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		
abacavir	T3	
abacavir-lamivudine	T5	
abacavir-lamivudine-zidovudine	T5	
ABELCET	T5	PA-BvD
acyclovir oral capsule	T2	
acyclovir oral suspension 200 mg/5 ml	T4	
acyclovir oral tablet	T2	
acyclovir sodium intravenous solution	T4	PA-BvD
adefovir	T5	
ALBENZA	T4	
ALINIA	T4	
amantadine hcl oral capsule	T2	QL (124 EA per 31 days)
amantadine hcl oral solution	T2	QL (1240 ML per 31 days)
amantadine hcl oral tablet	T2	QL (124 EA per 31 days)
AMBISOME	T4	PA-BvD
amikacin injection solution 500 mg/2 ml	T3	
amoxicillin oral capsule	T1	
amoxicillin oral suspension for reconstitution	T1	
amoxicillin oral tablet	T1	
amoxicillin oral tablet,chewable 125 mg, 250 mg	T1	
amoxicillin-pot clavulanate	T2	
amphotericin b	T2	PA-BvD
ampicillin oral capsule 500 mg	T2	
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg	T2	
ampicillin-sulbactam injection	T2	
APTIVUS	T5	
atazanavir	T3	
atovaquone	T5	
atovaquone-proguanil	T3	
ATRIPLA	T5	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	T4	
AVYCAZ	T5	
AZACTAM INJECTION RECON SOLN 2 GRAM	T4	
azithromycin	T2	
aztreonam injection recon soln 1 gram	T3	

Drug Name	Drug Tier	Requirements/Limits
BACIIM	T2	
bacitracin intramuscular	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	
caspofungin	T4	
CAYSTON	T5	
cefaclor oral capsule	T2	
cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml	T2	
cefaclor oral tablet extended release 12 hr	T3	
cefadroxil oral capsule	T2	
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	T2	
cefadroxil oral tablet	T2	
cefazolin injection recon soln 1 gram, 10 gram, 500 mg	T3	
cefdinir	T2	
cefepime	T4	
cefixime	T4	
cefotaxime injection recon soln 1 gram, 2 gram, 500 mg	T2	
cefotetan injection	T4	
cefoxitin	T4	
cefpodoxime	T2	
cefprozil	T3	
ceftazidime injection recon soln 1 gram, 2 gram	T4	
ceftazidime injection recon soln 6 gram	T3	
ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg	T3	
cefuroxime axetil oral tablet	T3	
cefuroxime sodium injection recon soln 750 mg	T3	

Drug Name	Drug Tier	Requirements/Limits
cefuroxime sodium intravenous	T3	
cephalexin	T2	
chloramphenicol sod succinate	T2	
chloroquine phosphate	T3	
CIMDUO	T5	QL (31 EA per 31 days)
ciprofloxacin	T2	
ciprofloxacin (mixture)	T2	
ciprofloxacin hcl oral	T1	
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	T2	
clarithromycin	T2	
clindamycin hcl	T2	
clindamycin in 5 % dextrose	T2	
clindamycin palmitate hcl	T2	
clindamycin phosphate injection	T2	
clindamycin phosphate intravenous solution 600 mg/4 ml	T2	
clotrimazole mucous membrane	T3	
COARTEM	T4	
colistin (colistimethate na)	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	
dapsone oral	T3	
daptomycin intravenous recon soln 500 mg	T5	
DARAPRIM	T5	
demeclocycline	T4	
DESCOVY	T5	QL (31 EA per 31 days)
dicloxacillin	T2	
didanosine oral capsule,delayed release(dr/ec) 200 mg, 250 mg, 400 mg	T4	
DIFICID	T5	QL (20 EA per 10 days)
doripenem intravenous recon soln 500 mg	T4	
DOXY-100	T2	
doxycycline hyclate oral capsule	T2	

Drug Name	Drug Tier	Requirements/Limits
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	T2	
doxycycline hyclate oral tablet,delayed release (dr/ec)	T2	
doxycycline monohydrate oral capsule	T2	
doxycycline monohydrate oral suspension for reconstitution	T2	
doxycycline monohydrate oral tablet	T2	
E.E.S. 400 ORAL TABLET	T4	
EDURANT	T5	
efavirenz	T3	
EMTRIVA	T3	
EMVERM	T4	
entecavir	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	
erythromycin ethylsuccinate oral suspension for reconstitution	T2	
erythromycin ethylsuccinate oral tablet	T4	
erythromycin oral capsule,delayed release(dr/ec)	T2	
erythromycin oral tablet	T2	
ethambutol	T2	
EVOTAZ	T4	
famciclovir	T3	
fluconazole	T2	
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml	T2	
flucytosine	T4	
fosamprenavir	T5	
FUZEON SUBCUTANEOUS RECON SOLN	T5	
ganciclovir sodium intravenous recon soln	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml	T2	
gentamicin injection solution 40 mg/ml	T1	
GENVOYA	T5	
griseofulvin microsize	T2	
griseofulvin ultramicrosize	T2	
HARVONI	T5	PA; QL (28 EA per 28 days)
hydroxychloroquine	T2	
imipenem-cilastatin	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	
isoniazid injection	T2	
isoniazid oral solution	T2	
isoniazid oral tablet	T1	
itraconazole oral capsule	T4	PA
ivermectin	T3	
JULUCA	T5	
KALETRA ORAL TABLET 100-25 MG	T3	
KALETRA ORAL TABLET 200-50 MG	T5	
ketoconazole oral	T4	
lamivudine	T2	
lamivudine-zidovudine	T2	
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	T2	
levofloxacin intravenous	T2	
levofloxacin oral	T2	
LEXIVA ORAL SUSPENSION	T4	
LINCOCIN	T4	

Drug Name	Drug Tier	Requirements/Limits
lincomycin	T2	
linezolid	T5	
linezolid in dextrose 5%	T4	
lopinavir-ritonavir	T5	
MAVYRET	T5	PA; QL (84 EA per 28 days)
mefloquine	T2	
meropenem	T4	
methenamine hippurate	T4	
metronidazole in nacl (iso-os)	T2	
metronidazole oral	T2	
minocycline	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	
moxifloxacin oral	T3	
MYCAMINE	T5	
nafcillin injection recon soln 1 gram, 10 gram	T4	
NEBUPENT	T4	PA-BvD
neomycin	T2	
nevirapine oral tablet	T2	
nevirapine oral tablet extended release 24 hr	T2	
nitrofurantoin	T2	PA; QL (1800 ML per 365 days)
nitrofurantoin macrocrystal oral capsule 100 mg	T2	PA; QL (90 EA per 365 days)
nitrofurantoin macrocrystal oral capsule 25 mg	T2	PA; QL (360 EA per 365 days)
nitrofurantoin macrocrystal oral capsule 50 mg	T2	PA; QL (180 EA per 365 days)
nitrofurantoin monohyd/m-cryst	T2	PA; QL (90 EA per 365 days)
NORVIR ORAL CAPSULE	T3	
NORVIR ORAL POWDER IN PACKET	T3	
NORVIR ORAL SOLUTION	T3	
nystatin oral suspension	T2	
nystatin oral tablet	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
ofloxacin oral tablet 300 mg, 400 mg	T2	
oseltamivir oral capsule 30 mg	T2	QL (170 EA per 365 days)
oseltamivir oral capsule 45 mg, 75 mg	T2	QL (90 EA per 365 days)
oseltamivir oral suspension for reconstitution	T3	QL (1080 ML per 365 days)

Drug Name	Drug Tier	Requirements/Limits
oxacillin in dextrose(iso-osm)	T4	
oxacillin injection recon soln 1 gram, 2 gram	T2	
oxacillin injection recon soln 10 gram	T4	
paromomycin	T4	
PASER	T4	
penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml	T4	
penicillin g potassium injection recon soln 20 million unit	T4	
penicillin g procaine intramuscular syringe 1.2 million unit/2 ml	T4	
penicillin g sodium	T4	
penicillin v potassium	T1	
PENTAM	T4	
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram	T4	
polymyxin b sulfate	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	
primaquine	T3	
pyrazinamide	T2	
quinine sulfate	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
ribavirin oral capsule	T3	
ribavirin oral tablet 200 mg	T3	
rifabutin	T4	
rifampin	T2	
RIFATER	T4	
rimantadine	T4	
ritonavir	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
stavudine oral capsule	T4	
streptomycin	T4	
STRIBILD	T5	
sulfadiazine	T4	
sulfamethoxazole-trimethoprim	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	
tenofovir disoproxil fumarate	T3	
terbinafine hcl oral	T2	QL (90 EA per 180 days)
tetracycline	T2	
tigecycline	T4	
tinidazole	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)
tobramycin in 0.225 % nacl	T5	PA
tobramycin sulfate injection solution	T2	
TRECATOR	T4	
trimethoprim	T2	
TRIUMEQ	T5	
TRUVADA	T5	
TYBOST	T3	
TYGACIL	T5	
VABOMERE	T4	
valacyclovir	T2	
valganciclovir oral recon soln	T4	
valganciclovir oral tablet	T5	
vancomycin intravenous recon soln 1,000 mg, 500 mg	T2	
vancomycin intravenous recon soln 10 gram	T3	
vancomycin oral capsule 125 mg	T4	
vancomycin oral capsule 250 mg	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	
voriconazole intravenous	T4	
voriconazole oral suspension for reconstitution	T4	
voriconazole oral tablet	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
zidovudine	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)
anastrozole	T2	
ARRANON	T4	
ASTAGRAF XL	T4	PA-BvD
AVASTIN	T5	
azacitidine	T5	
AZASAN	T4	PA-BvD
azathioprine	T2	PA-BvD
azathioprine sodium	T3	PA-BvD
BAVENCIO	T5	PA-NS
BELEODAQ	T5	PA-NS
bexarotene	T5	PA-NS
bicalutamide	T3	
BICNU	T4	
bleomycin injection recon soln 30 unit	T3	PA-BvD
bortezomib	T5	
BOSULIF	T5	PA-NS
busulfan	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
carboplatin intravenous solution	T4	
CELLCEPT INTRAVENOUS	T4	PA-BvD
cisplatin	T2	
cladribine	T2	PA-BvD
clofarabine	T4	
COMETRIQ	T5	PA-NS
COTELLIC	T5	PA-NS
cyclophosphamide oral capsule	T4	PA-BvD
cyclosporine intravenous	T2	PA-BvD
cyclosporine modified	T2	PA-BvD
cyclosporine oral capsule	T2	PA-BvD
cytarabine	T2	PA-BvD
cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)	T2	PA-BvD
dacarbazine intravenous recon soln 200 mg	T2	
dactinomycin	T5	
DARZALEX	T5	PA-NS
daunorubicin intravenous solution	T2	
dexrazoxane hcl intravenous recon soln 250 mg	T3	
docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 80 mg/4 ml (20 mg/ml)	T3	
doxorubicin intravenous solution 50 mg/25 ml	T2	PA-BvD
doxorubicin, peg-liposomal	T3	PA-BvD
DROXIA	T4	
ELIGARD	T4	
ELIGARD (3 MONTH)	T4	
ELIGARD (4 MONTH)	T4	
ELIGARD (6 MONTH)	T4	
ELITEK	T5	
EMCYT	T4	
ENVARSUS XR	T4	PA-BvD
epirubicin intravenous solution 200 mg/100 ml	T4	
ERIVEDGE	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA	T5	PA-NS; QL (124 EA per 31 days)
etoposide intravenous	T2	
exemestane	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	
fludarabine intravenous recon soln	T2	
fluorouracil intravenous solution 5 gram/100 ml	T2	PA-BvD
flutamide	T2	
FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)	T5	
FUSILEV	T4	
gemcitabine intravenous recon soln 1 gram	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	
hydroxyurea	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)
idarubicin	T2	
IDHIFA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 50 MG	T5	PA-NS; QL (62 EA per 31 days)
ifosfamide intravenous recon soln 1 gram	T2	
imatinib oral tablet 100 mg	T5	PA-NS; QL (93 EA per 31 days)
imatinib oral tablet 400 mg	T5	PA-NS; QL (62 EA per 31 days)
IMBRUVICA 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
irinotecan intravenous solution 100 mg/5 ml	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
letrozole	T2	
leucovorin calcium injection recon soln 100 mg, 350 mg	T2	
leucovorin calcium oral	T2	
LEUKERAN	T4	
leuprolide subcutaneous kit	T3	
levoleucovorin intravenous recon soln 50 mg	T4	
levoleucovorin intravenous solution	T4	
LONSURF	T5	PA-NS
LUPRON DEPOT (3 MONTH)	T5	
LUPRON DEPOT (4 MONTH)	T5	
LUPRON DEPOT (6 MONTH)	T5	
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	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	
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml	T2	PA
megestrol oral tablet	T2	PA-NS
MEKINIST	T5	PA-NS
melphalan hcl	T5	
mercaptopurine	T2	
mesna	T2	
MESNEX ORAL	T4	
methotrexate sodium (pf)	T2	PA-BvD
methotrexate sodium injection	T2	PA-BvD
methotrexate sodium oral	T1	PA-BvD
mitomycin intravenous	T2	
mitoxantrone	T3	
MUSTARGEN	T4	
mycophenolate mofetil hcl	T3	PA-BvD
mycophenolate mofetil oral capsule	T2	PA-BvD
mycophenolate mofetil oral suspension for reconstitution	T3	PA-BvD
mycophenolate mofetil oral tablet	T2	PA-BvD
mycophenolate sodium	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	
nilutamide	T5	
NINLARO	T5	PA-NS
NIPENT	T4	
NULOJIX	T5	PA-BvD
octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 50 mcg/ml	T3	
octreotide acetate injection solution 200 mcg/ml, 500 mcg/ml	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
oxaliplatin intravenous recon soln 100 mg	T4	
oxaliplatin intravenous solution 100 mg/20 ml	T4	
paclitaxel	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
sirolimus oral tablet 0.5 mg, 2 mg	T4	PA-BvD
sirolimus oral tablet 1 mg	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	
tacrolimus oral	T2	PA-BvD
TAFINLAR	T5	PA-NS
TAGRISSO	T5	PA-NS; QL (31 EA per 31 days)
tamoxifen	T1	
TARCEVA	T5	PA-NS; QL (31 EA per 31 days)
TARGRETIN 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)
thiotepa	T5	
TOPOSAR	T2	
topotecan intravenous recon soln	T2	
TREANDA INTRAVENOUS RECON SOLN	T4	
TRELSTAR INTRAMUSCULAR SYRINGE	T3	
tretinoin (chemotherapy)	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)
vinblastine intravenous solution	T3	PA-BvD
VINCASAR PFS INTRAVENOUS SOLUTION 1 MG/ML	T2	PA-BvD
vincristine intravenous solution 1 mg/ml	T2	PA-BvD
vinorelbine intravenous solution 50 mg/5 ml	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)
acetaminophen-codeine oral solution 120-12 mg/5 ml	T2	PA; QL (5167 ML per 31 days)
acetaminophen-codeine oral tablet	T2	PA; QL (403 EA per 31 days)
AIMOVIG AUTOINJECTOR (2 PACK)	T4	PA; QL (2 ML per 28 days)
ALLZITAL	T4	QL (372 EA per 31 days)
almotriptan malate oral tablet 12.5 mg	T4	QL (8 EA per 31 days)
almotriptan malate oral tablet 6.25 mg	T4	QL (16 EA per 31 days)
ALPRAZOLAM INTENSOL	T2	PA
alprazolam oral tablet 0.25 mg, 0.5 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet 1 mg, 2 mg	T2	PA; QL (155 EA per 31 days)
alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg	T2	PA; QL (31 EA per 31 days)
alprazolam oral tablet extended release 24 hr 2 mg	T2	PA; QL (155 EA per 31 days)
alprazolam oral tablet extended release 24 hr 3 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet,disintegrating 1 mg, 2 mg	T2	PA; QL (155 EA per 31 days)
amitriptyline	T2	PA-NS

Drug Name	Drug Tier	Requirements/Limits
amitriptyline-chlordiazepoxide	T2	PA-NS
amoxapine	T2	
AMPYRA	T5	PA; QL (62 EA per 31 days)
APLENZIN	T4	
APOKYN	T5	PA
APTENSIO XR	T4	
APTIOM	T4	
aripiprazole oral solution	T4	PA-NS
aripiprazole oral tablet	T4	PA-NS
aripiprazole oral tablet,disintegrating 10 mg	T4	PA-NS
aripiprazole oral tablet,disintegrating 15 mg	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	
armodafinil	T4	PA; QL (31 EA per 31 days)
atomoxetine oral capsule 10 mg, 25 mg, 40 mg	T4	PA; QL (62 EA per 31 days)
atomoxetine oral capsule 100 mg, 60 mg, 80 mg	T4	PA; QL (31 EA per 31 days)
atomoxetine oral capsule 18 mg	T4	PA; QL (124 EA per 31 days)
AUBAGIO	T5	PA; QL (31 EA per 31 days)
AZILECT	T3	
baclofen oral tablet 10 mg, 20 mg	T2	
BANZEL ORAL SUSPENSION	T5	PA-NS
BANZEL ORAL TABLET 200 MG	T4	PA-NS
BANZEL ORAL TABLET 400 MG	T5	PA-NS
benztropine	T2	
BRIVIACT	T4	
bromocriptine	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)
buprenorphine hcl injection	T4	QL (267 ML per 30 days)
buprenorphine hcl sublingual tablet 2 mg	T3	QL (93 EA per 31 days)
buprenorphine hcl sublingual tablet 8 mg	T3	QL (62 EA per 31 days)
buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour	T4	PA; QL (4 EA per 28 days)
buprenorphine-naloxone sublingual tablet	T4	ST; QL (93 EA per 31 days)
bupropion hcl oral tablet	T3	

Drug Name	Drug Tier	Requirements/Limits
bupropion hcl oral tablet extended release 24 hr 150 mg	T3	QL (93 EA per 31 days)
bupropion hcl oral tablet extended release 24 hr 300 mg	T3	QL (31 EA per 31 days)
bupropion hcl oral tablet sustained-release 12 hr	T3	QL (62 EA per 31 days)
buspirone	T2	
BUTALBITAL COMPOUND W/CODEINE	T2	PA; QL (372 EA per 31 days)
butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg	T2	PA; QL (403 EA per 31 days)
butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg	T2	PA; QL (372 EA per 31 days)
butalbital-acetaminophen oral tablet 50-300 mg	T2	QL (403 EA per 31 days)
butalbital-acetaminophen oral tablet 50-325 mg	T2	QL (372 EA per 31 days)
butalbital-acetaminophen-caff oral capsule 50-300-40 mg	T2	QL (403 EA per 31 days)
butalbital-acetaminophen-caff oral capsule 50-325-40 mg	T2	QL (372 EA per 31 days)
butalbital-acetaminophen-caff oral tablet 50-325-40 mg	T2	QL (372 EA per 31 days)
butalbital-aspirin-caffeine oral capsule	T2	
butorphanol tartrate injection solution 1 mg/ml	T4	QL (720 ML per 30 days)
butorphanol tartrate injection solution 2 mg/ml	T4	QL (360 ML per 30 days)
butorphanol tartrate nasal	T4	QL (5 ML per 28 days)
BUTRANS	T4	PA; QL (4 EA per 28 days)
CAMBIA	T4	
carbamazepine oral capsule, er multiphase 12 hr	T2	
carbamazepine oral suspension 100 mg/5 ml	T1	
carbamazepine oral tablet	T1	
carbamazepine oral tablet extended release 12 hr	T2	
carbamazepine oral tablet,chewable	T1	
carbidopa	T4	
carbidopa-levodopa	T2	
carbidopa-levodopa-entacapone	T2	
carisoprodol-asa-codeine	T2	PA; QL (2582 EA per 31 days)
celecoxib	T2	QL (62 EA per 31 days)
CELONTIN ORAL CAPSULE 300 MG	T4	
chlorpromazine	T4	
citalopram	T1	
clomipramine	T4	PA-NS
clonazepam oral tablet 0.5 mg	T2	QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
clonazepam oral tablet 1 mg	T2	QL (124 EA per 31 days)
clonazepam oral tablet 2 mg	T2	QL (310 EA per 31 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg	T2	QL (93 EA per 31 days)
clonazepam oral tablet,disintegrating 1 mg	T2	QL (124 EA per 31 days)
clonazepam oral tablet,disintegrating 2 mg	T2	QL (310 EA per 31 days)
clonidine hcl oral tablet extended release 12 hr	T4	PA
clorazepate dipotassium oral tablet 15 mg	T2	QL (186 EA per 31 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	T2	QL (93 EA per 31 days)
clozapine oral tablet	T2	
clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 25 mg	T2	
clozapine oral tablet,disintegrating 150 mg, 200 mg	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)
cyclobenzaprine oral tablet	T2	PA
dantrolene	T2	
DAYTRANA	T4	
desipramine	T2	
desvenlafaxine oral tablet extended release 24 hr	T4	
desvenlafaxine succinate	T4	QL (31 EA per 31 days)
dexmethylphenidate	T2	
dextroamphetamine oral capsule, extended release	T2	
dextroamphetamine oral tablet	T2	
dextroamphetamine-amphetamine oral capsule,extended release 24hr	T2	QL (31 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	T2	QL (62 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 20 mg	T2	QL (93 EA per 31 days)
DIASTAT	T4	
DIAZEPAM INTENSOL	T2	QL (248 ML per 31 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	T2	QL (1500 ML per 31 days)
diazepam oral tablet	T2	QL (124 EA per 31 days)
diclofenac potassium	T2	
diclofenac sodium oral	T2	

Drug Name	Drug Tier	Requirements/Limits
diclofenac sodium topical drops	T2	
diclofenac sodium topical gel 1 %	T3	
diclofenac-misoprostol	T2	
diflunisal	T2	
dihydroergotamine injection	T2	
dihydroergotamine nasal	T2	QL (8 ML per 31 days)
DILANTIN	T4	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	
DILANTIN-125	T4	
divalproex oral capsule, delayed rel sprinkle	T2	
divalproex oral tablet extended release 24 hr	T3	
divalproex oral tablet,delayed release (dr/ec)	T2	
donepezil	T2	
doxepin oral	T2	PA-NS
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 60 mg	T3	QL (62 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 30 mg, 40 mg	T3	QL (31 EA per 31 days)
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)
eletriptan oral tablet 20 mg	T4	QL (12 EA per 31 days)
eletriptan oral tablet 40 mg	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)
entacapone	T2	
EPITOL	T1	
EQUETRO	T4	
ergoloid	T4	
ergotamine-caffeine	T2	
escitalopram oxalate oral solution	T4	QL (620 ML per 31 days)
escitalopram oxalate oral tablet	T4	QL (31 EA per 31 days)
eszopiclone	T2	
ethosuximide	T2	
etodolac	T2	
EXONDYS 51	T5	PA

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

Drug Name	Drug Tier	Requirements/Limits
fluphenazine hcl	T2	
flurbiprofen	T2	
fluvoxamine	T2	
fosphenytoin injection solution 100 mg pe/2 ml	T2	
frovatriptan	T4	QL (12 EA per 31 days)
FYCOMPA ORAL SUSPENSION	T4	
FYCOMPA ORAL TABLET	T4	
gabapentin oral capsule	T2	
gabapentin oral solution 250 mg/5 ml	T2	
gabapentin oral tablet 600 mg, 800 mg	T2	
galantamine	T2	
GEODON INTRAMUSCULAR	T4	
GILENYA ORAL CAPSULE 0.5 MG	T5	PA; QL (31 EA per 31 days)
glatiramer subcutaneous syringe 20 mg/ml	T5	QL (31 ML per 31 days)
glatiramer subcutaneous syringe 40 mg/ml	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
guanfacine oral tablet extended release 24 hr	T4	PA
guanidine	T2	
haloperidol	T2	
haloperidol decanoate	T2	
haloperidol lactate	T2	
HETLIOZ	T5	PA
HORIZANT	T4	PA-NS
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	T4	PA; QL (5723 ML per 31 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	T3	PA; QL (155 EA per 31 days)
hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml	T2	PA; QL (124 ML per 31 days)
hydromorphone injection syringe 2 mg/ml	T2	PA; QL (155 ML per 31 days)
hydromorphone oral liquid	T2	PA; QL (1550 ML per 31 days)
hydromorphone oral tablet	T2	PA; QL (186 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	

Drug Name	Drug Tier	Requirements/Limits
ibuprofen oral suspension	T1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	T1	
imipramine hcl	T2	PA-NS
imipramine pamoate	T2	
INDOCIN ORAL	T4	
indomethacin oral	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)
ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg	T3	
ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)	T2	
ketorolac intramuscular cartridge	T2	
ketorolac oral	T2	
lamotrigine oral tablet	T2	
lamotrigine oral tablet extended release 24hr	T4	
lamotrigine oral tablet, chewable dispersible	T2	
lamotrigine oral tablet,disintegrating	T4	
lamotrigine oral tablets,dose pack	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)
levetiracetam in nacl (iso-os)	T4	
levetiracetam intravenous	T2	
levetiracetam oral solution 100 mg/ml	T2	
levetiracetam oral tablet	T2	
levetiracetam oral tablet extended release 24 hr	T2	
LIORESAL INTRATHECAL SOLUTION 2,000 MCG/ML, 500 MCG/ML	T4	PA-BvD
lithium carbonate oral capsule	T1	
lithium carbonate oral tablet	T1	
lithium carbonate oral tablet extended release	T2	
lithium citrate oral solution 8 meq/5 ml	T2	
lorazepam oral concentrate	T2	QL (155 ML per 31 days)
lorazepam oral tablet 0.5 mg	T2	QL (124 EA per 31 days)
lorazepam oral tablet 1 mg	T2	QL (186 EA per 31 days)
lorazepam oral tablet 2 mg	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)
loxapine succinate	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)
maprotiline	T2	
MARPLAN	T4	
meclofenamate	T2	
mefenamic acid	T2	
meloxicam oral tablet	T1	
memantine oral capsule,sprinkle,er 24hr	T3	
memantine oral solution	T3	
memantine oral tablet	T3	

Drug Name	Drug Tier	Requirements/Limits
memantine oral tablets,dose pack	T4	
MESTINON ORAL SYRUP	T5	
METADATE ER	T2	QL (93 EA per 31 days)
METAXALL	T2	
metaxalone	T2	
methadone injection solution	T2	PA-BvD; QL (160 ML per 30 days)
methadone oral solution 10 mg/5 ml	T2	PA; QL (1033 ML per 31 days)
methadone oral solution 5 mg/5 ml	T2	PA; QL (2066 ML per 31 days)
methadone oral tablet 10 mg	T2	PA; QL (206 EA per 31 days)
methadone oral tablet 5 mg	T2	PA; QL (248 EA per 31 days)
methamphetamine	T5	PA
methylphenidate hcl oral capsule, er biphasic 30-70	T2	QL (31 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 10 mg	T2	QL (186 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 20 mg	T2	QL (93 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 40 mg	T2	QL (62 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 60 mg	T2	QL (31 EA per 31 days)
methylphenidate hcl oral solution	T2	
methylphenidate hcl oral tablet	T2	QL (93 EA per 31 days)
methylphenidate hcl oral tablet extended release 10 mg	T2	QL (31 EA per 31 days)
methylphenidate hcl oral tablet extended release 20 mg	T2	QL (93 EA per 31 days)
methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 36 mg, 54 mg	T2	QL (31 EA per 31 days)
methylphenidate hcl oral tablet,chewable 10 mg	T2	QL (186 EA per 31 days)
methylphenidate hcl oral tablet,chewable 2.5 mg, 5 mg	T2	QL (93 EA per 31 days)
MIGERGOT	T5	
mirtazapine	T2	
modafinil	T2	PA; QL (31 EA per 31 days)
morphine concentrate oral solution	T2	PA; QL (310 ML per 31 days)
morphine injection syringe 5 mg/ml	T2	PA; QL (400 ML per 30 days)
morphine intravenous syringe 10 mg/ml	T4	PA; QL (200 ML per 30 days)
morphine intravenous syringe 2 mg/ml	T2	PA; QL (1000 ML per 30 days)
morphine intravenous syringe 4 mg/ml	T2	PA; QL (500 ML per 30 days)

Drug Name	Drug Tier	Requirements/Limits
morphine intravenous syringe 8 mg/ml	T4	PA; QL (250 ML per 30 days)
morphine oral capsule, er multiphase 24 hr 120 mg	T3	PA; QL (51 EA per 31 days)
morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	T3	PA; QL (62 EA per 31 days)
morphine oral capsule,extend.release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg	T3	PA; QL (62 EA per 31 days)
morphine oral solution 10 mg/5 ml	T2	PA; QL (2800 ML per 31 days)
morphine oral solution 20 mg/5 ml (4 mg/ml)	T2	PA; QL (1400 ML per 31 days)
morphine oral tablet	T2	PA; QL (186 EA per 31 days)
morphine oral tablet extended release 100 mg	T3	PA; QL (62 EA per 31 days)
morphine oral tablet extended release 15 mg, 30 mg, 60 mg	T3	PA; QL (100 EA per 31 days)
morphine oral tablet extended release 200 mg	T3	PA; QL (31 EA per 31 days)
nabumetone	T2	
nalbuphine injection solution 10 mg/ml	T2	QL (200 ML per 30 days)
nalbuphine injection solution 20 mg/ml	T2	QL (100 ML per 30 days)
naloxone	T2	
naltrexone	T2	
NAMENDA TITRATION PAK	T4	PA
NAMENDA XR	T4	PA
NAMZARIC	T4	PA
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 750 MG	T4	
naproxen oral suspension	T2	
naproxen oral tablet	T1	
naproxen oral tablet,delayed release (dr/ec)	T2	
naproxen sodium oral tablet 275 mg, 550 mg	T2	
naproxen sodium oral tablet, er multiphase 24 hr	T2	
naratriptan oral tablet 1 mg	T2	QL (20 EA per 31 days)
naratriptan oral tablet 2.5 mg	T2	QL (8 EA per 31 days)
NARCAN NASAL SPRAY,NON-AEROSOL 4 MG/ACTUATION	T4	
nefazodone	T2	
NEUPRO	T4	
nortriptyline	T2	
NUCYNTA	T4	QL (186 EA per 31 days)
NUEDEXTA	T3	
NUPLAZID ORAL TABLET 17 MG	T5	PA-NS
olanzapine intramuscular	T2	

Drug Name	Drug Tier	Requirements/Limits
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 7.5 mg	T2	QL (31 EA per 31 days)
olanzapine oral tablet 5 mg	T3	QL (31 EA per 31 days)
olanzapine oral tablet,disintegrating	T2	QL (31 EA per 31 days)
olanzapine-fluoxetine	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)
oxaprozin	T2	
oxcarbazepine	T2	
OXTELLAR XR	T4	
oxycodone oral capsule	T2	PA; QL (186 EA per 31 days)
oxycodone oral concentrate	T2	PA; QL (180 ML per 31 days)
oxycodone oral solution	T2	PA; QL (4133 ML per 31 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg	T2	PA; QL (186 EA per 31 days)
oxycodone oral tablet 30 mg	T3	PA; QL (138 EA per 31 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	T3	PA; QL (372 EA per 31 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	T4	QL (31 EA per 31 days)
paliperidone oral tablet extended release 24hr 6 mg	T4	QL (62 EA per 31 days)
PANLOR(ACETAM-CAFF-DIHYDROCOD)	T2	PA; QL (372 EA per 31 days)
paroxetine hcl oral tablet	T1	
paroxetine hcl oral tablet extended release 24 hr	T2	
paroxetine mesylate(menop.sym)	T4	
PAXIL ORAL SUSPENSION	T4	
PEGANONE	T4	
perphenazine	T2	
perphenazine-amitriptyline	T2	PA-NS
phenelzine	T2	
phenobarbital	T2	
PHENYTEK	T4	
phenytoin oral suspension 125 mg/5 ml	T2	
phenytoin oral tablet,chewable	T2	
phenytoin sodium extended	T2	
phenytoin sodium intravenous solution	T2	
pimozide	T2	
piroxicam	T2	

Drug Name	Drug Tier	Requirements/Limits
pramipexole oral tablet	T2	
pramipexole oral tablet extended release 24 hr	T4	
primidone	T2	
PRIMLEV	T4	PA; QL (403 EA per 31 days)
PROCENTRA	T2	
protriptyline	T3	
pyridostigmine bromide	T3	
quetiapine oral tablet	T2	QL (62 EA per 31 days)
QUILLIVANT XR	T4	
RADICAVA	T5	PA
rasagiline	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)
risperidone oral solution	T2	QL (496 ML per 31 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	T2	QL (31 EA per 31 days)
risperidone oral tablet 3 mg	T2	QL (93 EA per 31 days)
risperidone oral tablet 4 mg	T2	QL (124 EA per 31 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg	T2	QL (31 EA per 31 days)
risperidone oral tablet,disintegrating 3 mg	T2	QL (93 EA per 31 days)
risperidone oral tablet,disintegrating 4 mg	T2	QL (124 EA per 31 days)
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG	T4	QL (186 EA per 31 days)
rivastigmine	T3	QL (30 EA per 30 days)
rivastigmine tartrate	T3	
rizatriptan oral tablet 10 mg	T3	QL (12 EA per 31 days)
rizatriptan oral tablet 5 mg	T3	QL (24 EA per 31 days)
rizatriptan oral tablet,disintegrating 10 mg	T3	QL (12 EA per 31 days)
rizatriptan oral tablet,disintegrating 5 mg	T3	QL (24 EA per 31 days)
ropinirole	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
selegiline hcl	T2	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR	T3	QL (62 EA per 31 days)
sertraline	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)
sulindac	T2	
sumatriptan nasal spray,non-aerosol 20 mg/actuation	T2	QL (8 EA per 31 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	T2	QL (32 EA per 31 days)
sumatriptan succinate oral tablet 100 mg	T2	QL (9 EA per 31 days)
sumatriptan succinate oral tablet 25 mg	T2	QL (36 EA per 31 days)
sumatriptan succinate oral tablet 50 mg	T2	QL (18 EA per 31 days)
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml	T2	QL (6 ML per 31 days)
sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml	T2	QL (4 ML per 31 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml	T2	QL (6 ML per 31 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	T2	QL (4 ML per 31 days)
sumatriptan succinate subcutaneous solution	T2	QL (4 ML per 31 days)
sumatriptan-naproxen	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	
temazepam	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
tetrabenazine oral tablet 12.5 mg	T5	PA; QL (93 EA per 31 days)
tetrabenazine oral tablet 25 mg	T5	PA; QL (124 EA per 31 days)
thioridazine	T2	
thiothixene	T2	
tiagabine oral tablet 12 mg, 16 mg	T4	
tiagabine oral tablet 2 mg, 4 mg	T3	
tizanidine	T2	
tolcapone	T5	
tolmetin oral capsule	T2	
tolmetin oral tablet 600 mg	T2	
topiramate oral capsule, sprinkle	T2	
topiramate oral capsule,sprinkle,er 24hr	T4	
topiramate oral tablet	T2	
tramadol oral capsule,er biphase 24 hr 25-75 100 mg, 200 mg	T4	QL (30 EA per 30 days)
tramadol oral tablet	T2	QL (240 EA per 30 days)
tramadol-acetaminophen	T2	QL (372 EA per 31 days)
tranylcypromine	T4	
trazodone oral tablet 100 mg, 150 mg, 50 mg	T1	
trazodone oral tablet 300 mg	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)
trifluoperazine	T2	
trihexyphenidyl	T2	
trimipramine	T3	PA-NS
TRINTELLIX	T4	PA-NS
TROKENDI XR	T4	
TYSABRI	T5	PA; QL (15 ML per 28 days)
valproate sodium	T2	
valproic acid	T2	
valproic acid (as sodium salt) oral solution 500 mg/10 ml (10 ml)	T2	
venlafaxine oral capsule,extended release 24hr	T2	QL (31 EA per 31 days)
venlafaxine oral tablet	T2	
venlafaxine oral tablet extended release 24hr	T4	QL (31 EA per 31 days)
VERSACLOZ	T4	
vigabatrin	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)
zaleplon	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	
ziprasidone hcl	T3	QL (62 EA per 31 days)
zolmitriptan oral tablet 2.5 mg	T2	QL (16 EA per 31 days)
zolmitriptan oral tablet 5 mg	T2	QL (8 EA per 31 days)
zolmitriptan oral tablet,disintegrating 2.5 mg	T2	QL (16 EA per 31 days)
zolmitriptan oral tablet,disintegrating 5 mg	T2	QL (8 EA per 31 days)
zolpidem oral tablet	T2	
zolpidem oral tablet,ext release multiphase	T3	
zolpidem sublingual	T3	
ZOMIG NASAL SPRAY,NON-AEROSOL 2.5 MG	T4	QL (16 EA per 31 days)
ZOMIG NASAL SPRAY,NON-AEROSOL 5 MG	T4	QL (8 EA per 31 days)
zonisamide	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		
acebutolol	T1	

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

Drug Name	Drug Tier	Requirements/Limits
cholestyramine (with sugar) oral powder in packet	T2	
CHOLESTYRAMINE LIGHT ORAL POWDER	T2	
cilostazol	T2	
clonidine	T2	
clonidine hcl oral tablet	T1	
clopidogrel oral tablet 75 mg	T2	
colesevelam oral tablet	T3	
colestipol oral packet	T2	
colestipol oral tablet	T2	
CORLANOR ORAL TABLET 5 MG	T4	PA; QL (93 EA per 31 days)
CORLANOR ORAL TABLET 7.5 MG	T4	PA; QL (62 EA per 31 days)
COUMADIN ORAL	T4	
DEMSER	T3	
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
digoxin injection solution	T2	PA
digoxin oral solution 50 mcg/ml	T2	PA
digoxin oral tablet 125 mcg	T1	PA
digoxin oral tablet 250 mcg	T2	PA
diltiazem hcl intravenous	T1	
diltiazem hcl oral capsule,extended release 12 hr	T1	
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	T1	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	T1	
diltiazem hcl oral tablet	T1	
DILT-XR	T1	
dofetilide	T3	
DOPTELET	T5	PA
doxazosin	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)
enalapril maleate	T1	
enalapril-hydrochlorothiazide	T1	
enoxaparin subcutaneous solution	T4	
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	T4	
enoxaparin subcutaneous syringe 150 mg/ml	T5	
ENTRESTO	T3	PA; QL (62 EA per 31 days)
eplerenone	T2	
eprosartan	T1	
ethacrynic acid	T2	
ezetimibe	T2	
ezetimibe-simvastatin	T3	
felodipine	T2	
fenofibrate micronized	T2	
fenofibrate nanocrystallized oral tablet 145 mg	T3	
fenofibrate nanocrystallized oral tablet 48 mg	T2	
fenofibrate oral tablet 120 mg	T5	
fenofibrate oral tablet 160 mg, 54 mg	T2	
fenofibrate oral tablet 40 mg	T4	
fenofibric acid (choline)	T3	
fenofibric acid oral tablet 105 mg	T3	
fenofibric acid oral tablet 35 mg	T2	
flecainide	T2	
fluvastatin oral capsule	T2	
fluvastatin oral tablet extended release 24 hr	T3	
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	T5	
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	T4	
fosinopril	T1	
fosinopril-hydrochlorothiazide	T1	
FRAGMIN SUBCUTANEOUS SOLUTION	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 18,000 ANTI-XA UNIT/0.72 ML	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	
furosemide injection	T2	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	T2	
furosemide oral tablet	T1	
gemfibrozil	T2	
GONITRO	T4	
heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml), 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)	T2	
heparin (porcine) injection solution	T2	
hydralazine	T2	
hydrochlorothiazide	T1	
indapamide	T2	
INNOPRAN XL	T4	
irbesartan	T1	QL (31 EA per 31 days)
irbesartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
ISORDIL	T4	
isosorbide dinitrate oral	T2	
isosorbide mononitrate	T2	
isradipine	T2	
JANTOVEN	T2	
JUXTAPID	T5	PA
KYNAMRO	T5	PA
labetalol intravenous solution	T1	
labetalol oral	T1	
LANOXIN ORAL TABLET 62.5 MCG	T4	PA
LIPOFEN	T4	
lisinopril	T1	
lisinopril-hydrochlorothiazide	T1	
LIVALO	T4	
losartan oral tablet 100 mg	T1	QL (31 EA per 31 days)
losartan oral tablet 25 mg	T1	QL (93 EA per 31 days)
losartan oral tablet 50 mg	T1	QL (62 EA per 31 days)
losartan-hydrochlorothiazide	T1	

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

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

Drug Name	Drug Tier	Requirements/Limits
simvastatin	T1	
SORINE	T1	
SOTALOL AF ORAL TABLET 120 MG	T1	
sotalol oral tablet 160 mg, 240 mg, 80 mg	T1	
spironolactone	T1	
spironolacton-hydrochlorothiaz	T2	
TAVALISSE	T5	PA; QL (62 EA per 31 days)
TAZTIA XT	T2	
TEKTURNA	T4	
TEKTURNA HCT	T4	
telmisartan	T1	
telmisartan-amlodipine	T2	
telmisartan-hydrochlorothiazid	T1	
terazosin	T1	
timolol maleate oral	T1	
torsemide oral	T2	
trandolapril	T1	
trandolapril-verapamil	T2	
tranexamic acid intravenous	T3	
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg	T1	
triamterene-hydrochlorothiazid oral tablet	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)
valsartan oral tablet 160 mg, 40 mg, 80 mg	T1	QL (62 EA per 31 days)
valsartan oral tablet 320 mg	T2	QL (31 EA per 31 days)
valsartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
VASCEPA	T4	
verapamil intravenous solution	T2	
verapamil oral	T2	
warfarin	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	
acitretin	T5	
acyclovir topical	T3	
adapalene topical cream	T4	PA
adapalene topical gel	T4	PA
adapalene-benzoyl peroxide	T4	
ALA-CORT TOPICAL CREAM 1 %	T1	
ALA-CORT TOPICAL CREAM 2.5 %	T2	
alclometasone	T2	
amcinonide	T3	
ammonium lactate	T2	
AMNESTEEM	T4	
APEXICON E	T4	
AVITA TOPICAL CREAM	T2	PA
AVITA TOPICAL GEL	T4	PA
AZELEX	T4	
betamethasone dipropionate	T2	
betamethasone valerate	T2	
betamethasone, augmented	T2	
calcipotriene	T4	
calcipotriene-betamethasone	T4	
calcitriol topical	T2	
CAPEX	T4	
CARAC	T5	ST
ciclopirox	T2	
CLARAVIS ORAL CAPSULE 10 MG	T4	
CLINDACIN P	T4	
clindamycin phosphate topical foam	T2	
clindamycin phosphate topical gel	T2	
clindamycin phosphate topical lotion	T2	
clindamycin phosphate topical solution	T2	
clindamycin phosphate topical swab	T2	
clindamycin-benzoyl peroxide topical gel	T2	
clindamycin-tretinoin	T2	
clobetasol	T3	
CLODERM	T4	

Drug Name	Drug Tier	Requirements/Limits
clotrimazole topical	T3	
clotrimazole-betamethasone	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)
dapsone topical	T4	
DENAVIR	T4	
DESONATE	T4	
desonide	T3	
desoximetasone topical cream	T4	
desoximetasone topical gel	T4	
desoximetasone topical ointment	T4	
diclofenac sodium topical gel 3 %	T5	PA
DIFFERIN TOPICAL LOTION	T4	
diflorasone	T4	
doxepin topical	T2	
DUPIXENT	T5	PA; QL (4 ML per 28 days)
econazole	T3	
ELIDEL	T4	
EPIDUO FORTE	T4	
ERY PADS	T2	
ERYGEL	T3	
erythromycin with ethanol topical gel	T2	
erythromycin with ethanol topical solution	T2	
erythromycin-benzoyl peroxide	T4	
EURAX	T4	
EXELDERM	T4	
FINACEA	T4	
fluocinolone and shower cap	T2	
fluocinolone topical cream	T2	
fluocinolone topical ointment	T2	
fluocinolone topical solution	T2	
fluocinonide topical cream 0.1 %	T4	
fluocinonide topical gel	T2	
fluocinonide topical ointment	T2	
fluocinonide topical solution	T2	

Drug Name	Drug Tier	Requirements/Limits
FLUOCINONIDE-E	T2	
fluorouracil topical cream 0.5 %	T5	
fluorouracil topical cream 5 %	T3	
fluorouracil topical solution 2 %	T2	
fluorouracil topical solution 5 %	T3	
flurandrenolide	T3	
fluticasone topical	T2	
gentamicin topical	T2	
halobetasol propionate	T4	
HALOG	T4	
hydrocortisone butyrate topical cream	T2	
hydrocortisone butyrate topical ointment	T2	
hydrocortisone butyrate topical solution	T2	
hydrocortisone topical cream 1 %, 2.5 %	T1	
hydrocortisone topical lotion 2.5 %	T1	
hydrocortisone topical ointment 1 %, 2.5 %	T1	
hydrocortisone valerate	T2	
imiquimod topical cream in packet	T2	
isotretinoin	T4	
ketoconazole topical	T2	
lidocaine (pf) injection solution 10 mg/ml (1 %), 5 mg/ml (0.5 %)	T2	
lidocaine hcl injection solution 20 mg/ml (2 %)	T2	
lidocaine hcl mucous membrane jelly	T2	
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	T2	
lidocaine topical adhesive patch,medicated	T2	PA; QL (124 EA per 31 days)
lidocaine topical ointment	T2	
LIDOCAINE VISCOUS	T2	
lidocaine-prilocaine topical cream	T2	
LIDODERM	T4	PA; QL (124 EA per 31 days)
lindane topical shampoo	T3	
malathion	T4	
MENTAX	T4	
methoxsalen	T2	
metronidazole topical cream	T3	
metronidazole topical gel 0.75 %	T3	
metronidazole topical gel 1 %	T2	
metronidazole topical lotion	T3	

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

Drug Name	Drug Tier	Requirements/Limits
tacrolimus topical	T2	
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE	T5	PA; QL (1 ML per 28 days)
tazarotene	T4	PA
TAZORAC TOPICAL CREAM 0.05 %	T4	PA
TAZORAC TOPICAL GEL	T4	PA
TOLAK	T4	
tretinoin	T2	PA
tretinoin microspheres topical gel	T2	PA
triamcinolone acetonide topical aerosol	T2	
triamcinolone acetonide topical cream	T2	
triamcinolone acetonide topical lotion	T2	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	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		
acamprosate	T2	
ADAGEN	T5	
alendronate oral tablet 40 mg	T1	
anagrelide	T2	
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
AURYXIA	T5	PA
bupropion hcl (smoking deter)	T3	QL (62 EA per 31 days)
CARBAGLU	T5	PA
cevimeline	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
d10 %-0.45 % sodium chloride	T2	
d2.5 %-0.45 % sodium chloride	T2	
d5 % and 0.9 % sodium chloride	T2	
d5 %-0.45 % sodium chloride	T2	
dextrose 10 % and 0.2 % nacl	T2	
dextrose 10 % in water (d10w)	T2	
dextrose 5 % in water (d5w) intravenous parenteral solution	T2	
dextrose 5 %-lactated ringers	T2	
dextrose 5%-0.2 % sod chloride	T2	
dextrose 5%-0.3 % sod.chloride	T2	
DEXTROSE WITH SODIUM CHLORIDE	T2	
disulfiram	T2	
ENDARI	T4	PA; QL (180 EA per 30 days)
etidronate disodium oral tablet 200 mg	T2	
etidronate disodium oral tablet 400 mg	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	
lactated ringers irrigation	T1	
levocarnitine (with sugar)	T2	PA-BvD
levocarnitine oral tablet	T2	PA-BvD
midodrine	T2	
neomycin-polymyxin b gu	T2	
NICOTROL	T4	
NICOTROL NS	T3	
NORTHERA	T5	PA
NUTRESTORE	T4	
ORFADIN	T5	
pilocarpine hcl oral	T2	

Drug Name	Drug Tier	Requirements/Limits
PROLASTIN-C INTRAVENOUS RECON SOLN	T5	PA
RAVICTI	T5	PA
RENAGEL ORAL TABLET 800 MG	T4	
RENVELA ORAL TABLET	T3	
riluzole	T4	
ringer's irrigation	T1	
risedronate oral tablet 30 mg	T2	
sevelamer carbonate oral powder in packet	T3	
sodium chloride 0.9 % intravenous parenteral solution	T2	
sodium chloride irrigation	T2	
sodium phenylbutyrate	T5	
sodium polystyrene sulfonate oral powder	T2	
SPS (WITH SORBITOL) ORAL	T2	
SYPRINE	T4	
THIOLA	T5	
trientine	T4	
VELPHORO	T5	
VELTASSA	T4	PA; QL (30 EA per 30 days)
water for irrigation, sterile	T2	
XURIDEN	T5	PA
ZEMAIRA	T5	PA
zoledronic acid-mannitol-water	T4	
Ear, Nose / Throat Medications		
acetic acid otic (ear)	T2	
azelastine nasal	T2	
BACTROBAN NASAL	T4	
chlorhexidine gluconate mucous membrane	T1	
CIPRO HC	T4	
CIPRODEX	T3	
ciprofloxacin hcl otic (ear)	T2	
COLY-MYCIN S	T4	
fluocinolone acetonide oil	T2	
hydrocortisone-acetic acid	T2	
ipratropium bromide nasal	T1	
neomycin-polymyxin-hc otic (ear)	T2	
ofloxacin otic (ear)	T2	
olopatadine nasal	T2	

Drug Name	Drug Tier	Requirements/Limits
OTOVEL	T4	
PERIOGARD	T2	
triamcinolone acetonide dental	T2	
Endocrine/Diabetes		
acarbose	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	
alogliptin	T4	QL (31 EA per 31 days)
alogliptin-metformin	T4	QL (62 EA per 31 days)
alogliptin-pioglitazone	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	
cabergoline	T2	
calcitonin (salmon)	T3	
calcitriol intravenous solution 1 mcg/ml	T2	PA-BvD
calcitriol oral	T2	PA-BvD
CERDELGA	T5	PA
CEREZYME INTRAVENOUS RECON SOLN 400 UNIT	T5	
chorionic gonadotropin, human	T4	PA-BvD
cortisone	T2	
CYCLOSET	T4	
danazol	T4	

Drug Name	Drug Tier	Requirements/Limits
DDAVP NASAL SOLUTION	T4	
DEPO-MEDROL	T4	
desmopressin injection	T2	
desmopressin nasal spray,non-aerosol	T2	
desmopressin oral	T2	
DEXAMETHASONE INTENSOL	T2	
dexamethasone oral elixir	T2	
dexamethasone oral tablet	T2	
dexamethasone sodium phosphate injection solution	T2	
DEXPAK 13 DAY	T4	
doxercalciferol intravenous	T2	PA-BvD
doxercalciferol oral capsule 0.5 mcg	T2	PA-BvD
doxercalciferol oral capsule 1 mcg, 2.5 mcg	T5	PA-BvD
EMFLAZA	T5	PA
FABRAZYME	T5	PA
FARXIGA	T3	
FIASP FLEXTOUCH U-100 INSULIN	T3	
FIASP U-100 INSULIN	T3	
fludrocortisone	T2	
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T3	
glimepiride	T1	
glipizide	T1	
glipizide-metformin	T1	
GLUCAGEN HYPOKIT	T3	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
glyburide	T2	PA
glyburide micronized	T2	PA
glyburide-metformin	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	
hydrocortisone oral	T1	
insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge	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	
levothyroxine oral	T1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	T2	

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

Drug Name	Drug Tier	Requirements/Limits
pamidronate intravenous solution	T2	PA-BvD
paricalcitol oral	T4	PA-BvD
pen needle, diabetic needle 29 gauge x 1/2"	T4	
pioglitazone	T1	QL (31 EA per 31 days)
pioglitazone-glimepiride	T2	QL (31 EA per 31 days)
pioglitazone-metformin	T2	QL (93 EA per 31 days)
prednisolone oral solution 15 mg/5 ml	T2	
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)	T2	
prednisolone sodium phosphate oral tablet,disintegrating	T2	
PREDNISONE INTENSOL	T2	
prednisone oral solution	T2	
prednisone oral tablet	T1	
prednisone oral tablets,dose pack	T2	
PREGNYL	T4	PA-BvD
PROGLYCEM	T4	
propylthiouracil	T2	
repaglinide oral tablet 0.5 mg, 1 mg	T2	QL (124 EA per 31 days)
repaglinide oral tablet 2 mg	T2	QL (248 EA per 31 days)
repaglinide-metformin	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	
testosterone cypionate	T3	PA
testosterone enanthate	T3	PA
TIROSINT	T4	
tolazamide	T2	
tolbutamide	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
zoledronic acid intravenous solution	T2	
Gastroenterology		
alosetron	T5	
ALOXI	T4	
AMITIZA	T3	QL (62 EA per 31 days)
amoxicil-clarithromy-lansopraz	T4	
ANZEMET ORAL	T4	PA-BvD
aprepitant	T4	PA-BvD
ASACOL HD	T3	
atropine injection syringe 0.05 mg/ml	T2	
balsalazide	T2	
BONJESTA	T4	PA; QL (62 EA per 31 days)
budesonide oral	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	
cromolyn oral	T5	
CUVPOSA	T4	
CYSTADANE	T4	
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)	T3	
dicyclomine intramuscular	T2	
dicyclomine oral capsule	T2	
dicyclomine oral solution	T2	
dicyclomine oral tablet	T2	
diphenoxylate-atropine	T2	
dronabinol oral capsule 10 mg	T5	PA-BvD
dronabinol oral capsule 2.5 mg, 5 mg	T4	PA-BvD
ENULOSE	T2	
esomeprazole magnesium	T4	QL (31 EA per 31 days)
esomeprazole sodium	T4	
famotidine (pf)	T1	
famotidine (pf)-nacl (iso-os)	T2	
famotidine oral suspension	T2	
famotidine oral tablet 20 mg, 40 mg	T1	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T2	
GAVILYTE-G	T2	
GAVILYTE-N	T2	
GENERLAC	T2	
glycopyrrolate injection	T2	
glycopyrrolate oral tablet 1 mg, 2 mg	T2	
GOLYTELY ORAL POWDER IN PACKET	T4	
granisetron (pf) intravenous solution 100 mcg/ml	T3	
granisetron hcl intravenous	T3	
granisetron hcl oral	T3	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
PROCTO-PAK	T2	
PROCTOSOL HC TOPICAL	T2	
PROCTOZONE-HC	T2	
propantheline	T2	
PYLERA	T4	
rabeprazole	T2	QL (62 EA per 31 days)
ranitidine hcl injection solution 50 mg/2 ml (25 mg/ml)	T4	
ranitidine hcl oral capsule	T2	
ranitidine hcl oral syrup	T2	
ranitidine hcl oral tablet 150 mg, 300 mg	T1	
RECTIV	T4	
RELISTOR ORAL	T5	PA; QL (93 EA per 31 days)
RELISTOR SUBCUTANEOUS SOLUTION	T4	QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	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	
scopolamine base	T4	QL (10 EA per 30 days)
SUCRAID	T5	
sucralfate oral tablet	T2	
sulfasalazine	T2	
SUPREP BOWEL PREP KIT	T3	
SYMPROIC	T4	PA; QL (31 EA per 31 days)
TRILYTE WITH FLAVOR PACKETS	T2	
trimethobenzamide oral	T2	PA
ursodiol oral capsule	T4	
ursodiol oral tablet	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)
bcg vaccine, live (pf)	T4	
BETASERON SUBCUTANEOUS KIT	T5	QL (15 EA per 31 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T4	
BOTOX	T4	PA
CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM	T5	PA
DAPTACEL (DTAP PEDIATRIC) (PF)	T4	
DYSPORT	T4	PA
EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG	T5	PA-NS

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
fomepizole	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	
tetanus,diphtheria tox ped(pf)	T4	
tetanus-diphtheria toxoids-td	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)
alendronate oral solution	T2	
alendronate oral tablet 10 mg	T2	
alendronate oral tablet 35 mg, 5 mg, 70 mg	T1	
allopurinol	T1	
allopurinol sodium	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)
colchicine oral tablet	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)
ibandronate intravenous solution	T2	PA-BvD
ibandronate oral	T2	
KEVZARA SUBCUTANEOUS SYRINGE	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
leflunomide	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)
probenecid	T2	
probenecid-colchicine	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)

Drug Name	Drug Tier	Requirements/Limits
raloxifene	T3	
RIDAURA	T4	
risedronate	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	
CAZIANT (28)	T2	

Drug Name	Drug Tier	Requirements/Limits
CLEOCIN VAGINAL SUPPOSITORY	T4	
CLIMARA PRO	T4	
clindamycin phosphate vaginal	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	
desogestrel-ethinyl estradiol	T2	
DIVIGEL TRANSDERMAL GEL IN PACKET 1 MG/GRAM (0.1 %)	T4	
drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4)	T2	
drospirenone-ethinyl estradiol	T2	
EMOQUETTE	T2	
ENPRESSE	T2	
ENSKYCE	T2	
ERRIN	T2	
ESTARYLLA	T2	
ESTRACE VAGINAL	T4	
estradiol oral	T2	
estradiol transdermal	T2	
estradiol vaginal	T4	
estradiol valerate intramuscular oil 20 mg/ml	T2	
estradiol-norethindrone acet	T2	
ESTRING	T4	
estropipate oral tablet 0.75 mg	T2	
ethynodiol diac-eth estradiol	T2	
EVAMIST	T4	
FAYOSIM	T2	
FEMRING	T4	
FEMYNOR	T2	
FYAVOLV	T2	
GYNAZOLE-1	T4	
hydroxyprogesterone caproate	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	
l norgest/e.estradiol-e.estrad	T2	
LARISSIA	T2	
LAYOLIS FE	T2	
LESSINA	T2	
LEVONEST (28)	T2	
levonorgestrel-ethinyl estrad	T2	
levonorg-eth estrad triphasic	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	
medroxyprogesterone	T2	
MELODETTA 24 FE	T2	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	T4	
metronidazole vaginal	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	
noreth-ethinyl estradiol-iron	T2	
norethindrone (contraceptive)	T2	
norethindrone acetate	T2	
norethindrone ac-eth estradiol	T2	
norethindrone-e.estradiol-iron oral tablet,chewable	T2	
norgestimate-ethinyl estradiol	T2	
NORTREL 0.5/35 (28)	T2	
NORTREL 1/35 (21)	T2	
NORTREL 1/35 (28)	T2	
NORTREL 7/7/7 (28)	T2	
NUVARING	T3	
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	
progesterone micronized	T2	
QUASENSE	T2	
RECLIPSEN (28)	T2	
RIVELSA	T2	
SETLAKIN	T2	
SPRINTEC (28)	T2	
SRONYX	T2	

Drug Name	Drug Tier	Requirements/Limits
SYEDA	T2	
terconazole	T2	
tranexamic acid oral	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		
acetazolamide	T2	
acetazolamide sodium	T2	
ACUVAIL (PF)	T4	
ALOCRIL	T4	
ALOMIDE	T3	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
apraclonidine	T2	
atropine ophthalmic (eye) drops	T2	
AZASITE	T4	
azelastine ophthalmic (eye)	T2	
AZOPT	T3	
bacitracin ophthalmic (eye)	T2	
bacitracin-polymyxin b ophthalmic (eye)	T2	
BESIVANCE	T4	

Drug Name	Drug Tier	Requirements/Limits
betaxolol ophthalmic (eye)	T2	
BETIMOL	T4	
BETOPTIC S	T4	
bimatoprost ophthalmic (eye)	T2	
BLEPH-10	T4	
BLEPHAMIDE	T4	
BLEPHAMIDE S.O.P.	T4	
brimonidine	T2	
carteolol	T2	
CILOXAN OPHTHALMIC (EYE) OINTMENT	T3	
ciprofloxacin hcl ophthalmic (eye)	T2	
COMBIGAN	T3	
cromolyn ophthalmic (eye)	T2	
CYSTARAN	T5	
dexamethasone sodium phosphate ophthalmic (eye)	T2	
diclofenac sodium ophthalmic (eye)	T3	
dorzolamide	T2	
dorzolamide-timolol	T2	
DUREZOL	T3	
epinastine	T2	
erythromycin ophthalmic (eye)	T2	
fluorometholone	T2	
flurbiprofen sodium	T2	
gatifloxacin	T2	
GENTAK OPHTHALMIC (EYE) OINTMENT	T2	
gentamicin ophthalmic (eye) drops	T2	
ILEVRO	T3	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	T3	
ISTALOL	T4	
ketorolac ophthalmic (eye)	T2	
LACRISERT	T4	
LASTACAFT	T4	
latanoprost	T2	
levobunolol ophthalmic (eye) drops 0.5 %	T1	
levofloxacin ophthalmic (eye)	T2	

Drug Name	Drug Tier	Requirements/Limits
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
methazolamide	T4	
metipranolol	T2	
MOXEZA	T4	
moxifloxacin ophthalmic (eye)	T4	
NATACYN	T4	
neomycin-bacitracin-poly-hc	T3	
neomycin-bacitracin-polymyxin	T3	
neomycin-polymyxin b-dexameth	T2	
neomycin-polymyxin-gramicidin	T2	
neomycin-polymyxin-hc ophthalmic (eye)	T2	
NEVANAC	T4	
ofloxacin ophthalmic (eye)	T2	
olopatadine ophthalmic (eye)	T3	
PAZEO	T3	
PHOSPHOLINE IODIDE	T4	
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	T2	
polymyxin b sulf-trimethoprim	T2	
PRED-G	T4	
PRED-G S.O.P.	T4	
prednisolone acetate	T3	
prednisolone sodium phosphate ophthalmic (eye)	T2	
RESTASIS	T3	
SIMBRINZA	T3	
sulfacetamide sodium ophthalmic (eye)	T2	
sulfacetamide-prednisolone	T2	
timolol maleate ophthalmic (eye) drops	T1	
timolol maleate ophthalmic (eye) gel forming solution	T3	
TIMOPTIC OCUDOSE (PF)	T4	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
TOBRADEX ST	T3	
tobramycin	T2	
tobramycin-dexamethasone	T2	
TOBREX OPHTHALMIC (EYE) OINTMENT	T4	

Drug Name	Drug Tier	Requirements/Limits
TRAVATAN Z	T3	
trifluridine	T2	
XIIDRA	T4	
ZIOPTAN (PF)	T4	
ZIRGAN	T4	
ZYLET	T4	
Respiratory And Allergy		
acetylcysteine	T2	PA-BvD
ADCIRCA	T5	PA; QL (62 EA per 31 days)
ADEMPAS	T5	PA; QL (93 EA per 31 days)
ADRENALIN INJECTION SOLUTION 1 MG/ML (1 ML)	T2	
ADVAIR DISKUS	T4	QL (60 EA per 30 days)
ADVAIR HFA	T4	QL (12 GM per 30 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml	T2	PA-BvD
albuterol sulfate oral syrup	T1	
albuterol sulfate oral tablet	T2	
albuterol sulfate oral tablet extended release 12 hr	T2	
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
ASMANEX HFA	T3	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 220 MCG (120 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES)	T3	QL (1 EA per 30 days)
ATROVENT HFA	T3	QL (25.8 GM per 30 days)
BECONASE AQ	T4	
BERINERT INTRAVENOUS KIT	T5	PA
BEVESPI AEROSPHERE	T3	QL (10.7 GM per 30 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BROVANA	T4	PA-BvD
budesonide inhalation	T2	PA-BvD
cetirizine oral solution 1 mg/ml	T2	
CINRYZE	T5	PA; QL (20 EA per 28 days)
CLARINEX-D 12 HOUR	T4	
COMBIVENT RESPIMAT	T4	QL (4 GM per 30 days)
cromolyn inhalation	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
cyproheptadine oral syrup	T4	
cyproheptadine oral tablet	T2	
DALIRESP	T4	QL (31 EA per 31 days)
desloratadine	T2	
diphenhydramine hcl injection solution 50 mg/ml	T2	
DYMISTA	T4	
epinephrine injection auto-injector	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)
flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)	T2	
fluticasone nasal	T2	
fluticasone-salmeterol	T3	QL (1 EA per 30 days)
HAEGARDA	T5	PA
hydroxyzine hcl intramuscular	T2	PA
hydroxyzine hcl oral solution 10 mg/5 ml	T2	PA
hydroxyzine hcl oral tablet	T2	PA
ipratropium bromide inhalation	T2	PA-BvD
ipratropium-albuterol	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
LETAIRIS	T5	PA; QL (31 EA per 31 days)
levalbuterol hcl	T2	PA-BvD
levalbuterol tartrate	T4	QL (30 GM per 30 days)
levocetirizine	T2	
metaproterenol	T2	
mometasone nasal	T3	
montelukast oral granules in packet	T2	QL (31 EA per 31 days)
montelukast oral tablet	T3	QL (31 EA per 31 days)
montelukast oral tablet,chewable	T2	QL (31 EA per 31 days)
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)
promethazine injection solution	T2	
promethazine oral syrup	T2	PA
promethazine rectal suppository 12.5 mg, 25 mg	T3	
promethazine rectal suppository 50 mg	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)
sildenafil (antihypertensive) intravenous	T5	PA
sildenafil (antihypertensive) oral	T3	PA; QL (93 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER	T3	QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T4	QL (4 GM per 30 days)
SYMBICORT	T3	QL (10.2 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
terbutaline oral	T4	
terbutaline subcutaneous	T5	
THEO-24	T4	
theophylline oral solution	T2	
theophylline oral tablet extended release 12 hr 100 mg, 200 mg, 300 mg	T2	

Drug Name	Drug Tier	Requirements/Limits
theophylline oral tablet extended release 24 hr	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)
triamcinolone acetonide nasal	T3	
VENTAVIS	T5	PA-BvD
VENTOLIN HFA	T3	QL (36 GM per 30 days)
XOLAIR	T5	PA
zafirlukast	T2	
zileuton	T5	PA
Urologicals		
alfuzosin	T2	QL (31 EA per 31 days)
bethanechol chloride	T2	
CIALIS ORAL TABLET 2.5 MG	T4	PA; QL (62 EA per 31 days)
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T4	
darifenacin	T4	
dutasteride	T3	QL (31 EA per 31 days)
dutasteride-tamsulosin	T3	QL (31 EA per 31 days)
ELMIRON	T4	
finasteride oral tablet 5 mg	T2	
flavoxate	T2	
GELNIQUE TRANSDERMAL GEL IN PACKET	T4	QL (30 GM per 30 days)
MYRBETRIQ	T3	QL (31 EA per 31 days)
oxybutynin chloride oral syrup	T2	
oxybutynin chloride oral tablet	T2	
oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg	T3	QL (31 EA per 31 days)
oxybutynin chloride oral tablet extended release 24hr 15 mg	T3	QL (62 EA per 31 days)
OXYTROL	T4	QL (8 EA per 28 days)
potassium citrate	T2	
PROCYSBI	T5	PA
RAPAFLO	T3	
tamsulosin	T2	
tolterodine oral capsule,extended release 24hr	T4	QL (31 EA per 31 days)
tolterodine oral tablet 1 mg	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
tolterodine oral tablet 2 mg	T4	QL (62 EA per 31 days)
TOVIAZ	T4	QL (31 EA per 31 days)
trospium oral capsule,extended release 24hr	T2	QL (31 EA per 31 days)
trospium oral tablet	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
calcium acetate oral capsule	T2	
calcium acetate oral tablet 667 mg	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
fluoride (sodium) oral tablet	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	
lactated ringers intravenous	T2	
magnesium sulfate injection	T2	
NEPHRAMINE 5.4 %	T3	PA-BvD
NORMOSOL-M IN 5 % DEXTROSE	T4	PA-BvD
NORMOSOL-R IN 5 % DEXTROSE	T4	PA-BvD
NORMOSOL-R PH 7.4	T4	PA-BvD
NUTRILIPID	T4	PA-BvD
PHOSLYRA	T4	
PLASMA-LYTE 148	T4	PA-BvD
PLASMA-LYTE A	T4	PA-BvD
PLENAMINE	T3	PA-BvD
potassium chlorid-d5-0.45%nacl	T2	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	T2	
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 40 meq/l	T2	
potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	T2	
potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml	T2	
potassium chloride intravenous solution	T2	
potassium chloride oral capsule, extended release	T2	
potassium chloride oral liquid	T2	
potassium chloride oral tablet extended release	T2	

Drug Name	Drug Tier	Requirements/Limits
potassium chloride oral tablet,er particles/crystals	T1	
potassium chloride-0.45 % nacl	T2	
potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l	T2	
potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l	T2	
potassium chloride-d5-0.9%nacl	T2	
PREMASOL 10 %	T3	PA-BvD
PREMASOL 6 %	T3	PA-BvD
PRENATAL VITAMIN PLUS LOW IRON	T2	
PROCALAMINE 3%	T4	PA-BvD
PROSOL 20 %	T4	PA-BvD
ringer's intravenous	T2	
sodium chloride 0.45 % intravenous parenteral solution	T2	
sodium chloride 3 %	T2	
sodium chloride 5 %	T2	
sodium chloride intravenous parenteral solution 2.5 meq/ml	T2	
sodium lactate	T2	
TRAVASOL 10 %	T4	PA-BvD
TROPHAMINE 10 %	T4	PA-BvD

Index of Drugs

actemra

Products Affected

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

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

actimmune

Products Affected

- **ACTIMMUNE**

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

adempas

Products Affected

- **ADEMPAS**

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

ADHD Drugs

Products Affected

- *atomoxetine 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 lifetyle factors (e.g. sleep patterns, caffeine use). 3)Trial and failure or intolerance to one agent from 2 of the following prophylactive 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 osteoporisis.
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 treatement of hypomobility off-episones -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 aquedate 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

carbaglu

Products Affected

- **CARBAGLU**

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

CERDELGA

Products Affected

- **CERDELGA**

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

CF drugs

Products Affected

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

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

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 corticosteorid (e.g., prednisone or hydrocortisone) or Remicade-AND- the preferred biologic product, Humira, for a diagnosis of Crohn's disease. Patients must have an adequate trial or intolerance to both preferred products, Enbrel and Humira, for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis. For initial and indication therapy dosing, doses above plan quantity limit will be approved aligned with recommended initial and induction therapy dosing regimens per indication. 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 weekness or history of DMD starting before age 5 -AND- One of the following (1 or 2). 1) Documented trial of prednisone has resulted in intolerable adverse events (e.g. diabetes, hypertension that is difficult to manage, Cushingoid features, truncal obesity, greater than or equal to 10 percent increase in body weight over a 6 month period). 2) Documented severe behavioral adverse event while on prednisone that warrants prednisone dose reduction impacting efficacy for management of DMD (i.e. abnormal behavior, aggression, irritability, disturbance in mood)
Age Restrictions	Deny if less than 5 years of age
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	

enbrel

Products Affected

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

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

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 candadate 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 tratment 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	For all medications subject to this PA group, the following information (1 through 3) is required: 1. Documentation of diagnosis 2. Explanation of risk-benefit profile favoring use of the high-risk medication 3. Attestation of an intent to monitor and address treatment-related adverse events. In addition to requirements 1 through 3 above, for digoxin doses exceeding 0.125 mg daily, provider confirmation that a lower dose of digoxin has or would be ineffective in managing the member's condition is required. For the target high-risk medications glyburide, TCAs and nitrofurantoin, in addition to criteria 1 through 3 above, trial and failure or documentation of intolerance or contraindication to at least 2 non-high risk alternative drugs for the same indication, if available, is required. Non-high risk alternative medications for those target high-risk medications include the following: 1. Glyburide (non-high risk alternatives include glipizide and glimepiride) 2. TCAs (non-high risk alternatives include SSRIs and SNRIs) 3. Nitrofurantoin (non-high risk alternatives include Bactrim, Cipro, or cephalexin). If using one of the above 3 high-risk medications for a medically-accepted indication not shared by the safer alternatives listed, then no trial of alternatives is required for that target high-risk medication.
Age Restrictions	Automatic approval if less than 65 years of age

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

homozygous fh

Products Affected

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

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

horizant

Products Affected

- **HORIZANT**

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

humira

Products Affected

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

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

Ibrance

Products Affected

- **IBRANCE**

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

iclusig

Products Affected

- **ICLUSIG 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

ig

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For select diagnoses the following apply- 1) For Myasthenia Gravis Syndrome, documentation that the patient is refractory to other standard therapies (e.g., cholinesterase inhibitors, corticosteroids, azathioprine) given in therapeutic doses over at least 3 months OR is intolerant of/has a contraindication to those standard therapies. 2) For Multiple Sclerosis, patient is refractory to other standard therapies (e.g., interferons) given in therapeutic doses over at least 3 months, OR is intolerant of/has a contraindication to those standard therapies. 3) For Inflammatory Myopathies, the patient is refractory to corticosteroids given in therapeutic doses over at least 4 months, OR is intolerant of/has a contraindication to corticosteroids. 4) For CLL, IgG level less than 600mg/dL or evidence of a specific antibody deficiency or recurrent bacterial infections. 5) For Bone Marrow Transpant, 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/mm3 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, Orencia, Enbrel, Simponi, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and trial and failure of one DMARD -OR- neonatal-onset multisystem inflammatory disease (NOMID) or chronic infantile neurological, cutaneous and articular (CINCA) syndrome
Age Restrictions	
Prescriber Restrictions	rheumatologist, pediatrician
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for rheumatoid arthritis.

kisqali

Products Affected

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

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

korlym

Products Affected

- **KORLYM**

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

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	

namzaric

Products Affected

- **NAMZARIC**

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

natpara

Products Affected

- **NATPARA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of use as an adjunct to 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 rhuematoid 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 unconrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
Required Medical Information	Documentation of allergic rhinitis and use for Sweet Vernal, Orchard, Perennial Rye, or Kentucky Blue Grass pollens -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
Age Restrictions	Deny if less than 10 years of age or greater than 65 years of age
Prescriber Restrictions	allergy specialist, otolaryngologist, immunologist
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector

orencia

Products Affected

- **ORENCIA (WITH MALTOSE)** **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, Orencia, Simponi, Kineret, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis -OR- documentation of moderate to severe juvenile idiopathic rheumatoid arthritis -OR- documentation of psoriatic arthritis
Age Restrictions	
Prescriber Restrictions	rheumatologist
Coverage Duration	12 months
Other Criteria	For Orencia SubQ, patients must have an adequate trial or intolerance to the preferred SubQ products, Enbrel and Humira, for rheumatoid arthritis and psoriatic arthritis. For Orencia IV, patients must have an adequate trial or intolerance to one of the preferred IV products, Remicade or Simponi Aria, for rheumatoid arthritis or Remicade for psoriatic arthritis.

orkambi

Products Affected

- **ORKAMBI 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 24HR DOSE PACK** **HR 120 MG, 20 MG, 40 MG, 80 MG**
- **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 post-menopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug

provigil

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of 1 of the following. 1) Diagnosis of shift work sleep disorder (SWSD) as defined by a minimum of 5 night shifts per month with at least 3 of those nights occuring consecutively and the shift is 6 to 12 hours in duration occuring between 10pm and 8am. 2) Diagnosis of narcolepsy documented by MSLT less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) or other appropriate testing. 3) Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography. Diagnosis established in accordance with ICSD or DSM V criteria acceptable for all indications. 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 hyperenstion have been ruled out (e.g. left heard disease, chronic lung disease, venour 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 presensce 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, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe psoriasis after failure of systemic therapy or phototherapy -OR- moderate to severe Crohn's disease after failure of two immunosuppressants -OR- moderate to severe ulcerative colitis after failure of two immunosuppressants
Age Restrictions	For Crohn's disease, deny if less than 6 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required. For Crohn's disease and ulcerative colitis, trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine, 6-mercaptopurine) is required.

repatha

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	1.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 FD(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190mg/dL prior to lipid lowering therapy (greater than or equal to 160mg/dL if age less than 20) or LDL-C greater than or equal to 160mg/dL after treatment with antihyperlipidemic agents but prior to Repatha therapy AND Prior therapy with at least 2 trials of different high-intensity statins(e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. 3. Hypercholesterolemia ASCVD OR PrimaryHyperlipidemia(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
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	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 FD(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190mg/dL prior to lipid lowering therapy (greater than or equal to 160mg/dL if age less than 20) or LDL-C greater than or equal to 160mg/dL after treatment with antihyperlipidemic agents but prior to Repatha therapy AND Prior therapy with at least 2 trials of different high-intensity statins(e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. 3. Hypercholesterolemia ASCVD OR PrimaryHyperlipidemia(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

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 Pushtronex System per month will not be approved.

revlimid

Products Affected

- **REVLIMID**

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

rubraca

Products Affected

- **RUBRACA**

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

simponi aria

Products Affected

- **SIMPONI ARIA**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Actemra, Kineret, Remicade, Humira, Orencia, Enbrel, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -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 1.0x10*9/L -AND- baseline platelet count greater than or equal to 75x10*9/L -AND- baseline hemoglobin less than 17g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

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 slenectomy. 2) One of the following (A or B): A) Platelet count less than or equal to 50 x 10*9/L and has significant mucous member brleeding or at least one risk factor for bleeding (e.g. hypertension, peptic ulcer disease). B) Plateles count of less than or equal to 30 x 10*9/L.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

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 treatement-naive and has a contraindication or intolerance to ribavirin
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	

testosterone (androgens)

Products Affected

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

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 immunosuppresants 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, Orencia, Stelara, Actemra, azathioprine, cyclosporine
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and an inadequate response or intolerance to methotrexate -OR- Documentation of psoriatic arthritis in combination with a nonbiologic DMARD and member has an inadequate response or intolerance to systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy -OR- 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 dissease -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 fidaxomycin
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	7 days
Other Criteria	Zinplava will only be approved for one dose per active Clostridium Difficile infection. Zinplava will not be approved for repeat doses for recurrence of the same active infection.

zolinza

Products Affected

- **ZOLINZA**

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

ZYDELIG

Products Affected

- **ZYDELIG**

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

zykadia

Products Affected

- **ZYKADIA**

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

Index of Drugs

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

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

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

Index of Drugs