w)</i> ...	49	<i>drospirenone-ethinyl estradiol</i> ...	67
<i>d2.5 %-0.45 % sodium chloride</i> ...	49	<i>dextrose 5 % in water (d5w)</i>	49	DROXIA	15
<i>d5 % and 0.9 % sodium</i>		<i>dextrose 5 %-lactated ringers</i>	49	<i>duloxetine</i>	25
<i>chloride</i>	49	<i>dextrose 5%-0.2 % sod chloride</i> ...	49	DUPIXENT	45
<i>d5 %-0.45 % sodium chloride</i>	49	<i>dextrose 5%-0.3 % sod.chloride</i> ...	49	DURAMORPH (PF)	25
<i>dacarbazine</i>	15	DEXTROSE WITH SODIUM		DUREZOL	71
<i>dactinomycin</i>	15	CHLORIDE	49	<i>dutasteride</i>	76
DAKLINZA	7	DIASTAT	24	<i>dutasteride-tamsulosin</i>	76
DALIRESP	74	<i>diazepam</i>	24	DYMISTA	74
DALVANCE	7	DIAZEPAM INTENSOL	24	DYRENIUM	38
<i>danazol</i>	51	<i>diclofenac potassium</i>	24	DYSPORT	60
<i>dantrolene</i>	24	<i>diclofenac sodium</i>	24, 25, 45, 71	E.E.S. 400	8
<i>dapsone</i>	7, 45	<i>diclofenac-misoprostol</i>	25	<i>econazole</i>	45
DAPTACEL (DTAP		<i>dicloxacillin</i>	7	EDARBYCLOR	38
PEDIATRIC) (PF)	60	<i>dicyclomine</i>	57	EDURANT	8
<i>daptomycin</i>	7	<i>didanosine</i>	7	<i>efavirenz</i>	8
DARAPRIM	7	DIFFERIN	45	EFFIENT	38
<i>darifenacin</i>	76	DIFICID	7	EGRIFTA	60
DARZALEX	15	<i>diflorasone</i>	45	<i>eletriptan</i>	25
<i>daunorubicin</i>	15	<i>diflunisal</i>	25	ELIDEL	45
DAYTRANA	24	DIGITEK	38	ELIGARD	15
DDAVP	52	DIGOX	38	ELIGARD (3 MONTH)	15
DELZICOL	57	<i>digoxin</i>	38	ELIGARD (4 MONTH)	15
<i>demeclocycline</i>	7	<i>dihydroergotamine</i>	25	ELIGARD (6 MONTH)	15
DEMSEK	38	DILANTIN	25	ELIQUIS	38, 39
DENAVIR	45	DILANTIN EXTENDED	25	ELITEK	15
DEPEN TITRATABS	64	DILANTIN INFATABS	25	ELMIRON	76
DEPO-ESTRADIOL	67	DILANTIN-125	25	EMCYT	15
DEPO-MEDROL	52	<i>diltiazem hcl</i>	38	EMFLAZA	52
DEPO-PROVERA	67	DILT-XR	38	EMOQUETTE	67
DESCOVY	7	<i>diphenhydramine hcl</i>	74	EMSAM	25
<i>desipramine</i>	24	<i>diphenoxylate-atropine</i>	57	EMTRIVA	8
<i>desloratadine</i>	74	<i>disulfiram</i>	49	EMVERM	8
<i>desmopressin</i>	52	<i>divalproex</i>	25	<i>enalapril maleate</i>	39
<i>desogestrel-ethinyl estradiol</i>	67	DIVIGEL	67	<i>enalapril-hydrochlorothiazide</i> ...	39
DESONATE	45	<i>docetaxel</i>	15	ENBREL	64
<i>desonide</i>	45	<i>dofetilide</i>	38	ENBREL SURECLICK	64
<i>desoximetasone</i>	45	<i>donepezil</i>	25	ENDARI	49
<i>desvenlafaxine</i>	24	DOPTELET	38	ENDOCET	25

ENGERIX-B (PF)	61	<i>ethacrynic acid</i>	39	<i>flavoxate</i>	76
ENGERIX-B PEDIATRIC (PF)	61	<i>ethambutol</i>	8	FLEBOGAMMA DIF	61
<i>enoxaparin</i>	39	<i>ethosuximide</i>	25	<i>flecainide</i>	39
ENPRESSE	67	<i>ethynodiol diac-eth estradiol</i>	67	FLECTOR	26
ENSKYCE	67	<i>etidronate disodium</i>	49	<i>fluconazole</i>	8
<i>entacapone</i>	25	<i>etodolac</i>	25	<i>fluconazole in nacl (iso-osm)</i>	8
<i>entecavir</i>	8	<i>etoposide</i>	15	<i>flucytosine</i>	8
ENTRESTO	39	EURAX	45	<i>fludarabine</i>	16
ENULOSE	57	EVAMIST	67	<i>fludrocortisone</i>	52
ENVARUSUS XR	15	EVOTAZ	8	<i>flunisolide</i>	74
EPCLUSA	8	EXELDERM	45	<i>fluocinolone</i>	45
EPIDUO FORTE	45	<i>exemestane</i>	15	<i>fluocinolone acetonide oil</i>	50
<i>epinastine</i>	71	EXJADE	49	<i>fluocinolone and shower cap</i>	45
<i>epinephrine</i>	74	EXONDYS 51	25	<i>fluocinonide</i>	45
<i>epirubicin</i>	15	EXTAVIA	61	FLUOCINONIDE-E	46
EPITOL	25	<i>ezetimibe</i>	39	<i>fluoride (sodium)</i>	77
EPIVIR HBV	8	<i>ezetimibe-simvastatin</i>	39	<i>fluorometholone</i>	71
<i>eplerenone</i>	39	FABRAZYME	52	<i>fluorouracil</i>	16, 46
<i>eprosartan</i>	39	<i>famciclovir</i>	8	<i>fluoxetine</i>	26
EPZICOM	8	<i>famotidine</i>	57	<i>fluphenazine decanoate</i>	26
EQUETRO	25	<i>famotidine (pf)</i>	57	<i>fluphenazine hcl</i>	27
ERAXIS(WATER DILUENT) ..	8	<i>famotidine (pf)-nacl (iso-os)</i>	57	<i>flurandrenolide</i>	46
<i>ergoloid</i>	25	FANAPT	26	<i>flurbiprofen</i>	27
<i>ergotamine-caffeine</i>	25	FARESTON	15	<i>flurbiprofen sodium</i>	71
ERIVEDGE	15	FARXIGA	52	<i>flutamide</i>	16
ERLEADA	15	FARYDAK	15	<i>fluticasone</i>	46, 74
ERRIN	67	FASENRA	74	<i>fluticasone-salmeterol</i>	74
ERY PADS	45	FASLODEX	15	<i>fluvastatin</i>	39
ERYGEL	45	FAYOSIM	67	<i>fluvoxamine</i>	27
ERYPED 200	8	<i>felbamate</i>	26	FOLOTYN	16
ERYPED 400	8	<i>felodipine</i>	39	<i>fomepizole</i>	61
ERY-TAB	8	FEMRING	67	<i>fondaparinux</i>	39
ERYTHROCIN	8	FEMYNOR	67	FORTEO	64
ERYTHROCIN (AS STEARATE)	8	<i>fenofibrate</i>	39	<i>fosamprenavir</i>	8
<i>erythromycin</i>	8, 71	<i>fenofibrate micronized</i>	39	<i>fosinopril</i>	39
<i>erythromycin ethylsuccinate</i>	8	<i>fenofibrate nanocrystallized</i>	39	<i>fosinopril-hydrochlorothiazide</i> ...	39
<i>erythromycin with ethanol</i>	45	<i>fenofibric acid</i>	39	<i>fosphenytoin</i>	27
<i>erythromycin-benzoyl peroxide</i> ..	45	<i>fenofibric acid (choline)</i>	39	FOSRENOL	49
ESBRIET	74	<i>fenopropfen</i>	26	FRAGMIN	39, 40
<i>escitalopram oxalate</i>	25	<i>fentanyl</i>	26	FREAMINE HBC 6.9 %	77
<i>esomeprazole magnesium</i>	57	<i>fentanyl citrate</i>	26	<i>frovatriptan</i>	27
<i>esomeprazole sodium</i>	57	FENTORA	26	<i>furosemide</i>	40
ESTARYLLA	67	FERRIPROX	49	FUSILEV	16
ESTRACE	67	FETZIMA	26	FUZEON	8
<i>estradiol</i>	67	FIASP FLEXTOUCH U-100		FYAVOLV	67
<i>estradiol valerate</i>	67	INSULIN	52	FYCOMPA	27
<i>estradiol-norethindrone acet</i>	67	FIASP U-100 INSULIN	52	<i>gabapentin</i>	27
ESTRING	67	FINACEA	45	<i>galantamine</i>	27
<i>estropipate</i>	67	<i>finasteride</i>	76	GAMASTAN S/D	61
<i>eszopiclone</i>	25	FIRAZYR	74	GAMMAGARD LIQUID	61
		FIRMAGON KIT W		GAMMAGARD S-D (IGA < 1	
		DILUENT SYRINGE	16	MCG/ML)	61

GAMMAKED	61	<i>guanfacine</i>	27	HUMULIN R U-500 (CONC)	
GAMMAPLEX	61	<i>guanidine</i>	27	INSULIN	53
GAMMAPLEX (WITH		GYNAZOLE-1	67	HUMULIN R U-500 (CONC)	
SORBITOL)	61	HAEGARDA	74	KWIKPEN	53
GAMUNEX-C	61	HALAVEN	16	<i>hydralazine</i>	40
<i>ganciclovir sodium</i>	8	<i>halobetasol propionate</i>	46	<i>hydrochlorothiazide</i>	40
GARDASIL 9 (PF)	61	HALOG	46	<i>hydrocodone-acetaminophen</i>	27
<i>gatifloxacin</i>	71	<i>haloperidol</i>	27	<i>hydrocodone-ibuprofen</i>	27
GATTEX 30-VIAL	57	<i>haloperidol decanoate</i>	27	<i>hydrocortisone</i>	46, 53, 58
GAUZE PAD	52	<i>haloperidol lactate</i>	27	<i>hydrocortisone butyrate</i>	46
GAVILYTE-C	57	HARVONI	9	<i>hydrocortisone valerate</i>	46
GAVILYTE-G	57	HAVRIX (PF)	61	<i>hydrocortisone-acetic acid</i>	50
GAVILYTE-N	57	<i>heparin (porcine)</i>	40	<i>hydrocortisone-pramoxine</i>	58
GELNIQUE	76	<i>heparin (porcine) in 5 % dex</i>	40	<i>hydromorphone</i>	27
<i>gemcitabine</i>	16	HEPATAMINE 8%	77	<i>hydromorphone (pf)</i>	27
<i>gemfibrozil</i>	40	HERCEPTIN	16	<i>hydroxychloroquine</i>	9
GENERLAC	57	HETLIOZ	27	<i>hydroxyprogesterone caproate</i> ...	67
GENGRAF	16	HEXALEN	16	<i>hydroxyurea</i>	16
GENOTROPIN	61	HIBERIX (PF)	61	<i>hydroxyzine hcl</i>	74
GENOTROPIN MINIQUICK	61	HORIZANT	27	HYPERRAB S/D (PF)	61
GENTAK	71	HUMALOG JUNIOR		<i>ibandronate</i>	65
<i>gentamicin</i>	9, 46, 71	KWIKPEN U-100	52	IBRANCE	16
<i>gentamicin in nacl (iso-osm)</i>	9	HUMALOG KWIKPEN		IBU	27
GENVOYA	9	INSULIN	52	<i>ibuprofen</i>	28
GEODON	27	HUMALOG MIX 50-50		ICLUSIG	16
GILENYA	27	INSULN U-100	52	<i>idarubicin</i>	16
GILOTRIF	16	HUMALOG MIX 50-50		IDHIFA	16
GLASSIA	49	KWIKPEN	52	<i>ifosfamide</i>	16
<i>glatiramer</i>	27	HUMALOG MIX 75-25		ILARIS (PF)	61
GLATOPA	27	KWIKPEN	52	ILEVRO	71
GLEOSTINE	16	HUMALOG MIX 75-25(U-		<i>imatinib</i>	16
<i>glimepiride</i>	52	100)INSULN	52	IMBRUVICA	16
<i>glipizide</i>	52	HUMALOG U-100 INSULIN ..	52	IMFINZI	16
<i>glipizide-metformin</i>	52	HUMATROPE	61	<i>imipenem-cilastatin</i>	9
GLUCAGEN HYPOKIT	52	HUMIRA	64	<i>imipramine hcl</i>	28
GLUCAGON EMERGENCY		HUMIRA PEDIATRIC		<i>imipramine pamoate</i>	28
KIT (HUMAN)	52	CROHN'S START	65	<i>imiquimod</i>	46
<i>glyburide</i>	52	HUMIRA PEN	65	IMOGAM RABIES-HT (PF) ...	61
<i>glyburide micronized</i>	52	HUMIRA PEN CROHN'S-		IMOVAX RABIES	
<i>glyburide-metformin</i>	52	UC-HS START	65	VACCINE (PF)	62
<i>glycopyrrolate</i>	57	HUMIRA PEN PSORIASIS-		INCASSIA	67
GLYXAMBI	52	UVEITIS	65	INCRELEX	49
GOLYTELY	57	HUMULIN 70/30 U-100		<i>indapamide</i>	40
GONITRO	40	INSULIN	52	INDOCIN	28
GRALISE	27	HUMULIN 70/30 U-100		<i>indomethacin</i>	28
GRALISE 30-DAY		KWIKPEN	53	INFANRIX (DTAP) (PF)	62
STARTER PACK	27	HUMULIN N NPH INSULIN		INFLECTRA	58
<i>granisetron (pf)</i>	57	KWIKPEN	53	INGREZZA	28
<i>granisetron hcl</i>	57	HUMULIN N NPH U-100		INLYTA	16
GRANIX	61	INSULIN	53	INNOPRAN XL	40
<i>griseofulvin microsize</i>	9	HUMULIN R REGULAR U-		<i>insulin syringe-needle u-100</i>	53
<i>griseofulvin ultramicrosize</i>	9	100 INSULN	53	INTELENCE	9

INTRALIPID	77	JUNEL FE 1/20 (28)	68	LARTRUVO	17
INTRAROSA	68	JUNEL FE 24	68	LASTACAPT	71
INTRON A	62	JUXTAPID	40	<i>latanoprost</i>	71
INTROVALE	68	JYNARQUE	53	LATUDA	28
INVANZ	9	KADCYLA	17	LAYOLIS FE	68
INVEGA SUSTENNA	28	KAITLIB FE	68	LAZANDA	29
INVEGA TRINZA	28	KALETRA	9	<i>leflunomide</i>	65
INVIRASE	9	KALYDECO	74	LENVIMA	17
INVOKAMET	53	KARIVA (28)	68	LESSINA	68
INVOKAMET XR	53	KELNOR 1/35 (28)	68	LETAIRIS	74
INVOKANA	53	KELNOR 1-50	68	<i>letrozole</i>	17
IONOSOL-MB IN D5W	78	<i>ketoconazole</i>	9, 46	<i>leucovorin calcium</i>	17
IOPIDINE	71	<i>ketoprofen</i>	28	LEUKERAN	17
IPOL	62	<i>ketorolac</i>	28, 71	LEUKINE	62
<i>ipratropium bromide</i>	50, 74	KEVZARA	65	<i>leuprolide</i>	17
<i>ipratropium-albuterol</i>	74	KEYTRUDA	17	<i>levalbuterol hcl</i>	74
<i>irbesartan</i>	40	KIMIDESS (28)	68	<i>levalbuterol tartrate</i>	74
<i>irbesartan-hydrochlorothiazide</i> ..	40	KINERET	65	LEVEMIR FLEXTOUCH U-	
IRESSA	16	KINRIX (PF)	62	100 INSULN	53
<i>irinotecan</i>	16	KIONEX (WITH		LEVEMIR U-100 INSULIN ...	53
ISENTRESS	9	SORBITOL)	49	<i>levetiracetam</i>	29
ISENTRESS HD	9	KISQALI	17	<i>levetiracetam in nacl (iso-os)</i>	29
ISIBLOOM	68	KISQALI FEMARA CO-		<i>levobunolol</i>	71
ISOLYTE-P IN 5 %		PACK	17	<i>levocarnitine</i>	49
DEXTROSE	78	KLOR-CON	78	<i>levocarnitine (with sugar)</i>	49
ISOLYTE-S	78	KLOR-CON 10	78	<i>levocetirizine</i>	74
<i>isoniazid</i>	9	KLOR-CON 8	78	<i>levofloxacin</i>	9, 71
ISORDIL	40	KLOR-CON M10	78	<i>levofloxacin in d5w</i>	9
<i>isosorbide dinitrate</i>	40	KLOR-CON M15	78	<i>levoleucovorin</i>	17
<i>isosorbide mononitrate</i>	40	KLOR-CON M20	78	LEVONEST (28)	68
<i>isotretinoin</i>	46	KLOR-CON SPRINKLE	78	<i>levonorgestrel-ethinyl estrad</i>	68
<i>isradipine</i>	40	KOMBIGLYZE XR	53	<i>levonorg-eth estrad triphasic</i>	68
ISTALOL	71	KORLYM	53	LEVORA-28	68
ISTODAX	16	K-TAB	78	<i>levothyroxine</i>	53
<i>itraconazole</i>	9	KURVELO	68	LEVOXYL	53
<i>ivermectin</i>	9	KUVAN	53	LEXIVA	9
IXIARO (PF)	62	KYNAMRO	40	LIALDA	58
JAKAFI	16	KYPROLIS	17	<i>lidocaine</i>	46
JANTOVEN	40	<i>l norgest/e.estradiol-e.estrad</i>	68	<i>lidocaine (pf)</i>	46
JANUMET	53	<i>labetalol</i>	40	<i>lidocaine hcl</i>	46
JANUMET XR	53	LACRISERT	71	LIDOCAINE VISCOUS	46
JANUVIA	53	<i>lactated ringers</i>	49, 78	<i>lidocaine-prilocaine</i>	46
JARDIANCE	53	<i>lactulose</i>	58	LIDODERM	46
JENTADUETO	53	<i>lamivudine</i>	9	LINCOCIN	9
JENTADUETO XR	53	<i>lamivudine-zidovudine</i>	9	<i>lincomycin</i>	10
JINTELI	68	<i>lamotrigine</i>	28	<i>lindane</i>	46
JOLIVETTE	68	LANOXIN	40	<i>linezolid</i>	10
JULEBER	68	<i>lansoprazole</i>	58	<i>linezolid in dextrose 5%</i>	10
JULUCA	9	LANTUS SOLOSTAR U-100		LINZESS	58
JUNEL 1.5/30 (21)	68	INSULIN	53	LIORESAL	29
JUNEL 1/20 (21)	68	LANTUS U-100 INSULIN	53	<i>liothyronine</i>	54
JUNEL FE 1.5/30 (28)	68	LARISSIA	68	LIPOFEN	40

<i>lisinopril</i>	40	<i>medroxyprogesterone</i>	68	MIBELAS 24 FE	69
<i>lisinopril-hydrochlorothiazide</i>	40	<i>mefenamic acid</i>	29	MICONAZOLE-3	69
<i>lithium carbonate</i>	29	<i>mefloquine</i>	10	MICROGESTIN 1.5/30 (21)	69
<i>lithium citrate</i>	29	<i>megestrol</i>	18	MICROGESTIN 1/20 (21)	69
LIVALO	40	MEKINIST	18	MICROGESTIN FE 1.5/30	
LO LOESTRIN FE	68	MELODETTA 24 FE	68	(28)	69
LONSURF	17	<i>meloxicam</i>	29	MICROGESTIN FE 1/20 (28) ..	69
<i>loperamide</i>	58	<i>melphalan hcl</i>	18	<i>midodrine</i>	49
<i>lopinavir-ritonavir</i>	10	<i>memantine</i>	29, 30	MIGERGOT	30
<i>lorazepam</i>	29	MENACTRA (PF)	62	<i>miglitol</i>	54
LORCET		MENEST	68	<i>miglustat</i>	54
(HYDROCODONE)	29	MENTAX	46	MILI	69
LORCET HD	29	MENVEO A-C-Y-W-135-DIP		MILLIPRED	54
LORCET PLUS	29	(PF)	62	<i>minocycline</i>	10
LORYNA (28)	68	<i>mercaptapurine</i>	18	<i>minoxidil</i>	41
<i>losartan</i>	40	<i>meropenem</i>	10	MIRCERA	62
<i>losartan-hydrochlorothiazide</i>	40	<i>mesalamine</i>	58	<i>mirtazapine</i>	30
<i>lovastatin</i>	41	<i>mesna</i>	18	<i>misoprostol</i>	58
LOW-OGESTREL (28)	68	MESNEX	18	MITIGARE	65
<i>loxapine succinate</i>	29	MESTINON	30	<i>mitomycin</i>	18
LUCEMYRA	29	METADATE ER	30	<i>mitoxantrone</i>	18
LUMIGAN	72	<i>metaproterenol</i>	74	M-M-R II (PF)	62
LUMIZYME	54	METAXALL	30	<i>modafinil</i>	30
LUPRON DEPOT	17	<i>metaxalone</i>	30	MODERIBA	10
LUPRON DEPOT (3		<i>metformin</i>	54	MODERIBA DOSE PACK	10
MONTH)	17	<i>methadone</i>	30	<i>moexipril</i>	41
LUPRON DEPOT (4		<i>methamphetamine</i>	30	<i>moexipril-hydrochlorothiazide</i> ...	41
MONTH)	17	<i>methazolamide</i>	72	<i>mometasone</i>	47, 74
LUPRON DEPOT (6		<i>methenamine hippurate</i>	10	MONONESSA (28)	69
MONTH)	17	<i>methimazole</i>	54	<i>montelukast</i>	74
LUPRON DEPOT-PED	17	<i>methotrexate sodium</i>	18	MONUROL	10
LUPRON DEPOT-PED (3		<i>methotrexate sodium (pf)</i>	18	MORGIDOX	10
MONTH)	17	<i>methoxsalen</i>	46	<i>morphine</i>	30, 31
LUTERA (28)	68	<i>methscopolamine</i>	58	<i>morphine concentrate</i>	30
LYNPARZA	18	<i>methyclothiazide</i>	41	MOVANTIK	58
LYRICA	29	<i>methyldopa-</i>		MOVIPREP	58
LYRICA CR	29	<i>hydrochlorothiazide</i>	41	MOXEZA	72
LYSODREN	18	<i>methylphenidate hcl</i>	30	<i>moxifloxacin</i>	10, 72
LYZA	68	<i>methylprednisolone</i>	54	MOZOBIL	62
<i>magnesium sulfate</i>	78	<i>methylprednisolone acetate</i>	54	MULTAQ	41
MAKENA	68	<i>methylprednisolone sodium succ</i>	54	<i>mupirocin</i>	47
MAKENA (PF)	68	<i>methyltestosterone</i>	54	<i>mupirocin calcium</i>	47
<i>malathion</i>	46	<i>metipranolol</i>	72	MUSTARGEN	18
<i>maprotiline</i>	29	<i>metoclopramide hcl</i>	58	MYALEPT	54
MARLISSA	68	<i>metolazone</i>	41	MYCAMINE	10
MARPLAN	29	<i>metoprolol succinate</i>	41	<i>mycophenolate mofetil</i>	18
MATULANE	18	<i>metoprolol ta-hydrochlorothiaz</i> ..	41	<i>mycophenolate mofetil hcl</i>	18
MATZIM LA	41	<i>metoprolol tartrate</i>	41	<i>mycophenolate sodium</i>	18
MAVYRET	10	<i>metronidazole</i>	10, 46, 68	MYLOTARG	18
<i>meclizine</i>	58	<i>metronidazole in nacl (iso-os)</i>	10	MYORISAN	47
<i>meclofenamate</i>	29	<i>mexiletine</i>	41	MYRBETRIQ	76
MEDROL	54	MIACALCIN	54	MYTESI	58

<i>nabumetone</i>	31	NILANDRON	18	NUCYNTA	31
<i>nadolol</i>	41	<i>nilutamide</i>	18	NUDEXTA	31
<i>nadolol-bendroflumethiazide</i>	41	<i>nimodipine</i>	41	NULOJIX	18
<i>nafcillin</i>	10	NINLARO	18	NUPLAZID	31
<i>naftifine</i>	47	NIPENT	18	NUTRESTORE	49
NAFTIN	47	<i>nisoldipine</i>	41	NUTRILIPID	78
NAGLAZYME	54	NITRO-BID	41	NUTROPIN AQ NUSPIN	62
<i>nalbuphine</i>	31	NITRO-DUR	41	NUVARING	69
<i>naloxone</i>	31	<i>nitrofurantoin</i>	10	NYAMYC	47
<i>naltrexone</i>	31	<i>nitrofurantoin macrocrystal</i>	10	NYMALIZE	41
NAMENDA TITRATION		<i>nitrofurantoin monohyd/m-cryst.</i>	10	<i>nystatin</i>	10, 47
PAK	31	<i>nitroglycerin</i>	41	<i>nystatin-triamcinolone</i>	47
NAMENDA XR	31	NITROSTAT	41	NYSTOP	47
NAMZARIC	31	NOLIX	47	OALIVA	58
NAPRELAN CR	31	NORDITROPIN FLEXP	62	OCTAGAM	62
<i>naproxen</i>	31	<i>noreth-ethinyl estradiol-iron</i>	69	<i>octreotide acetate</i>	18
<i>naproxen sodium</i>	31	<i>norethindrone (contraceptive)</i>	69	ODEFSEY	10
<i>naratriptan</i>	31	<i>norethindrone acetate</i>	69	ODOMZO	18
NARCAN	31	<i>norethindrone ac-eth estradiol</i>	69	OFEV	74
NATACYN	72	<i>norethindrone-e.estradiol-iron</i>	69	<i>ofloxacin</i>	10, 50, 72
<i>nateglinide</i>	54	<i>norgestimate-ethinyl estradiol</i>	69	OGESTREL (28)	69
NATPARA	54	NORITATE	47	<i>olanzapine</i>	31, 32
NEBUPENT	10	NORMOSOL-M IN 5 %		<i>olanzapine-fluoxetine</i>	32
NECON 0.5/35 (28)	69	DEXTROSE	78	<i>olmesartan</i>	41
NECON 7/7/7 (28)	69	NORMOSOL-R IN 5 %		<i>olmesartan-amlodipin-hcthiazyd</i>	41
<i>nefazodone</i>	31	DEXTROSE	78	<i>olmesartan-hydrochlorothiazide</i>	42
<i>neomycin</i>	10	NORMOSOL-R PH 7.4	78	<i>olopatadine</i>	50, 72
<i>neomycin-bacitracin-poly-hc</i>	72	NORTHERA	49	OLUMIANT	65
<i>neomycin-bacitracin-polymyxin</i>	72	NORTREL 0.5/35 (28)	69	<i>omega-3 acid ethyl esters</i>	42
<i>neomycin-polymyxin b gu</i>	49	NORTREL 1/35 (21)	69	<i>omeprazole</i>	58
<i>neomycin-polymyxin b-</i>		NORTREL 1/35 (28)	69	<i>omeprazole-sodium bicarbonate</i>	58
<i>dexameth</i>	72	NORTREL 7/7/7 (28)	69	OMNARIS	74
<i>neomycin-polymyxin-gramicidin</i>	72	<i>nortriptyline</i>	31	OMNITROPE	62
<i>neomycin-polymyxin-hc</i>	50, 72	NORVIR	10	<i>ondansetron</i>	58
NEORAL	18	NOVAREL	54	<i>ondansetron hcl</i>	58
NEO-SYNALAR	47	NOVOLIN 70/30 U-100		<i>ondansetron hcl (pf)</i>	58
NEPHRAMINE 5.4 %	78	INSULIN	54	ONFI	32
NERLYNX	18	NOVOLIN N NPH U-100		ONGLYZA	54
NESINA	54	INSULIN	54	ONZETRA XSAIL	32
NEUAC	47	NOVOLIN R REGULAR U-		OPDIVO	19
NEULASTA	62	100 INSULN	54	OPSUMIT	74
NEUPOGEN	62	NOVOLOG FLEXPEN U-100		ORALAIR	62
NEUPRO	31	INSULIN	54	ORENCIA	65
NEVANAC	72	NOVOLOG MIX 70-30 U-100		ORENCIA (WITH	
<i>nevirapine</i>	10	INSULN	54	MALTOSE)	65
NEXAVAR	18	NOVOLOG MIX 70-		ORENCIA CLICKJECT	65
<i>niacin</i>	41	30FLEXPEN U-100	54	ORENITRAM	42
NIACOR	41	NOVOLOG PENFILL U-100		ORFADIN	49
<i>nicardipine</i>	41	INSULIN	54	ORKAMBI	74
NICOTROL	49	NOVOLOG U-100 INSULIN		ORSYTHIA	69
NICOTROL NS	49	ASPART	54	<i>oseltamivir</i>	10
<i>nifedipine</i>	41	NUCALA	74	OSENI	54

OSMOPREP	58	PERFOROMIST	75	PRADAXA	42
OSPHENA	69	<i>perindopril erbumine</i>	42	PRALUENT PEN	42
OTEZLA	65	PERIOGARD	51	<i>pramipexole</i>	33
OTEZLA STARTER	65	<i>permethrin</i>	47	<i>pravastatin</i>	42
OTOVEL	51	<i>perphenazine</i>	32	<i>prazosin</i>	42
<i>oxacillin</i>	11	<i>perphenazine-amitriptyline</i>	32	PRED-G	72
<i>oxacillin in dextrose(iso-osm)</i>	11	PHENADOZ	75	PRED-G S.O.P.	72
<i>oxaliplatin</i>	19	<i>phenelzine</i>	32	<i>prednicarbate</i>	47
<i>oxandrolone</i>	54	<i>phenobarbital</i>	32	<i>prednisolone</i>	55
<i>oxaprozin</i>	32	<i>phenoxybenzamine</i>	42	<i>prednisolone acetate</i>	72
<i>oxcarbazepine</i>	32	PHENYTEK	32	<i>prednisolone sodium phosphate</i>	55, 72
<i>oxiconazole</i>	47	<i>phenytoin</i>	32	<i>prednisone</i>	55
OXISTAT	47	<i>phenytoin sodium</i>	32	PREDNISON	55
OXTELLAR XR	32	<i>phenytoin sodium extended</i>	32	PREDNISON INTENSOL	55
<i>oxybutynin chloride</i>	76	PHOSLYRA	78	PREFEST	69
<i>oxycodone</i>	32	PHOSPHOLINE IODIDE	72	PREGNYL	55
<i>oxycodone-acetaminophen</i>	32	PICATO	47	PREMARIN	69
OXYTROL	76	<i>pilocarpine hcl</i>	49, 72	PREMASOL 10 %	79
OZEMPIC	54	<i>pimozide</i>	32	PREMASOL 6 %	79
PACERONE	42	PIMTREA (28)	69	PRENATAL VITAMIN PLUS LOW IRON	79
<i>paclitaxel</i>	19	<i>pindolol</i>	42	PREPOPIK	58
<i>paliperidone</i>	32	<i>pioglitazone</i>	55	PREVALITE	42
PALYNZIQ	54	<i>pioglitazone-glimepiride</i>	55	PREVIFEM	69
<i>pamidronate</i>	55	<i>pioglitazone-metformin</i>	55	PREZCOBIX	11
PANLOR(ACETAM-CAFF-DIHYDROCOD)	32	<i>piperacillin-tazobactam</i>	11	PREZISTA	11
PANRETIN	47	PIRMELLA	69	PRIFTIN	11
<i>pantoprazole</i>	58	<i>piroxicam</i>	32	<i>primaquine</i>	11
<i>paricalcitol</i>	55	PLASMA-LYTE 148	78	<i>primidone</i>	33
<i>paromomycin</i>	11	PLASMA-LYTE A	78	PRIMLEV	33
<i>paroxetine hcl</i>	32	PLEGRIDY	63	PRIVIGEN	63
<i>paroxetine mesylate(menop.sym)</i>	32	PLENAMINE	78	PROAIR HFA	75
PASER	11	<i>podofilox</i>	47	PROAIR RESPICLICK	75
PAXIL	32	<i>polyethylene glycol 3350</i>	58	<i>probenecid</i>	65
PAZEO	72	<i>polymyxin b sulfate</i>	11	<i>probenecid-colchicine</i>	65
PEDIARIX (PF)	62	<i>polymyxin b sulf-trimethoprim</i>	72	<i>procainamide</i>	42
PEDVAX HIB (PF)	62	POMALYST	19	PROCALAMINE 3%	79
<i>peg 3350-electrolytes</i>	58	PORTIA	69	PROCENTRA	33
PEGANONE	32	<i>potassium chlorid-d5-0.45%nacl</i>	78	<i>prochlorperazine</i>	58
PEGASYS	63	<i>potassium chloride</i>	78, 79	<i>prochlorperazine edisylate</i>	58
PEGASYS PROCLICK	63	<i>potassium chloride in 0.9%nacl</i>	78	<i>prochlorperazine maleate</i>	58
<i>peg-electrolyte soln</i>	58	<i>potassium chloride in 5 % dex</i>	78	PROCRIT	63
<i>pen needle, diabetic</i>	55	<i>potassium chloride in lr-d5</i>	78	PROCTO-PAK	59
<i>penicillin g pot in dextrose</i>	11	<i>potassium chloride in water</i>	78	PROCTOSOL HC	59
<i>penicillin g potassium</i>	11	<i>potassium chloride-0.45 % nacl</i>	79	PROCTOZONE-HC	59
<i>penicillin g procaine</i>	11	<i>potassium chloride-d5-0.2%nacl</i>	79	PROCYSBI	76
<i>penicillin g sodium</i>	11	<i>potassium chloride-d5-0.3%nacl</i>	79	<i>progesterone micronized</i>	69
<i>penicillin v potassium</i>	11	<i>potassium chloride-d5-0.9%nacl</i>	79	PROGLYCEM	55
PENTAM	11	<i>potassium citrate</i>	76	PROGRAF	19
PENTASA	58			PROLASTIN-C	50
<i>pentoxifylline</i>	42			PROLEUKIN	63
				PROLIA	65

PROMACTA	42	RENAGEL	50	SANDIMMUNE	19
<i>promethazine</i>	75	RENFLEXIS	59	SANDOSTATIN LAR	
PROMETHAZINE VC	75	REVELA	50	DEPOT	19
PROMETHEGAN	75	<i>repaglinide</i>	55	SANTYL	47
<i>propafenone</i>	42	<i>repaglinide-metformin</i>	55	SAPHRIS	33
<i>propantheline</i>	59	REPATHA PUSHTRONEX	42	SAVELLA	66
<i>propranolol</i>	42	REPATHA SURECLICK	42	<i>scopolamine base</i>	59
<i>propranolol-hydrochlorothiazid</i>	42	REPATHA SYRINGE	42	<i>selegiline hcl</i>	34
<i>propylthiouracil</i>	55	RESCRIPTOR	11	<i>selenium sulfide</i>	47
PROQUAD (PF)	63	RESTASIS	72	SELZENTRY	12
PROSOL 20 %	79	RETIN-A MICRO PUMP	47	SEMPREX-D	75
<i>protriptyline</i>	33	RETROVIR	11	SENSIPAR	55
PRUDOXIN	47	REVATIO	75	SEREVENT DISKUS	75
PULMOZYME	75	REVLIMID	19	SEROQUEL XR	34
PURIXAN	19	REXULTI	33	SEROSTIM	63
PYLERA	59	REYATAZ	11	<i>sertraline</i>	34
<i>pyrazinamide</i>	11	RIBASPHERE	11	SETLAKIN	69
<i>pyridostigmine bromide</i>	33	RIBASPHERE RIBAPAK	11	<i>sevelamer carbonate</i>	50
QBRELIS	42	<i>ribavirin</i>	12	SHINGRIX (PF)	63
QUADRACEL (PF)	63	RIDAURA	66	SIGNIFOR	19
QUASENSE	69	<i>rifabutin</i>	12	<i>sildenafil (antihypertensive)</i>	75
<i>quetiapine</i>	33	<i>rifampin</i>	12	SILENOR	34
QUILLIVANT XR	33	RIFATER	12	SILIQ	47
<i>quinapril</i>	42	<i>riluzole</i>	50	<i>silver sulfadiazine</i>	47
<i>quinapril-hydrochlorothiazide</i>	42	<i>rimantadine</i>	12	SIMBRINZA	72
<i>quinidine gluconate</i>	42	<i>ringer's</i>	50, 79	SIMPONI	66
<i>quinidine sulfate</i>	42	RIOMET	55	SIMPONI ARIA	66
<i>quinine sulfate</i>	11	<i>risedronate</i>	50, 66	SIMULECT	19
QVAR REDHALER	75	RISPERDAL CONSTA	33	<i>simvastatin</i>	43
RABAVERT (PF)	63	<i>risperidone</i>	33	<i>sirolimus</i>	19
<i>rabeprazole</i>	59	RITALIN LA	33	SIRTURO	12
RADICAVA	33	<i>ritonavir</i>	12	SIVEXTRO	12
<i>raloxifene</i>	66	RITUXAN	19	<i>sodium chloride</i>	50, 79
<i>ramipril</i>	42	<i>rivastigmine</i>	33	<i>sodium chloride 0.45 %</i>	79
RANEXA	42	<i>rivastigmine tartrate</i>	33	<i>sodium chloride 0.9 %</i>	50
<i>ranitidine hcl</i>	59	RIVELSA	69	<i>sodium chloride 3 %</i>	79
RAPAFLO	76	<i>rizatriptan</i>	33	<i>sodium chloride 5 %</i>	79
RAPAMUNE	19	<i>ropinirole</i>	33	<i>sodium lactate</i>	79
<i>rasagiline</i>	33	<i>rosuvastatin</i>	42	<i>sodium phenylbutyrate</i>	50
RAVICTI	50	ROTARIX	63	<i>sodium polystyrene sulfonate</i>	50
REBETOL	11	ROTATEQ VACCINE	63	SOLTAMOX	19
REBIF (WITH ALBUMIN)	63	ROWEEPRA	33	SOLU-CORTEF (PF)	55
REBIF REBIDOSE	63	ROWEEPRA XR	33	SOLU-MEDROL	55
REBIF TITRATION PACK	63	ROZEREM	33	SOLU-MEDROL (PF)	55
RECLIPSEN (28)	69	RUBRACA	19	SOMATULINE DEPOT	19
RECOMBIVAX HB (PF)	63	RUCONEST	75	SOMAVERT	55
RECTIV	59	RYDAPT	19	SORINE	43
REGRANEX	47	SABRIL	33	<i>sotalol</i>	43
RELENZA DISKHALER	11	SAIZEN	63	SOTALOL AF	43
RELISTOR	59	SAIZEN SAIZENPREP	63	SOVALDI	12
REMICADE	59	SAMSCA	55	SPIRIVA RESPIMAT	75
REMODULIN	42	SANCUSO	59		

SPIRIVA WITH HANDIHALER	75	SYNJARDY XR	55	<i>thiotepa</i>	20
<i>spironolactone</i>	43	SYNRIBO	19	<i>thiothixene</i>	35
<i>spironolacton-hydrochlorothiaz.</i>	43	SYNTHROID	56	<i>tiagabine</i>	35
SPORANOX	12	SYPRINE	50	<i>tigecycline</i>	12
SPRINTEC (28)	69	TABLOID	19	<i>timolol maleate</i>	43, 72
SPRITAM	34	TACLONEX	47	TIMOPTIC OCUDOSE (PF) ..	72
SPRYCEL	19	<i>tacrolimus</i>	19, 48	<i>tinidazole</i>	12
SPS (WITH SORBITOL)	50	TAFINLAR	19	TIROSINT	56
SRONYX	69	TAGRISSE	19	TIVICAY	12
SSD	47	TALTZ AUTOINJECTOR	48	<i>tizanidine</i>	35
<i>stavudine</i>	12	TALTZ SYRINGE	48	TOBI PODHALER	13
STELARA	47	<i>tamoxifen</i>	19	TOBRADEX	72
STIMATE	55	<i>tamsulosin</i>	76	TOBRADEX ST	72
STIOLTO RESPIMAT	75	TAPERDEX	56	<i>tobramycin</i>	72
STIVARGA	19	TARCEVA	19	<i>tobramycin in 0.225 % nacl</i>	13
STRENSIQ	55	TARGRETIN	19	<i>tobramycin sulfate</i>	13
<i>streptomycin</i>	12	TASIGNA	19	<i>tobramycin-dexamethasone</i>	72
STRIBILD	12	TAVALISSE	43	TOBREX	72
STRIVERDI RESPIMAT	75	<i>tazarotene</i>	48	TOLAK	48
SUBSYS	34	TAZICEF	12	<i>tolazamide</i>	56
SUCRAID	59	TAZORAC	48	<i>tolbutamide</i>	56
<i>sucralfate</i>	59	TAZTIA XT	43	<i>tolcapone</i>	35
<i>sulfacetamide sodium</i>	72	TECENTRIQ	19	<i>tolmetin</i>	35
<i>sulfacetamide sodium (acne)</i>	47	TECFIDERA	34	<i>tolterodine</i>	76, 77
<i>sulfacetamide-prednisolone</i>	72	TECHNIVIE	12	<i>topiramate</i>	35
<i>sulfadiazine</i>	12	TEFLARO	12	TOPOSAR	20
<i>sulfamethoxazole-trimethoprim</i> ..	12	TEGRETOL	34	<i>topotecan</i>	20
SULFAMYLON	47	TEGRETOL XR	34	<i>torse mide</i>	43
<i>sulfasalazine</i>	59	TEKTRUNA	43	TOUJEO MAX U-300	
<i>sulindac</i>	34	TEKTRUNA HCT	43	SOLOSTAR	56
<i>sumatriptan</i>	34	<i>telmisartan</i>	43	TOUJEO SOLOSTAR U-300	
<i>sumatriptan succinate</i>	34	<i>telmisartan-amlodipine</i>	43	INSULIN	56
<i>sumatriptan-naproxen</i>	34	<i>telmisartan-hydrochlorothiazid</i> ..	43	TOVIAZ	77
SUPRAX	12	<i>temazepam</i>	34	TRACLEER	76
SUPREP BOWEL PREP KIT	59	TENCON	34	TRADJENTA	56
SUSTIVA	12	TENIVAC (PF)	63	<i>tramadol</i>	35
SUTENT	19	<i>tenofovir disoproxil fumarate</i>	12	<i>tramadol-acetaminophen</i>	35
SYEDA	70	<i>terazosin</i>	43	<i>trandolapril</i>	43
SYLATRON	63	<i>terbinafine hcl</i>	12	<i>trandolapril-verapamil</i>	43
SYLVANT	19	<i>terbutaline</i>	75	<i>tranexamic acid</i>	43, 70
SYMBICORT	75	<i>terconazole</i>	70	<i>tranylcypromine</i>	35
SYMDEKO	75	<i>testosterone cypionate</i>	56	TRAVASOL 10 %	79
SYMFI	12	<i>testosterone enanthate</i>	56	TRAVATAN Z	73
SYMFI LO	12	<i>tetanus,diphtheria tox ped(pf)</i>	63	<i>trazodone</i>	35
SYMLINPEN 120	55	<i>tetanus-diphtheria toxoids-td</i>	63	TREANDA	20
SYMLINPEN 60	55	<i>tetrabenazine</i>	35	TRECTOR	13
SYMPROIC	59	<i>tetracycline</i>	12	TRELEGY ELLIPTA	76
SYNAGIS	12	THALOMID	20	TRELSTAR	20
SYNAREL	55	THEO-24	75	TRESIBA FLEXTOUCH U-	
SYNERCID	12	<i>theophylline</i>	75, 76	100	56
SYNJARDY	55	THIOLA	50	TRESIBA FLEXTOUCH U-	
		<i>thioridazine</i>	35	200	56

<i>tretinoin</i>	48	<i>valganciclovir</i>	13	VOTRIENT	20
<i>tretinoin (chemotherapy)</i>	20	<i>valproate sodium</i>	35	VPRIV	56
<i>tretinoin microspheres</i>	48	<i>valproic acid</i>	35	VRAYLAR	36
TREXALL	20	<i>valproic acid (as sodium salt)</i>	35	VYFEMLA (28)	70
TREXIMET	35	<i>valsartan</i>	43	VYLIBRA	70
<i>triamcinolone acetonide</i> . 48, 51, 76		<i>valsartan-hydrochlorothiazide</i> ... 43		VYVANSE	36
<i>triamterene-hydrochlorothiazid</i> ..43		<i>vancomycin</i>	13	VYXEOS	20
TRIANEX	48	VANDAZOLE	70	<i>warfarin</i>	43
TRIDERM	48	VAQTA (PF)	64	<i>water for irrigation, sterile</i>	50
<i>trientine</i>	50	VARIVAX (PF)	64	WELCHOL	43
<i>trifluoperazine</i>	35	VARIZIG	64	XALKORI	20
<i>trifluridine</i>	73	VARUBI	59	XARELTO	43
<i>trihexyphenidyl</i>	35	VASCEPA	43	XATMEP	20
TRI-LEGEST FE	70	VELCADE	20	XELJANZ	66
TRI-LO-ESTARYLLA	70	VELIVET TRIPHASIC		XELJANZ XR	66
TRI-LO-SPRINTEC	70	REGIMEN (28)	70	XEOMIN	64
TRILYTE WITH FLAVOR		VELPHORO	50	XERMELO	20
PACKETS	59	VELTASSA	50	XGEVA	20
<i>trimethobenzamide</i>	59	VEMLIDY	13	XIFAXAN	13
<i>trimethoprim</i>	13	VENCLEXTA	20	XIGDUO XR	56
TRI-MILI	70	VENCLEXTA STARTING		XIIDRA	73
<i>trimipramine</i>	35	PACK	20	XOLAIR	76
TRINESSA (28)	70	<i>venlafaxine</i>	35	XTANDI	20
TRINTELLIX	35	VENTAVIS	76	XULTOPHY 100/3.6	56
TRI-PREVIFEM (28)	70	VENTOLIN HFA	76	XURIDEN	50
TRISENOX	20	<i>verapamil</i>	43	XYREM	36
TRI-SPRINTEC (28)	70	VEREGEN	48	YERVOY	20
TRIUMEQ	13	VERSACLOZ	35	YF-VAX (PF)	64
TRIVORA (28)	70	VERZENIO	20	YONDELIS	20
TRI-VYLIBRA	70	VESICARE	77	YONSA	20
TROKENDI XR	35	VIBERZI	59	YOSPRALA	43
TROPHAMINE 10 %	79	VICTOZA 3-PAK	56	YUVAFEM	70
<i>trospium</i>	77	VIDEX 4 GRAM		<i>zafirlukast</i>	76
TRULICITY	56	PEDIATRIC	13	<i>zaleplon</i>	36
TRUMENBA	63	VIDEX EC	13	ZANOSAR	20
TRUVADA	13	VIEKIRA PAK	13	ZARAH	70
TWINRIX (PF)	63	VIEKIRA XR	13	ZARXIO	64
TYBOST	13	VIENVA	70	ZAVESCA	56
TYDEMY	70	<i>vigabatrin</i>	35	ZEJULA	20
TYGACIL	13	VIIBRYD	35, 36	ZELAPAR	36
TYKERB	20	VIMOVO	36	ZELBORAF	20
TYMLOS	66	VIMPAT	36	ZEMAIRA	50
TYPHIM VI	63, 64	<i>vinblastine</i>	20	ZEMBRACE SYMTOUCH	36
TYSABRI	35	VINCASAR PFS	20	ZENATANE	48
ULORIC	66	<i>vincristine</i>	20	ZENPEP	59, 60
UNITHROID	56	<i>vinorelbine</i>	20	ZENZEDI	36
UPTRAVI	43	VIRACEPT	13	ZEPATIER	13
<i>ursodiol</i>	59	VIRAMUNE	13	ZERBAXA	13
VABOMERE	13	VIREAD	13	ZERIT	13
VAGIFEM	70	VIVITROL	36	<i>zidovudine</i>	14
<i>valacyclovir</i>	13	<i>voriconazole</i>	13	<i>zileuton</i>	76
VALCHLOR	48	VOSEVI	13	ZINECARD (AS HCL)	20

ZINPLAVA	64
ZIOPTAN (PF)	73
<i>ziprasidone hcl</i>	36
ZIRGAN	73
<i>zoledronic acid</i>	56
<i>zoledronic acid-mannitol-water</i> ..	50
ZOLINZA	21
<i>zolmitriptan</i>	36
<i>zolpidem</i>	36
ZOMACTON	64
ZOMIG	36
<i>zonisamide</i>	36
ZONTIVITY	44
ZORBTIVE	64
ZORTRESS	21
ZOSTAVAX (PF)	64
ZOVIA 1/35E (28)	70
ZOVIRAX	48
ZUBSOLV	36
ZUPLENZ	60
ZURAMPIC	66
ZYCLARA	48
ZYDELIG	21
ZYKADIA	21
ZYLET	73
ZYPREXA RELPREVV	36
ZYTIGA	21

actemra

Products Affected

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

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

acthar h.p.

Products Affected

- ACTHAR H.P.

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

actimmune

Products Affected

- ACTIMMUNE

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

adempas

Products Affected

- ADEMPAS

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

ADHD Drugs

Products Affected

- *atomoxetine oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg*
- *clonidine hcl oral tablet extended release 12 hr*
- *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	

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.
Age Restrictions	
Prescriber Restrictions	oncologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For renal cell carcinoma with clear cell histology additional trial/failure of cabozantinib or nivolumab per NCCN guidelines.

aimovig

Products Affected

- **AIMOVIG AUTOINJECTOR (2 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. 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 xceeding 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 of the following prophylactic migraine medication classes: 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.

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

ALPHA1-PROTEINASE INHIBITORS

Products Affected

- ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG
- GLASSIA
- 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.

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

ampyra

Products Affected

- AMPYRA

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

anabolic steroids

Products Affected

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

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

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	

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

aubagio

Products Affected

- AUBAGIO

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

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	

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 aqedate 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.

bavencio

Products Affected

- BAVENCIO

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

BELEODAQ

Products Affected

- BELEODAQ

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

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	

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	

bonjesta

Products Affected

- **BONJESTA**

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	

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

botulinum toxin

Products Affected

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

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

brand metformin

Products Affected

- *metformin oral tablet extended release 24hr*
- **RIOMET**

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

butrans

Products Affected

- *buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour*
- **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 a documented acute pain condition (e.g. acute traumatic injury) in which treatment with other agents would cause insufficient pain control or if the member requires treatment for pain related to a terminal illness. For concomitant use of an opiate agonist, benzodiazepine and a centrally acting skeletal muscle relaxant, documentation that the member has tried/failed at least 2 other skeletal muscle relaxant (e.g. methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients AND attestation of an intent to monitor and address concomitant drug-drug interaction adverse events
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Buprenorphine topical patch should not be used concomitantly with substance abuse therapies.

cabometyx

Products Affected

- **CABOMETYX**

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

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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

caprelsa

Products Affected

- CAPRELSA

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

carbagli

Products Affected

- CARBAGLU

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

CERDELGA

Products Affected

- CERDELGA

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

CF drugs

Products Affected

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

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

cholbam

Products Affected

- CHOLBAM

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

cialis

Products Affected

- CIALIS ORAL TABLET 2.5 MG, 5 MG

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

cimzia

Products Affected

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

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

cinryze

Products Affected

- CINRYZE

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

cometriq

Products Affected

- COMETRIQ

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

corlanor

Products Affected

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

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

Cosentyx

Products Affected

- **COSENTYX (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 moderate to severe psoriasis and failure of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy -OR- active psoriatic arthritis -OR- active ankylosing spondylitis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis and the preferred products, Enbrel and Humira, for psoriatic arthritis and ankylosing spondylitis. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.

cotellic

Products Affected

- COTELLIC

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

crinone

Products Affected

- CRINONE

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

daklinza

Products Affected

- DAKLINZA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member is unable to utilize regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, peritaprevir/ombitasvir/ritonavir/dasabuvir and peritaprevir/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 90mg/day will not be approved

darzalex

Products Affected

- **DARZALEX**

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

doptelet

Products Affected

- DOPTelet

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	Platelet count is provided for applicable dosing.

dupixent

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3): 1) moderate to severe atopic dermatitis 2) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- trial & failure, intolerance, or contraindication to at least one non-fluorinated topical corticosteroid for patients requesting treatment for atopic dermatitis of the face 3) trial & failure, intolerance, or contraindication to tacrolimus ointment, or pimecrolimus cream, or crisaborole ointment
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For induction 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.

egfr tyrosine kinase inhibitors

Products Affected

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

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

egrifta

Products Affected

- **EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG**

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

emflaza

Products Affected

- EMFLAZA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of Duchenne muscular dystrophy (DMD) with mutation of dystrophin gene -AND- onset of weakness or history of DMD starting before age 5 -AND- One of the following (1 or 2). 1) Documented trial of prednisone has resulted in intolerable adverse events (e.g. diabetes, hypertension that is difficult to manage, Cushingoid features, truncal obesity, greater than or equal to 10 percent increase in body weight over a 6 month period). 2) Documented severe behavioral adverse event while on prednisone that warrants prednisone dose reduction impacting efficacy for management of DMD (i.e. abnormal behavior, aggression, irritability, disturbance in mood)
Age Restrictions	Deny if less than 5 years of age
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	

enbrel

Products Affected

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

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

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	

entresto

Products Affected

- ENTRESTO

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

epclusa

Products Affected

- EPCLUSA

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

erivedge

Products Affected

- **ERIVEDGE**

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

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 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

exondys

Products Affected

- EXONDYS 51

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

fabrazyme

Products Affected

- **FABRAZYME**

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	

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

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 2 or more 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	Non-oral steroid dependent patients must have a peripheral blood eosinophil count of at least 300 cells/microliter within the 6 weeks prior to therapy. Oral steroid dependent patients must have a peripheral blood eosinophil count of at least 150 cells/microliter within the 6 weeks prior to therapy

firazyr

Products Affected

- **FIRAZYR**

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

flector

Products Affected

- **FLECTOR**

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

forteo

Products Affected

- FORTEO

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

gattex

Products Affected

- **GATTEX 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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

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	neurologist
Coverage Duration	12 months
Other Criteria	Doses greater than 0.5mg/day will not be approved

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

gralise

Products Affected

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

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

growth hormone

Products Affected

- **GENOTROPIN**
- **GENOTROPIN MINIQUICK**
- **HUMATROPE**
- **NORDITROPIN FLEXPRO**
- **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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

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	

HARVONI

Products Affected

- HARVONI

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

HETLIOZ

Products Affected

- HETLIOZ

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

high-risk meds

Products Affected

- amitriptyline
- amitriptyline-chlordiazepoxide
- carisoprodol-asa-codeine
- clomipramine
- cyclobenzaprine oral tablet
- **DIGITEK**
- **DIGOX**
- digoxin injection solution
- digoxin oral solution 50 mcg/ml
- digoxin oral tablet
- doxepin oral
- glyburide
- glyburide micronized
- glyburide-metformin
- hydroxyzine hcl intramuscular
- hydroxyzine hcl oral solution 10 mg/5 ml
- hydroxyzine hcl oral tablet
- imipramine hcl
- **LANOXIN ORAL TABLET 62.5 MCG**
- nitrofurantoin
- nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg
- nitrofurantoin monohyd/m-cryst
- perphenazine-amitriptyline
- promethazine oral syrup
- **SILENOR**
- trimipramine

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	<p>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:</p> <ol style="list-style-type: none"> 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). <p>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.</p>
Age Restrictions	Automatic approval if less than 65 years of age

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

homozygous fh

Products Affected

- JUXTAPID
- KYNAMRO

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

horizant

Products Affected

- **HORIZANT**

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

humira

Products Affected

- **HUMIRA**
- **HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 40 MG/0.8 ML (6 PACK), 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML**
- **HUMIRA PEN**
- **HUMIRA PEN CROHN'S-UC-HS**
- **START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML, 80 MG/0.8 ML**
- **HUMIRA PEN PSORIASIS-UVEITIS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML, 80 MG/0.8 ML-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, Oencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of moderate to severe hidradenitis suppurativa -OR- moderate to severe rheumatoid arthritis -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe juvenile idiopathic rheumatoid arthritis and an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunamide) -OR- moderate to severe psoriasis after failure of either systemic therapy (e.g., methotrexate or cyclosporine) or phototherapy. -OR- moderate to severe Crohn's disease after failure of two immunosuppressants (e.g., corticosteroids, azathioprine) or monotherapy with infliximab -OR- moderate to severe ulcerative colitis after failure of two immunosuppressants (e.g. corticosteroids, azathioprine or 6-mercaptopurine)-OR-non-infectious uveitis (including intermediate, posterior, and panuveitis)
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	rheumatologist, dermatologist, gastroenterologist, ophthalmologist
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	<p>For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required. For Crohn's disease in adults (18 years or older), trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine) or monotherapy with infliximab is required. For Crohn's disease in pediatrics, trial of 1 immunosuppressant (e.g. corticosteroids, azathioprine) or monotherapy with infliximab is required. For Ulcerative Colitis, trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine or 6-mercaptopurine) is required. For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis therapy without concomitant methotrexate, doses above plan quantity limit will be approved aligned with recommended weekly dosing regimen. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit.</p>

Ibrance

Products Affected

- **IBRANCE**

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

iclusig

Products Affected

- **ICLUSIG 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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For select diagnoses the following apply- 1) For Myasthenia Gravis Syndrome, documentation that the patient is refractory to other standard therapies (e.g., cholinesterase inhibitors, corticosteroids, azathioprine) given in therapeutic doses over at least 3 months OR is intolerant of/has a contraindication to those standard therapies. 2) For Multiple Sclerosis, patient is refractory to other standard therapies (e.g., interferons) given in therapeutic doses over at least 3 months, OR is intolerant of/has a contraindication to those standard therapies. 3) For Inflammatory Myopathies, the patient is refractory to corticosteroids given in therapeutic doses over at least 4 months, OR is intolerant of/has a contraindication to corticosteroids. 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 fist line therapy (i.e. corticosteroids or immunosuppressants). 7) For Pediatric HIV, the patient is less than 13 y.o. who have entry CD4 lymphocyte count greater than or equal to 200/mm ³ and IgG less than 400 mg/dL OR a history of recurrent bacterial infections.
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	Covered under Part B when administered in the home to a member with a diagnosis of primary immunodeficiency disease

imbruvica

Products Affected

- **IMBRUVICA 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

imfinzi

Products Affected

- **IMFINZI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic urothelial carcinoma in patients with progression on or after platinum-based chemotherapy -OR- in patients with progression within 12 months of neoadjuvant or adjuvant platinum-based chemotherapy -OR- unresectable, stage 3 non-small cell lung cancer (NSCLC) with no disease progression following concurrent platinum-based chemotherapy & radiation therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

increlex

Products Affected

- INCRELEX

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

inflectra

Products Affected

- INFLECTRA

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

ingrezza

Products Affected

- **INGREZZA ORAL CAPSULE 40 MG, 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	

inlyta

Products Affected

- INLYTA

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

interferon alfa

Products Affected

- **INTRON A INJECTION**
- **PEGASYS**
- **PEGASYS PROCLICK**
- **SYLATRON**

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

interleukin-1b blockers

Products Affected

- **ARCALYST**
- **ILARIS (PF) SUBCUTANEOUS SOLUTION**

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

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	

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%.
Age Restrictions	
Prescriber Restrictions	pulmonologist
Coverage Duration	12 months
Other Criteria	

iressa

Products Affected

- **IRESSA**

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

itraconazole

Products Affected

- *itraconazole oral capsule*
- **SPORANOX 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 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.

jakafi

Products Affected

- **JAKAFI**

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

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	

kalydeco

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Homozygous for the F508del mutation in the CFTR gene
Required Medical Information	Documentation of cystic fibrosis (CF) in patients who have one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to ivacaftor based on clinical and or in vitro assay (e.g. G551D, G1244E, G1349D)
Age Restrictions	Deny if less than 2 years of age.
Prescriber Restrictions	pulmonologist
Coverage Duration	12 months
Other Criteria	Doses greater than 300mg/day will not be approved

kevzara

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	
Prescriber Restrictions	Deny if less than 18 years of age
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for rheumatoid arthritis.

KEYTRUDA

Products Affected

- **KEYTRUDA INTRAVENOUS SOLUTION**

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

kineret

Products Affected

- **KINERET**

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

kisqali

Products Affected

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

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

korlym

Products Affected

- **KORLYM**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of hyperglycemia secondary to hypercortisolism in patients with endogenous Cushing's syndrome who have Type 2 Diabetes Mellitus or glucose intolerance -AND- patient is not a candidate for surgery or radiotherapy or where surgery or radiotherapy has failed -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	

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

lenvima

Products Affected

- **LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X 2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 8 MG/DAY (4 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 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

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 in patients 55 years or older -OR- in patients with Hodgkin's disease, AML, 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	

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	

lidoderm

Products Affected

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

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

lonsurf

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic colorectal cancer in patients who have previously been treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy
Age Restrictions	
Prescriber Restrictions	oncologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

lynparza

Products Affected

- LYNPARZA ORAL CAPSULE
- LYNPARZA ORAL TABLET

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

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of DPN and trial/failure or intolerance to duloxetine-OR- PHN and trial/failure or intolerance to gabapentin -OR- seizures and trial/failure or intolerance to two AEDS -OR- neuropathic pain associated with spinal cord injury -OR- documentation to support a diagnosis of fibromyalgia and trial/failure or intolerance to duloxetine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

mavyret

Products Affected

- MAVYRET

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

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	

mekinist

Products Affected

- MEKINIST

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

methamphetamine

Products Affected

- *methamphetamine*

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

mozobil

Products Affected

- **MOZOBIL**

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

myalept

Products Affected

- MYALEPT

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

namenda

Products Affected

- NAMENDA TITRATION PAK
- NAMENDA XR

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

namzarin

Products Affected

- **NAMZARIC**

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

natpara

Products Affected

- NATPARA

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

nerlynx

Products Affected

- **NERLYNX**

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

nexavar

Products Affected

- NEXAVAR

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

ninlaro

Products Affected

- NINLARO

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

NORTHERA

Products Affected

- NORTHERA

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

nucala

Products Affected

- NUCALA

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

nuplazid

Products Affected

- NUPLAZID ORAL TABLET 17 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

ocaliva

Products Affected

- **OCALIVA**

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

odomzo

Products Affected

- ODOMZO

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

olumiant

Products Affected

- OLUMIANT

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	Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for rheumatoid arthritis.

onfi

Products Affected

- 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- aquedate 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	

opdivo

Products Affected

- **OPDIVO INTRAVENOUS SOLUTION**
100 MG/10 ML, 40 MG/4 ML

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

PA Criteria	Criteria Details
Other Criteria	Applies to new starts only

oralair

Products Affected

- **ORALAIR SUBLINGUAL TABLET 300
INDX REACTIVITY**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Asthma (severe, unstable or 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, or Kentucky Blue Grass pollens -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies - AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
Age Restrictions	Deny if less than 10 years of age or greater than 65 years of age
Prescriber Restrictions	allergy specialist, otolaryngologist, immunologist
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector

orencia

Products Affected

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

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 moderate to severe rheumatoid arthritis -OR- documentation of moderate to severe juvenile idiopathic rheumatoid arthritis -OR- documentation of psoriatic arthritis
Age Restrictions	
Prescriber Restrictions	rheumatologist
Coverage Duration	12 months
Other Criteria	For Orenzia SubQ, patients must have an adequate trial or intolerance to the preferred SubQ products, Enbrel and Humira, for rheumatoid arthritis and psoriatic arthritis. For Orenzia IV, patients must have an adequate trial or intolerance to one of the preferred IV products, Remicade or Simponi Aria, for rheumatoid arthritis or Remicade for psoriatic arthritis.

orkambi

Products Affected

- **ORKAMBI 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 6 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation showing a FEV1 improvement from baseline must be provided.

osphena

Products Affected

- OSPHENA

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	

OTEZLA

Products Affected

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

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

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.

pomalyst

Products Affected

- POMALYST

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

praluent

Products Affected

- PRALUENT PEN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of the following: 1. 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 (e.g. acute coronary syndrome, history of myocardial infarction) 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
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist

PA Criteria	Criteria Details
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.

prescription drug combo

Products Affected

- acetaminophen-codeine oral solution 120-12 mg/5 ml
- acetaminophen-codeine oral tablet
- **ALPRAZOLAM INTENSOL**
- alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg
- alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg
- alprazolam oral tablet, disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg
- **BUTALBITAL COMPOUND W/CODEINE**
- butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg
- **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, 2.5-325 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 injection syringe 5 mg/ml
- morphine intravenous syringe 10 mg/ml, 2 mg/ml, 4 mg/ml, 8 mg/ml
- morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg
- morphine oral capsule, extend. release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg
- morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)
- morphine oral tablet
- morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg
- 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
- **PANLOR (ACETAM-CAFF-DIHYDROCOD)**
- **PRIMLEV**

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

PA Criteria	Criteria Details
Required Medical Information	For concomitant use of an opiate agonist and substance abuse therapy, documentation that the member has a documented acute pain condition (e.g. acute traumatic injury) in which treatment with other agents would cause insufficient pain control or if the member requires treatment for pain related to a terminal illness. For concomitant use of an opiate agonist, benzodiazepine and a centrally acting skeletal muscle relaxant, documentation that the member has tried/failed at least 2 other skeletal muscle relaxant (e.g, methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients AND attestation of an intent to monitor and address concomitant drug-drug interaction adverse events
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Opiate+subs. abuse tx, approve opiate x 1mo. Opiate+benzo+carisoprodol, approve x 12mo.
Other Criteria	Opiate agonists will receive automatic approval if no recent claims for a substance abuse therapy (e.g, buprenorphine-naloxone) OR a benzodiazepine (e.g., triazolam, alprazolam) AND a centrally acting skeletal muscle relaxant (e.g., carisoprodol). Benzodiazepines (e.g, triazolam, alprazolam) will receive automatic approval if no recent claims for an opiate agonist (e.g., oxycodone, hydrocodone, oxymorphone) AND a centrally acting skeletal muscle relaxant (e.g., carisoprodol).

pristiq

Products Affected

- **FETZIMA 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	12 months
Other Criteria	Applies to new starts only

PROCYSBI

Products Affected

- **PROCYSBI**

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

prolia

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy or women at high risk for fracture receiving adjuvant aromatase inhibitor therapy -OR- use for treatment of osteoporosis and the prevention of fractures in postmenopausal women and men having a T score of less than -2.5 and a trial and failure or contraindication to at least one bisphosphonate -OR- use to prevent fractures in men and postmenopausal women with a low bone mass (T score between -1.0 and -2.5) and history of previous osteoporotic fracture or those who are found to have a 10-year risk of major osteoporotic fracture greater than or equal to 20 percent or a risk of hip fracture greater than or equal to 3 percent and had a trial and failure or contraindication to at least one bisphosphonate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Covered under Part B for female patients eligible for home health services when provider certifies that patient sustained bone fracture related to postmenopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug

provigil

Products Affected

- *armodafinil*
- *modafinil*

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	

pulmonary arterial hypertension

Products Affected

- **ADCIRCA**
- **LETAIRIS**
- **OPSUMIT**
- **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG**
- **REVATIO INTRAVENOUS**
- **REVATIO ORAL SUSPENSION FOR RECONSTITUTION**
- **REVATIO ORAL TABLET**
- *sildenafil (antihypertensive) intravenous*
- *sildenafil (antihypertensive) oral*
- **TRACLEER 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	cardiologist, pulmonologist
Coverage Duration	12 months
Other Criteria	

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

radicava

Products Affected

- RADICAVA

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

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	

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	

relistor

Products Affected

- **RELISTOR ORAL**

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

remicade

Products Affected

- REMICADE

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

renflexis

Products Affected

- **RENFLEXIS**

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

repatha

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	<p>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. 2. 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 (PH) 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. For HeFH, ASCVD and PH, 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</p>
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 .

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

repatha pushtronex

Products Affected

- **REPATHA PUSHTRONEX**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	<p>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. 2. 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 (PH) 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. For HeFH, ASCVD and PH, 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</p>

PA Criteria	Criteria Details
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 Pushtonex System per month will not be approved.

revlimid

Products Affected

- **REVLIMID**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Documentation of severe neutropenia, severe thrombocytopenia, or treatment-related MDS
Required Medical Information	Diagnosis of multiple myeloma -OR- diagnosis of 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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

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 of deleterious BRCA mutated, advanced ovarian cancer -AND- Rubraca will be used as monotherapy -AND- trial and failure of 2 prior chemotherapy regimens
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

ruconest

Products Affected

- RUCONEST

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

rydapt

Products Affected

- RYDAPT

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

sabril

Products Affected

- **SABRIL**
- *vigabatrin*

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	

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 euvoletic hyponatremia evidenced by serum Na less than 125 mEq/L, 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

savella

Products Affected

- SAVELLA

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

signifor

Products Affected

- SIGNIFOR

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

siliq

Products Affected

- SILIQ

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

simponi

Products Affected

- **SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML**
- **SIMPONI SUBCUTANEOUS SYRINGE 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, Oencia, Enbrel, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe ulcerative colitis and an inadequate response to two immunosuppressants or in those patients requiring continuous steroid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Alternatives for Ulcerative Colitis include immunosuppressants such as corticosteroids, azathioprine or 6-mercaptopurine. Patients must have an adequate trial or intolerance to the preferred product, Humira, for ulcerative colitis and the preferred products, Enbrel and Humira, for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis. For ulcerative colitis indication therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.

simponi aria

Products Affected

- SIMPONI ARIA

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

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	

sovaldi

Products Affected

- SOVALDI

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

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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

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 one of the following (1-3): 1) Moderate to severe plaque psoriasis and failure of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy. 2) Psoriatic arthritis. 3) Crohn's Disease and documentation of trial and failure, intolerance, or contraindication to an immunosuppressant (e.g. corticosteroids, azathioprine, 6-mercaptopurine, methotrexate) and Humira and documentation of clinical remission following IV administration of Stelara. -AND- Documentation of member weight and prescribed dose.
Age Restrictions	
Prescriber Restrictions	dermatologist, rheumatologist
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis and the preferred products, Enbrel and Humira, for psoriatic arthritis. Must follow recommended dosing guidelines based upon weight. Psoriasis: For patients weighing less than 100 kilograms (220 pounds), 45 mg dosing will be approved. For patients weighing more than 100 kilograms (220 pounds), 90 mg dosing will be approved. Psoriatic Arthritis: 45 mg dosing will be approved. For patients with co-existent moderate to severe plaque psoriasis weighing greater than 100 kilograms (220 pounds), 90 mg dosing will be approved.

stelara iv

Products Affected

- **STELARA INTRAVENOUS**

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

stivarga

Products Affected

- **STIVARGA**

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

strensiq

Products Affected

- STRENSIQ

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

sutent

Products Affected

- SUTENT

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

sylvant

Products Affected

- SYLVANT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documented diagnosis of multicentric Castleman's disease -AND- negative HIV and HHV-8 test -AND- baseline absolute neutrophil count greater than or equal to $1.0 \times 10^9/L$ -AND- baseline platelet count greater than or equal to $75 \times 10^9/L$ -AND- baseline hemoglobin less than 17g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

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 ivacaftor based on clinical and or in vitro assay (e.g. E56K, R117C, A455E)
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, 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.

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	

tagrisso

Products Affected

- TAGRISSO

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

taltz

Products Affected

- TALTZ AUTOINJECTOR
- 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 one of the following (1 or 2): 1) Psoriatic arthritis. 2) Moderate to severe psoriasis and trial/failure or intolerance of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy, or contraindication to systemic therapies or phototherapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	dermatologist
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis and Humira and Enbrel for psoriatic arthritis. For psoriasis and psoriatic arthritis induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen.

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	

tasigna

Products Affected

- **TASIGNA**

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

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	

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) on of which must be generic topical tretinoin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

tecentriq

Products Affected

- **TECENTRIQ**

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 with progression on or after platinum-based chemotherapy OR with locally advanced or metastatic urothelial carcinoma with progression within 12 months of neoadjuvant or adjuvant treatment with platinum-based chemotherapy OR metastatic non-small cell lung cancer with progression on or after platinum-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

tecfidera

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use with other disease modifying agents such as interferons, Copaxone , Tysabri, Aubagio, Gilenya
Required Medical Information	Documentation of relapsing form of multiple sclerosis (relapsing-remitting, relapsing secondary progressive, or progressive relapsing multiple sclerosis)
Age Restrictions	
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	Doses greater than 240 mg twice-daily will not be approved

technivie

Products Affected

- **TECHNIVIE**

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

testosterone (androgens)

Products Affected

- **ANDRODERM** **PACKET 1.62 % (20.25 MG/1.25 GRAM),**
- **ANDROGEL TRANSDERMAL GEL IN** **1.62 % (40.5 MG/2.5 GRAM)**
- **METERED-DOSE PUMP 20.25 MG/1.25**
 - *testosterone cypionate*
 - *testosterone enanthate*
- **GRAM (1.62 %)**
- **ANDROGEL TRANSDERMAL GEL IN**

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
Other Criteria	

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

thrombopoiesis stimulating agents

Products Affected

- **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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Platelet count to be provided

tigan

Products Affected

- *trimethobenzamide oral*

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

transmucosal fentanyl citrate

Products Affected

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

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

tretinoin

Products Affected

- *adapalene topical cream*
 - *adapalene topical gel*
 - **AVITA**
 - **RETIN-A MICRO PUMP TOPICAL**
- **GEL WITH PUMP 0.06 %, 0.08 %**
 - *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	

tykerb

Products Affected

- **TYKERB**

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

tymlos

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Diagnosis of underlying hypercalcemic disorder such as hypercalcemia, hyperparathyroidism or hypoparathyroidism, or high risk for osteosarcoma (Paget's disease, prior radiation therapy, bone metastases, open epiphyses, etc.). Treatment duration greater than 24 months.
Required Medical Information	Documentation to support use for treatment of osteoporosis and the prevention of fractures for patients meeting the following criteria 1) 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.

tysabri

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Patients with concomitant use of immunosuppressants or inhibitors of TNF-alpha
Required Medical Information	Documentation of treatment as monotherapy for relapsing forms of multiple sclerosis (relapsing-remitting, relapsing secondary progressive, or progressive relapsing multiple sclerosis) -OR- Documentation of Crohn's disease -AND- trial and failure, contraindication, or intolerance to at least 2 immunosuppressants (corticosteroids, azathioprine, 6-mercaptopurine, or methotrexate)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months for use in MS -OR- 3 months initial, 12 months reauthorization for use in CD
Other Criteria	Documentation of therapeutic benefit by 12 weeks after induction therapy must be provided for consideration of reauthorization in patients with CD

VALCHLOR

Products Affected

- VALCHLOR

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

veltassa

Products Affected

- VELTASSA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of hyperkalemia as defined by serum potassium level between 5.1 and 6.4 mmol/L on at least two (2) screenings -AND- modification of medications to reduce serum potassium levels, when applicable -AND- trial and failure, intolerance, or contraindication to sodium polystyrene sulfonate
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For reauthorization, documentation of reduction in serum potassium levels following Veltassa administration is required.

venclexta

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

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

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	The member meets one of the following: 1)The member is a female with documented disease progression following endocrine therapy and will be using concomitant fulvestrant therapy -OR- 2) The member has documented disease progression following endocrine therapy and prior chemotherapy in the metastatic setting and will be using verzenio (abemaciclib) as monotherapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

viberzi

Products Affected

- **VIBERZI**

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

VIEKIRA PAK

Products Affected

- VIEKIRA PAK

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

VIEKIRA XR

Products Affected

- VIEKIRA XR

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

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 any two antidepressants
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

vimovo

Products Affected

- **VIMOVO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Both of the following. 1) Trial/failure of naproxen used in combination with omeprazole. 2) Trial/failure of one additional generic formulary NSAID (other than naproxen) used in combination with another generic formulary PPI (other than omeprazole).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

vosevi

Products Affected

- VOSEVI

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

votrient

Products Affected

- VOTRIENT

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

vraylar

Products Affected

- VRAYLAR ORAL CAPSULE
- 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 schizophrenia OR acute treatment of manic or mixed episodes associated with bipolar I disorder
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

vyxeos

Products Affected

- VYXEOS

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

xalkori

Products Affected

- **XALKORI**

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

xeljanz

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orenzia, 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- Documentation of ulcerative colitis after failure of two immunosuppressants.
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. Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for rheumatoid arthritis and psoriatic arthritis. Alternatives for Ulcerative Colitis include immunosuppressants such as corticosteroids, azathioprine or 6-mercaptopurine. Patients must have an adequate trial or intolerance to the preferred product, Humira, for ulcerative colitis.

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.

xermelo

Products Affected

- XERMELO

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

xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

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

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

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

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	

xyrem

Products Affected

- XYREM

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

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

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	

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 -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	

zejula

Products Affected

- ZEJULA

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

zelboraf

Products Affected

- TAFINLAR
- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	Documentation of unresectable or metastatic melanoma with BRAFV600E mutation -OR- unresectable or metastatic melanoma with BRAF V600E or V600K mutations in combination with trametinib (Mekinist) -OR- documentation of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation in use of dabrafenib (Tafinlar) in combination with trametinib (Mekinist) -OR- documentation of ErdheimChester Disease with BRAF V600 mutation in use of vemurafenib (Zelboraf)
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

zepatier

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member is unable to utilize regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, peritaprevir/ombitasvir/ritonavir/dasabuvir and peritaprevir/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

zinplava

Products Affected

- ZINPLAVA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of high risk for Clostridium Difficile (C.diff) infection defined as meeting one or more of the following criteria: 1. 65 yo or older. 2. active C.diff infection as confirmed by having passed 3 or more loose bowel movements in 24 or fewer hours and a positive stool test for toxigenic C. difficile from a stool sample collected no more than 10 days before treatment with Zinplava. 2. receipt one or more systemic antibacterial therapy in the past 3 months prior to current active C.diff infection. 3. one or more episodes of C. Diff within the six months prior to current active infection. 4. immunocompromised state. 5. clinically severe C.diff (e.g. CDI with abdominal distension, hypoalbuminemia, and a white blood cell count greater than or equal to 15,000 cells/ mm ³) or C.diff ribotype 027 upon presentation. -AND- Zinplava is being used for the prevention of C.diff recurrence with standard of care antibacterial drugs such as metronidazole, vancomycin, or fidaxomicin
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	7 days
Other Criteria	Zinplava will only be approved for one dose per active Clostridium Difficile infection. Zinplava will not be approved for repeat doses for recurrence of the same active infection.

zolinza

Products Affected

- ZOLINZA

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

ZYDELIG

Products Affected

- ZYDELIG

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

zykadia

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive 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

zytiga

Products Affected

- ZYTIGA ORAL TABLET 250 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of metastatic castration resistant prostate cancer and concurrent use with prednisone 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

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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
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carac

Products Affected

- **CARAC 0.5 % TOPICAL CREAM**

Details

Criteria	Require a 1 month trial of generic fluorouracil topical product (Step 1 drug) in the last 90 days
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suboxone

Products Affected

- *buprenorphine 2 mg-naloxone 0.5 mg sublingual tablet*
- *buprenorphine 8 mg-naloxone 2 mg sublingual tablet*

Details

Criteria	Require a 1 month trial of Zubsolv (Step 1 drug) in the last 90 days
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**BUNAVAIL 4.2 MG-0.7 MG BUCCAL
FILM..... 1**

**BUNAVAIL 6.3 MG-1 MG BUCCAL
FILM..... 1**

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