

## **Medicare Part D: 5 Tier Closed Performance Formulary 2022**

Please click here.

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

Please click here.

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

Please click here.

For more recent information or other questions, please contact:

Freedom Blue PPO (DE) Customer Service at 1-844-576-1246  
Freedom Blue PPO (PA) Customer Service at 1-800-550-8722  
Freedom Blue PPO (WV) Customer Service at 1-888-459-4020  
Security Blue HMO-POS Customer Service at 1-800-935-2583  
Community Blue Medicare HMO Customer Service at 1-888-234-5397  
Community Blue Medicare PPO Customer Service at 1-888-757-2946  
Community Blue Medicare Plus PPO Customer Service at 1-888-757-2946  
Complete Blue PPO Customer Service at 1-833-227-9375

For TTY users, *711 National Relay Service*, Monday through Sunday, 8:00 a.m. to 8:00 p.m. Visit [medicare.highmark.com](http://medicare.highmark.com).

Formulary ID: 22038 Version: 25

Updated: 12/2022

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

When this drug list (formulary) refers to “we,” “us,” or “our,” it means Highmark Senior Health Company, Highmark Choice Company, Highmark Senior Solutions Company, Highmark BCBSD Inc., or HM Health Insurance Company.

When it refers to “plan” or “our plan,” it means 2022 Freedom Blue PPO, Security Blue HMO- POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Complete Blue PPO.

This document includes a list of the drugs (formulary) for our plan which is current as of July 1, 2022. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2022, and from time to time during the year.

## **What is the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, and Complete Blue PPO Formulary?**

A formulary is a list of covered drugs selected by our plans in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plans will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at one of our plan’s network pharmacies, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

## **Can the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Complete Blue PPO Formulary (drug list) change?**

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we

may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.

- o If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Complete Blue PPO Formulary?”
- o **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 31-day supply of the drug.
  - o If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Complete Blue PPO Formulary?”

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of July 1, 2022. To get updated information about the drugs covered by our plans, please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, members will be

notified by mail and prospective members will receive an update with this formulary. The most up-to-date formulary is available on our website, [medicare.highmark.com](http://medicare.highmark.com).

## **How do I use the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO or Complete Blue PPO Formulary?**

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

### **Medical Condition**

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

### **Alphabetical Listing**

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

## **What are generic drugs?**

Our plans cover both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

## **Are there any restrictions on my coverage?**

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

- **Prior Authorization:** Our plans require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plans before you fill your prescriptions. If you don't get approval, our plans may not cover the drug.
- **Quantity Limits:** For certain drugs, our plans limit the amount of the drug that is covered. For example, our plans provide 9 tablets per prescription for 100mg lomitrex. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plans require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A

and Drug B both treat your medical condition, our plans may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plans will then cover Drug B.

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

You can ask our plans to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Complete Blue PPO Formulary?” on page 6 for information about how to request an exception.

## **What if my drug is not on the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Complete Blue PPO Formulary?**

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

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

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

## **How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Complete Blue PPO Formulary?**

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

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved, this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plans limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, our plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions, would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, or utilization restriction exception. **When you request a formulary or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

## **What do I do before I can talk to my doctor about changing my drugs or requesting an exception?**

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

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

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

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

## **For more information**

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

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

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day / 7 days a week. TTY users should call 1-877-486-2048. Or visit <http://www.medicare.gov>.

## **Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Complete Blue PPO Formulary**

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

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

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

*The following is a Formulary Format Example Only:*

<b>Drug Name</b>	<b>Performance Drug Tier</b>	<b>Requirements/ Limits</b>
<b>Anti - Infectives</b>		
<i>XYZ DRUG</i>	NF	QL- 28





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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.

**LA:** Limited access

**PA:** Prior authorization required

**PA-BvD:** This drug may be covered under Medicare part B or D depending on the circumstance. Information may need to be submitted describing the use and setting of the drug to make the determination.

**PA-NS:** Prior authorization required for new starts only

**QL:** Quantity limit applies. The quantity limit is noted for each drug. For example, if the quantity limit is QL (90 EA per 180 days), the quantity limit would be 90 units per 180-day supply.

**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.

**SI:** Select Insulin Drug under the Part D Senior Savings Model. For complete coverage details on these preferred select insulins see Chapter 6 of your Evidence of Coverage.

**ST:** Step therapy applies

**ST-NS:** Step therapy applies to new starts only

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

## List of Patterns

**lowercase italics:** Generic drugs

**UPPERCASE BOLD:** Brand name drugs



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>Anti - Infectives</b>		
<i>abacavir</i>	T4	
<i>abacavir-lamivudine</i>	T4	
<b>ABELCET</b>	T4	PA-BvD
<i>acyclovir oral capsule</i>	T2	
<i>acyclovir oral suspension 200 mg/5 ml</i>	T4	
<i>acyclovir oral tablet</i>	T2	
<i>acyclovir sodium intravenous solution</i>	T4	PA-BvD
<i>adefovir</i>	T4	
<i>albendazole</i>	T4	
<i>amantadine hcl oral capsule</i>	T3	QL (124 EA per 31 days)
<i>amantadine hcl oral solution</i>	T3	
<i>amantadine hcl oral tablet</i>	T3	
<b>AMBISOME</b>	T5	PA-BvD
<i>amikacin injection solution 500 mg/2 ml</i>	T3	
<i>amoxicillin oral capsule</i>	T1	
<i>amoxicillin oral suspension for reconstitution</i>	T1	
<i>amoxicillin oral tablet</i>	T2	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	T1	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	T2	
<i>amoxicillin-pot clavulanate oral tablet</i>	T2	
<i>amoxicillin-pot clavulanate oral tablet, chewable</i>	T2	
<i>amphotericin b</i>	T4	PA-BvD
<i>ampicillin oral capsule 500 mg</i>	T2	
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	T2	
<i>ampicillin-sulbactam injection</i>	T2	
<b>APTIVUS</b>	T5	
<b>ARIKAYCE</b>	T5	PA
<i>atazanavir</i>	T4	
<i>atovaquone</i>	T4	
<i>atovaquone-proguanil</i>	T3	
<i>azithromycin intravenous</i>	T2	
<i>azithromycin oral packet</i>	T2	
<i>azithromycin oral tablet</i>	T2	
<i>aztreonam</i>	T4	
<b>BETHKIS</b>	T4	PA
<b>BICILLIN C-R</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>BICILLIN L-A INTRAMUSCULAR SYRINGE 600,000 UNIT/ML</b>	T3	
<b>BIKTARVY</b>	T5	QL (31 EA per 31 days)
<i>caspofungin intravenous recon soln 50 mg</i>	T5	
<i>caspofungin intravenous recon soln 70 mg</i>	T4	
<b>CAYSTON</b>	T5	
<i>cefaclor oral capsule 500 mg</i>	T2	
<i>cefaclor oral tablet extended release 12 hr</i>	T3	
<i>cefadroxil oral capsule</i>	T2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml</i>	T2	
<i>cefadroxil oral suspension for reconstitution 500 mg/5 ml</i>	T3	
<i>cefadroxil oral tablet</i>	T3	
<i>cefazolin injection recon soln 1 gram, 500 mg</i>	T2	
<i>cefazolin injection recon soln 10 gram</i>	T4	
<i>cefdinir oral capsule</i>	T2	
<i>cefepime injection</i>	T4	
<i>cefixime oral capsule</i>	T2	
<i>cefoxitin</i>	T4	
<i>cefpodoxime oral suspension for reconstitution 100 mg/5 ml</i>	T4	
<i>cefpodoxime oral suspension for reconstitution 50 mg/5 ml</i>	T3	
<i>cefpodoxime oral tablet</i>	T3	
<i>cefprozil</i>	T2	
<i>ceftazidime</i>	T4	
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	T2	
<i>cefuroxime axetil oral tablet</i>	T2	
<i>cefuroxime sodium injection recon soln 750 mg</i>	T3	
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	T3	
<i>cephalexin</i>	T2	
<i>chloroquine phosphate oral tablet 250 mg</i>	T3	PA; QL (50 EA per 30 days)
<i>chloroquine phosphate oral tablet 500 mg</i>	T3	PA; QL (25 EA per 30 days)
<b>CIMDUO</b>	T5	QL (31 EA per 31 days)
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	T1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	T2	
<i>clarithromycin oral suspension for reconstitution</i>	T4	
<i>clarithromycin oral tablet</i>	T2	
<i>clarithromycin oral tablet extended release 24 hr</i>	T2	
<i>clindamycin hcl</i>	T2	
<i>clindamycin in 5 % dextrose</i>	T2	
<b>CLINDAMYCIN PEDIATRIC</b>	T4	
<i>clindamycin phosphate injection</i>	T2	
<i>clindamycin phosphate intravenous</i>	T2	
<i>clotrimazole mucous membrane</i>	T2	
<b>COARTEM</b>	T4	
<i>colistin (colistimethate na)</i>	T4	
<b>COMPLERA</b>	T5	
<i>dapsone oral</i>	T3	
<i>daptomycin</i>	T5	
<b>DELSTRIGO</b>	T5	QL (31 EA per 31 days)
<b>DESCOVY ORAL TABLET 200-25 MG</b>	T5	QL (31 EA per 31 days)
<i>dicloxacillin</i>	T2	
<b>DIFICID ORAL SUSPENSION FOR RECONSTITUTION</b>	T5	QL (136 ML per 12 days)
<b>DIFICID ORAL TABLET</b>	T5	QL (20 EA per 10 days)
<b>DOVATO</b>	T5	QL (31 EA per 31 days)
<b>DOXY-100</b>	T4	
<i>doxycycline hyclate oral capsule</i>	T2	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	T2	
<i>doxycycline hyclate oral tablet 150 mg, 50 mg, 75 mg</i>	T4	
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 100 mg, 50 mg, 80 mg</i>	T4	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	T2	
<i>doxycycline monohydrate oral capsule 150 mg, 75 mg</i>	T4	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	T4	
<i>doxycycline monohydrate oral tablet</i>	T2	
<b>E.E.S. 400 ORAL TABLET</b>	T4	
<b>EDURANT</b>	T5	
<i>efavirenz</i>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>efavirenz-emtricitabin-tenofof</i>	T5	
<i>efavirenz-lamivu-tenofof disop</i>	T5	QL (31 EA per 31 days)
<i>emtricitabine</i>	T3	
<i>emtricitabine-tenofovir (tdf)</i>	T5	
<b>EMTRIVA ORAL SOLUTION</b>	T3	
<b>EMVERM</b>	T5	
<i>entecavir</i>	T4	
<b>EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG</b>	T5	PA; QL (28 EA per 28 days)
<b>EPCLUSA ORAL PELLETS IN PACKET 200-50 MG</b>	T5	PA; QL (56 EA per 28 days)
<b>EPCLUSA ORAL TABLET</b>	T5	PA; QL (28 EA per 28 days)
<b>EPIVIR HBV ORAL SOLUTION</b>	T4	
<i>ertapenem</i>	T4	
<b>ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 333 MG</b>	T4	
<b>ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG</b>	T4	
<b>ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG</b>	T4	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	T4	
<i>erythromycin ethylsuccinate oral tablet</i>	T4	
<i>erythromycin oral tablet</i>	T2	
<i>ethambutol</i>	T2	
<i>etravirine oral tablet 100 mg</i>	T4	
<i>etravirine oral tablet 200 mg</i>	T5	
<b>EVOTAZ</b>	T4	
<i>famciclovir</i>	T3	
<b>FIRVANQ</b>	T4	
<i>fluconazole</i>	T2	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml</i>	T2	
<i>flucytosine</i>	T4	
<i>fosamprenavir</i>	T4	
<b>FUZEON SUBCUTANEOUS RECON SOLN</b>	T5	
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	T2	
<i>gentamicin injection solution 40 mg/ml</i>	T1	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>GENVOYA</b>	T5	
<i>griseofulvin microsize</i>	T4	
<i>griseofulvin ultramicrosize</i>	T4	
<b>HARVONI ORAL PELLETS IN PACKET</b>	T5	PA; QL (28 EA per 28 days)
<b>HARVONI ORAL TABLET 90-400 MG</b>	T5	PA; QL (28 EA per 28 days)
<i>hydroxychloroquine oral tablet 100 mg</i>	T4	QL (93 EA per 31 days)
<i>hydroxychloroquine oral tablet 200 mg</i>	T2	QL (93 EA per 31 days)
<i>hydroxychloroquine oral tablet 300 mg</i>	T4	QL (62 EA per 31 days)
<i>hydroxychloroquine oral tablet 400 mg</i>	T4	QL (31 EA per 31 days)
<i>imipenem-cilastatin</i>	T4	
<b>IMPAVIDO</b>	T5	
<b>INTELENCE ORAL TABLET 25 MG</b>	T4	
<b>ISENTRESS</b>	T3	
<b>ISENTRESS HD</b>	T5	
<i>isoniazid oral solution</i>	T2	
<i>isoniazid oral tablet</i>	T1	
<i>itraconazole</i>	T4	PA
<i>ivermectin oral</i>	T3	
<b>JULUCA</b>	T5	
<i>ketoconazole oral</i>	T2	
<i>lamivudine</i>	T2	
<i>lamivudine-zidovudine</i>	T2	
<i>ledipasvir-sofosbuvir</i>	T5	PA; QL (28 EA per 28 days)
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	T2	
<i>levofloxacin intravenous</i>	T4	
<i>levofloxacin oral solution</i>	T4	
<i>levofloxacin oral tablet</i>	T2	
<b>LEXIVA ORAL SUSPENSION</b>	T4	
<i>linezolid in dextrose 5%</i>	T4	
<i>linezolid oral tablet</i>	T4	
<b>LIVTENCITY</b>	T5	PA; QL (124 EA per 31 days)
<i>lopinavir-ritonavir oral solution</i>	T4	
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	T3	
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	T5	
<i>maraviroc</i>	T5	
<b>MAVYRET ORAL PELLETS IN PACKET</b>	T5	PA; QL (140 EA per 28 days)
<b>MAVYRET ORAL TABLET</b>	T5	PA; QL (84 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>mefloquine</i>	T2	
<i>meropenem</i>	T4	
<i>methenamine hippurate</i>	T4	
<i>metronidazole in nacl (iso-os)</i>	T2	
<i>metronidazole oral tablet</i>	T2	
<i>micafungin</i>	T5	
<i>minocycline oral capsule</i>	T2	
<i>minocycline oral tablet</i>	T2	
<i>minocycline oral tablet extended release 24 hr 105 mg, 115 mg, 135 mg, 45 mg, 65 mg, 80 mg, 90 mg</i>	T4	
<i>nafcillin injection</i>	T4	
<i>neomycin</i>	T2	
<i>nevirapine</i>	T2	
<i>nitazoxanide</i>	T4	
<i>nitrofurantoin macrocrystal oral capsule 100 mg</i>	T2	QL (90 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	T2	QL (360 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 50 mg</i>	T2	QL (180 EA per 365 days)
<i>nitrofurantoin monohyd/m-cryst</i>	T2	QL (90 EA per 365 days)
<b>NORVIR ORAL POWDER IN PACKET</b>	T4	
<b>NORVIR ORAL SOLUTION</b>	T4	
<i>nystatin oral</i>	T2	
<b>ODEFSEY</b>	T5	QL (31 EA per 31 days)
<i>ofloxacin oral tablet 300 mg</i>	T4	
<i>ofloxacin oral tablet 400 mg</i>	T2	
<i>oseltamivir oral capsule 30 mg</i>	T2	QL (170 EA per 365 days)
<i>oseltamivir oral capsule 45 mg, 75 mg</i>	T2	QL (90 EA per 365 days)
<i>oseltamivir oral suspension for reconstitution</i>	T3	QL (1080 ML per 365 days)
<i>oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml</i>	T4	
<i>oxacillin injection recon soln 1 gram, 2 gram</i>	T2	
<b>PASER</b>	T4	
<i>penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml</i>	T4	
<i>penicillin g potassium injection recon soln 20 million unit</i>	T4	
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	T4	
<i>penicillin v potassium oral tablet</i>	T1	
<i>pentamidine inhalation</i>	T4	PA-BvD; QL (1 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pentamidine injection</i>	T4	
<b>PIFELTRO</b>	T5	QL (62 EA per 31 days)
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	T4	
<i>praziquantel</i>	T4	
<b>PREVYMIS ORAL TABLET 240 MG</b>	T4	
<b>PREVYMIS ORAL TABLET 480 MG</b>	T5	
<b>PREZCOBIX</b>	T5	
<b>PREZISTA ORAL SUSPENSION</b>	T5	
<b>PREZISTA ORAL TABLET 150 MG, 600 MG, 800 MG</b>	T5	
<b>PREZISTA ORAL TABLET 75 MG</b>	T3	
<b>PRIFTIN</b>	T4	
<i>primaquine</i>	T3	
<i>pyrazinamide</i>	T4	
<i>pyrimethamine</i>	T5	PA
<i>quinine sulfate</i>	T4	PA; QL (42 EA per 28 days)
<b>RELENZA DISKHALER</b>	T3	
<b>REYATAZ ORAL POWDER IN PACKET</b>	T4	
<i>ribavirin oral capsule</i>	T3	
<i>ribavirin oral tablet 200 mg</i>	T3	
<i>rifabutin</i>	T4	
<i>rifampin</i>	T4	
<i>rimantadine</i>	T4	
<i>ritonavir</i>	T3	
<b>RUKOBIA</b>	T5	QL (62 EA per 31 days)
<b>SELZENTRY ORAL SOLUTION</b>	T5	
<b>SELZENTRY ORAL TABLET 150 MG, 300 MG, 75 MG</b>	T5	
<b>SELZENTRY ORAL TABLET 25 MG</b>	T4	
<b>SIRTURO</b>	T5	
<b>SIVEXTRO ORAL</b>	T5	QL (6 EA per 31 days)
<i>sofosbuvir-velpatasvir</i>	T5	PA; QL (28 EA per 28 days)
<b>SOVALDI ORAL PELLETS IN PACKET</b>	T5	PA; QL (28 EA per 28 days)
<b>SOVALDI ORAL TABLET 400 MG</b>	T5	PA; QL (28 EA per 28 days)
<i>streptomycin</i>	T4	
<b>STRIBILD</b>	T5	
<i>sulfadiazine</i>	T4	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sulfamethoxazole-trimethoprim oral tablet</i>	T1	
<b>SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML</b>	T3	
<b>SYMFI</b>	T5	QL (31 EA per 31 days)
<b>SYMFI LO</b>	T5	QL (31 EA per 31 days)
<b>SYMTUZA</b>	T5	QL (31 EA per 31 days)
<b>TEFLARO</b>	T5	
<i>tenofovir disoproxil fumarate</i>	T3	
<i>terbinafine hcl oral</i>	T1	QL (90 EA per 180 days)
<i>tetracycline</i>	T4	
<i>tigecycline</i>	T5	
<b>TIVICAY ORAL TABLET 10 MG</b>	T4	
<b>TIVICAY ORAL TABLET 25 MG, 50 MG</b>	T5	
<b>TIVICAY PD</b>	T4	
<b>TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE</b>	T3	PA; QL (224 EA per 56 days)
<i>tobramycin in 0.225 % nacl</i>	T5	PA
<i>tobramycin inhalation</i>	T4	PA
<i>tobramycin sulfate injection solution</i>	T4	
<b>TRECTOR</b>	T4	
<i>trimethoprim</i>	T2	
<b>TRIUMEQ</b>	T5	
<b>TRIUMEQ PD</b>	T5	QL (186 EA per 31 days)
<b>TRIZIVIR</b>	T5	
<b>TYBOST</b>	T3	
<b>VABOMERE</b>	T4	
<i>valacyclovir</i>	T2	
<i>valganciclovir oral recon soln</i>	T5	
<i>valganciclovir oral tablet</i>	T3	
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg</i>	T4	
<i>vancomycin oral capsule 125 mg</i>	T4	QL (124 EA per 31 days)
<i>vancomycin oral capsule 250 mg</i>	T4	QL (248 EA per 31 days)
<i>vancomycin oral recon soln</i>	T4	
<b>VEMLIDY</b>	T5	QL (31 EA per 31 days)
<b>VIRACEPT ORAL TABLET</b>	T5	
<b>VIREAD ORAL POWDER</b>	T4	
<b>VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>VIVJOA</b>	T4	PA; QL (18 EA per 84 days)
<i>voriconazole intravenous</i>	T5	PA
<i>voriconazole oral suspension for reconstitution</i>	T5	
<i>voriconazole oral tablet</i>	T4	
<b>VOSEVI</b>	T5	PA; QL (28 EA per 28 days)
<b>XENLETA ORAL</b>	T5	
<b>XIFAXAN ORAL TABLET 200 MG</b>	T4	QL (9 EA per 3 days)
<b>XIFAXAN ORAL TABLET 550 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>XOFLUZA ORAL TABLET 40 MG, 80 MG</b>	T3	QL (9 EA per 365 days)
<b>ZEPATIER</b>	T5	PA; QL (28 EA per 28 days)
<i>zidovudine</i>	T2	
<b>Antineoplastic / Immunosuppressant Drugs</b>		
<i>abiraterone oral tablet 250 mg</i>	T5	PA-NS; QL (124 EA per 31 days)
<i>abiraterone oral tablet 500 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<b>ALECENSA</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>ALUNBRIG ORAL TABLET 180 MG, 90 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>ALUNBRIG ORAL TABLET 30 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>ALUNBRIG ORAL TABLETS,DOSE PACK</b>	T5	PA-NS; QL (30 EA per 365 days)
<i>anastrozole</i>	T2	
<b>AYVAKIT</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>azathioprine oral tablet 50 mg</i>	T2	PA-BvD
<b>BALVERSA</b>	T5	PA-NS
<i>bexarotene oral</i>	T5	PA-NS
<i>bexarotene topical</i>	T5	PA-NS; QL (60 GM per 28 days)
<i>bicalutamide</i>	T2	
<b>BOSULIF</b>	T5	PA-NS
<b>BRAFTOVI ORAL CAPSULE 75 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>BRUKINSA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>CABOMETYX</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>CALQUENCE</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>CALQUENCE (ACALABRUTINIB MAL)</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>CAPRELSA</b>	T5	PA-NS
<b>COMETRIQ</b>	T5	PA-NS
<b>COPIKTRA</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>COTELLIC</b>	T5	PA-NS; LA
<i>cyclophosphamide oral</i>	T3	PA-BvD
<i>cyclosporine modified</i>	T2	PA-BvD

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cyclosporine oral capsule</i>	T2	PA-BvD
<b>DAURISMO ORAL TABLET 100 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>DAURISMO ORAL TABLET 25 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>DROXIA</b>	T4	
<b>ELIGARD</b>	T4	
<b>ELIGARD (3 MONTH)</b>	T4	
<b>ELIGARD (4 MONTH)</b>	T4	
<b>ELIGARD (6 MONTH)</b>	T4	
<b>EMCYT</b>	T4	
<b>ENSPRYNG</b>	T5	PA; QL (1 ML per 28 days)
<b>ERIVEDGE</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>ERLEADA</b>	T5	PA-NS; QL (124 EA per 31 days)
<i>erlotinib</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 7.5 mg</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg, 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>everolimus (immunosuppressive)</i>	T5	PA-BvD
<i>exemestane</i>	T4	
<b>EXKIVITY</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>FOTIVDA</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>GAVRETO</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>GENGRAF</b>	T2	PA-BvD
<b>GILOTRIF</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>hydroxyurea</i>	T2	
<b>IBRANCE</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>ICLUSIG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>IDHIFA ORAL TABLET 100 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>IDHIFA ORAL TABLET 50 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<i>imatinib oral tablet 100 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>imatinib oral tablet 400 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<b>IMBRUVICA ORAL CAPSULE 140 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>IMBRUVICA ORAL CAPSULE 70 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>IMBRUVICA ORAL SUSPENSION</b>	T5	PA-NS; QL (216 ML per 25 days)
<b>IMBRUVICA ORAL TABLET</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>INLYTA</b>	T5	PA-NS; QL (124 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>INQOVI</b>	T5	PA-NS; QL (5 EA per 28 days)
<b>INREBIC</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>IRESSA</b>	T5	PA-NS
<b>JAKAFI</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG</b>	T5	PA-NS; QL (49 EA per 28 days)
<b>KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG</b>	T5	PA-NS; QL (70 EA per 28 days)
<b>KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG</b>	T5	PA-NS; QL (91 EA per 28 days)
<b>KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)</b>	T5	PA-NS; QL (42 EA per 28 days)
<b>KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)</b>	T5	PA-NS; QL (63 EA per 28 days)
<b>KLISYRI</b>	T4	PA
<b>KOSELUGO ORAL CAPSULE 10 MG</b>	T5	PA-NS; QL (279 EA per 31 days)
<b>KOSELUGO ORAL CAPSULE 25 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<i>lapatinib</i>	T5	PA-NS
<i>lenalidomide</i>	T5	PA-NS; QL (21 EA per 28 days)
<b>LENVIMA</b>	T5	PA-NS
<i>letrozole</i>	T2	
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg</i>	T3	
<i>leucovorin calcium oral tablet 5 mg</i>	T2	
<b>LEUKERAN</b>	T4	
<i>leuprolide subcutaneous kit</i>	T3	
<b>LONSURF</b>	T5	PA-NS
<b>LORBRENA ORAL TABLET 100 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>LORBRENA ORAL TABLET 25 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>LUMAKRAS</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>LUPKYNIS</b>	T5	PA; QL (186 EA per 31 days)
<b>LUPRON DEPOT</b>	T5	ST
<b>LUPRON DEPOT (3 MONTH)</b>	T5	ST
<b>LUPRON DEPOT (4 MONTH)</b>	T5	ST
<b>LUPRON DEPOT (6 MONTH)</b>	T5	ST
<b>LYNPARZA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>LYSODREN</b>	T3	
<b>MATULANE</b>	T5	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml)</i>	T2	PA
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	T4	PA
<i>megestrol oral tablet</i>	T2	PA-NS
<b>MEKINIST</b>	T5	PA-NS
<b>MEKTOVI</b>	T5	PA-NS; QL (186 EA per 31 days)
<i>mercaptopurine</i>	T2	
<b>MESNEX ORAL</b>	T4	
<i>methotrexate sodium</i>	T2	PA-BvD
<i>methotrexate sodium (pf) injection solution</i>	T2	PA-BvD
<b>MYCAPSSA</b>	T5	PA; QL (124 EA per 31 days)
<i>mycophenolate mofetil</i>	T2	PA-BvD
<i>mycophenolate sodium</i>	T4	PA-BvD
<b>NEORAL</b>	T3	PA-BvD
<b>NERLYNX</b>	T5	PA-NS; QL (186 EA per 31 days)
<i>nilutamide</i>	T5	
<b>NINLARO</b>	T5	PA-NS
<b>NUBEQA</b>	T5	PA-NS; QL (124 EA per 31 days)
<i>octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	T3	PA
<i>octreotide acetate injection solution 500 mcg/ml</i>	T5	PA
<b>ODOMZO</b>	T5	PA-NS; LA
<b>ONUREG</b>	T5	PA-NS; QL (14 EA per 28 days)
<b>ORGOVYX</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>PEMAZYRE</b>	T5	PA-NS; QL (14 EA per 21 days)
<b>PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)</b>	T5	PA-NS; QL (28 EA per 28 days)
<b>PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)</b>	T5	PA-NS; QL (56 EA per 28 days)
<b>POMALYST</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>PROGRAF ORAL GRANULES IN PACKET</b>	T4	PA-BvD
<b>PURIXAN</b>	T4	
<b>QINLOCK</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>RETEVMO ORAL CAPSULE 40 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>RETEVMO ORAL CAPSULE 80 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>ROZLYTREK ORAL CAPSULE 100 MG</b>	T5	PA-NS; QL (155 EA per 31 days)
<b>ROZLYTREK ORAL CAPSULE 200 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>RUBRACA</b>	T5	PA-NS; QL (124 EA per 31 days)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>RYDAPT</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>SANDIMMUNE ORAL SOLUTION</b>	T3	PA-BvD
<b>SCSEMBLIX ORAL TABLET 20 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>SCSEMBLIX ORAL TABLET 40 MG</b>	T5	PA-NS; QL (310 EA per 31 days)
<b>SIGNIFOR</b>	T5	PA
<i>sirolimus</i>	T4	PA-BvD
<b>SOLTAMOX</b>	T4	
<i>sorafenib</i>	T5	PA-NS; QL (124 EA per 31 days)
<b>SPRYCEL</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>STIVARGA</b>	T5	PA-NS; QL (84 EA per 28 days)
<i>sunitinib</i>	T5	PA-NS
<b>SYNRIBO</b>	T5	
<b>TABLOID</b>	T4	
<b>TABRECTA</b>	T5	PA-NS; QL (124 EA per 31 days)
<i>tacrolimus oral capsule 0.5 mg, 1 mg</i>	T2	PA-BvD
<i>tacrolimus oral capsule 5 mg</i>	T4	PA-BvD
<b>TAFINLAR</b>	T5	PA-NS
<b>TAGRISSE</b>	T5	PA-NS; LA; QL (31 EA per 31 days)
<b>TALZENNA ORAL CAPSULE 0.25 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>TALZENNA ORAL CAPSULE 0.5 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>TALZENNA ORAL CAPSULE 0.75 MG, 1 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>tamoxifen</i>	T1	
<b>TASIGNA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>TAZVERIK</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>TEPMETKO</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>THALOMID ORAL CAPSULE 100 MG, 150 MG, 50 MG</b>	T5	PA-NS; QL (28 EA per 28 days)
<b>THALOMID ORAL CAPSULE 200 MG</b>	T5	PA-NS; QL (56 EA per 28 days)
<b>TIBSOVO</b>	T5	PA-NS; QL (62 EA per 31 days)
<i>toremifene</i>	T4	
<b>TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG, 22.5 MG</b>	T3	PA
<b>TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG</b>	T5	PA
<i>tretinoin (antineoplastic)</i>	T5	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1)</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>TRUSELTIQ ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2)</b>	T5	PA-NS; QL (42 EA per 28 days)
<b>TRUSELTIQ ORAL CAPSULE 75 MG/DAY (25 MG X 3)</b>	T5	PA-NS; QL (63 EA per 28 days)
<b>TUKYSA ORAL TABLET 150 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>TUKYSA ORAL TABLET 50 MG</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>TURALIO</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>VENCLEXTA ORAL TABLET 10 MG</b>	T4	PA-NS
<b>VENCLEXTA ORAL TABLET 100 MG, 50 MG</b>	T5	PA-NS
<b>VENCLEXTA STARTING PACK</b>	T5	PA-NS
<b>VERZENIO</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>VIJOICE ORAL TABLET 125 MG, 50 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)</b>	T5	PA-NS; QL (56 EA per 28 days)
<b>VITRAKVI ORAL CAPSULE 100 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>VITRAKVI ORAL CAPSULE 25 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>VITRAKVI ORAL SOLUTION</b>	T5	PA-NS; QL (310 ML per 31 days)
<b>VIZIMPRO</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>VONJO</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>VOTRIENT</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>WELIREG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>XALKORI</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>XATMEP</b>	T4	PA-BvD
<b>XERMELO</b>	T5	PA; QL (93 EA per 31 days)
<b>XGEVA</b>	T5	PA-NS
<b>XOSPATA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2)</b>	T5	PA-NS; QL (8 EA per 28 days)
<b>XPOVIO ORAL TABLET 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1)</b>	T5	PA-NS; QL (4 EA per 28 days)
<b>XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)</b>	T5	PA-NS; QL (24 EA per 28 days)
<b>XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)</b>	T5	PA-NS; QL (32 EA per 28 days)
<b>XTANDI ORAL CAPSULE</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>XTANDI ORAL TABLET 40 MG</b>	T5	PA-NS; QL (124 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>XTANDI ORAL TABLET 80 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>YONSA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>ZEJULA</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>ZELBORAF</b>	T5	PA-NS
<b>ZOLINZA</b>	T5	PA-NS
<b>ZORTRESS ORAL TABLET 1 MG</b>	T5	PA-BvD
<b>ZYDELIG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>ZYKADIA</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>Autonomic / Cns Drugs, Neurology / Psych</b>		
<b>ABILIFY MAINTENA</b>	T5	QL (1 EA per 28 days)
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	T2	PA; QL (5167 ML per 31 days)
<i>acetaminophen-codeine oral tablet</i>	T2	PA; QL (403 EA per 31 days)
<b>AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML</b>	T3	PA; QL (1 ML per 28 days)
<b>AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML</b>	T3	PA; QL (2 ML per 28 days)
<b>AJOVY AUTOINJECTOR</b>	T3	PA; QL (1.5 ML per 28 days)
<b>AJOVY SYRINGE</b>	T3	PA; QL (1.5 ML per 28 days)
<i>alprazolam oral tablet 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>amitriptyline</i>	T2	PA-NS
<i>amoxapine</i>	T2	
<i>apomorphine</i>	T5	PA; QL (60 ML per 30 days)
<b>APTIOM ORAL TABLET 200 MG, 800 MG</b>	T4	
<b>APTIOM ORAL TABLET 400 MG, 600 MG</b>	T5	
<i>aripiprazole</i>	T4	PA-NS
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
<i>asenapine maleate</i>	T4	QL (62 EA per 31 days)
<i>atomoxetine oral capsule 10 mg, 25 mg, 40 mg</i>	T4	QL (62 EA per 31 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	T4	QL (31 EA per 31 days)
<i>atomoxetine oral capsule 18 mg</i>	T4	QL (124 EA per 31 days)
<b>AUBAGIO</b>	T5	PA; QL (31 EA per 31 days)
<i>baclofen oral tablet 10 mg, 20 mg</i>	T2	
<b>BAFIERTAM</b>	T5	PA; QL (124 EA per 31 days)
<b>BANZEL ORAL SUSPENSION</b>	T5	PA-NS

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>benztropine oral</i>	T2	PA
<b>BRIVIACT ORAL</b>	T5	
<i>bromocriptine</i>	T4	
<i>buprenorphine</i>	T4	PA; QL (4 EA per 28 days)
<i>buprenorphine hcl sublingual tablet 2 mg</i>	T3	QL (93 EA per 31 days)
<i>buprenorphine hcl sublingual tablet 8 mg</i>	T3	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 12-3 mg, 4-1 mg, 8-2 mg</i>	T2	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet</i>	T2	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	T2	QL (31 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 450 mg</i>	T4	
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	T2	QL (62 EA per 31 days)
<i>bupirone</i>	T2	
<i>butorphanol nasal</i>	T4	QL (5 ML per 28 days)
<b>CAPLYTA</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	T3	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	T2	
<i>carbamazepine oral tablet</i>	T2	
<i>carbamazepine oral tablet extended release 12 hr</i>	T3	
<i>carbamazepine oral tablet, chewable</i>	T2	
<i>carbidopa-levodopa</i>	T2	
<i>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg</i>	T3	
<i>carbidopa-levodopa-entacapone oral tablet 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg</i>	T4	
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	T2	ST; QL (62 EA per 31 days)
<i>celecoxib oral capsule 400 mg</i>	T3	ST; QL (62 EA per 31 days)
<b>CELONTIN ORAL CAPSULE 300 MG</b>	T4	
<i>chlorpromazine oral</i>	T4	
<i>citalopram oral solution</i>	T3	
<i>citalopram oral tablet</i>	T1	
<i>clobazam oral suspension</i>	T4	PA-NS; QL (496 ML per 31 days)
<i>clobazam oral tablet</i>	T4	PA-NS; QL (62 EA per 31 days)
<i>clomipramine</i>	T4	PA-NS

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>clonazepam oral tablet 0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>clonazepam oral tablet 1 mg</i>	T2	QL (124 EA per 31 days)
<i>clonazepam oral tablet 2 mg</i>	T2	QL (310 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 1 mg</i>	T2	QL (124 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 2 mg</i>	T2	QL (310 EA per 31 days)
<i>clorazepate dipotassium oral tablet 15 mg</i>	T3	QL (186 EA per 31 days)
<i>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</i>	T3	QL (93 EA per 31 days)
<i>clozapine oral tablet 100 mg</i>	T3	QL (279 EA per 31 days)
<i>clozapine oral tablet 200 mg</i>	T3	QL (124 EA per 31 days)
<i>clozapine oral tablet 25 mg</i>	T2	QL (279 EA per 31 days)
<i>clozapine oral tablet 50 mg</i>	T2	QL (93 EA per 31 days)
<i>clozapine oral tablet, disintegrating 100 mg, 25 mg</i>	T4	QL (279 EA per 31 days)
<i>clozapine oral tablet, disintegrating 12.5 mg</i>	T4	QL (93 EA per 31 days)
<i>clozapine oral tablet, disintegrating 150 mg</i>	T4	QL (186 EA per 31 days)
<i>clozapine oral tablet, disintegrating 200 mg</i>	T4	QL (124 EA per 31 days)
<b>COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML</b>	T5	ST; QL (31 ML per 31 days)
<b>COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML</b>	T5	ST; QL (12 ML per 28 days)
<i>cyclobenzaprine oral tablet 10 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>cyclobenzaprine oral tablet 5 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>dalfampridine</i>	T5	PA; QL (62 EA per 31 days)
<i>dantrolene oral</i>	T4	
<i>desipramine oral tablet 10 mg, 25 mg</i>	T3	
<i>desipramine oral tablet 100 mg, 150 mg, 50 mg, 75 mg</i>	T4	
<i>desvenlafaxine succinate</i>	T4	QL (31 EA per 31 days)
<i>dexmethylphenidate oral capsule, er biphasic 50-50</i>	T2	QL (31 EA per 31 days)
<i>dexmethylphenidate oral tablet 10 mg</i>	T2	QL (62 EA per 31 days)
<i>dexmethylphenidate oral tablet 2.5 mg, 5 mg</i>	T2	QL (93 EA per 31 days)
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr</i>	T4	QL (31 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	T2	QL (62 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 20 mg</i>	T2	QL (93 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>DIACOMIT ORAL CAPSULE 250 MG</b>	T5	PA-NS; QL (341 EA per 31 days)
<b>DIACOMIT ORAL CAPSULE 500 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>DIACOMIT ORAL POWDER IN PACKET 250 MG</b>	T5	PA-NS; QL (341 EA per 31 days)
<b>DIACOMIT ORAL POWDER IN PACKET 500 MG</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>DIAZEPAM INTENSOL</b>	T2	QL (248 ML per 31 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	T2	QL (1500 ML per 31 days)
<i>diazepam oral tablet</i>	T2	QL (124 EA per 31 days)
<i>diazepam rectal</i>	T4	
<i>diclofenac epolamine</i>	T4	PA; QL (62 EA per 31 days)
<i>diclofenac potassium oral tablet 50 mg</i>	T2	
<i>diclofenac sodium oral</i>	T2	
<i>diclofenac sodium topical drops</i>	T2	QL (450 ML per 28 days)
<i>diclofenac sodium topical gel 1 %</i>	T3	QL (900 GM per 28 days)
<i>diflunisal</i>	T2	
<i>dihydroergotamine nasal</i>	T4	PA; QL (8 ML per 31 days)
<b>DILANTIN</b>	T4	
<b>DILANTIN EXTENDED</b>	T4	
<b>DILANTIN INFATABS</b>	T4	
<b>DILANTIN-125</b>	T4	
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg (14)- 240 mg (46)</i>	T5	PA; QL (120 EA per 365 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 240 mg</i>	T5	PA; QL (62 EA per 31 days)
<i>divalproex oral capsule, delayed rel sprinkle</i>	T2	
<i>divalproex oral tablet extended release 24 hr 250 mg</i>	T2	
<i>divalproex oral tablet extended release 24 hr 500 mg</i>	T3	
<i>divalproex oral tablet, delayed release (dr/ec)</i>	T2	
<i>donepezil oral tablet 10 mg, 5 mg</i>	T2	
<i>donepezil oral tablet 23 mg</i>	T3	QL (31 EA per 31 days)
<i>donepezil oral tablet, disintegrating</i>	T2	
<i>doxepin oral capsule 10 mg, 150 mg, 25 mg</i>	T2	PA-NS
<i>doxepin oral capsule 100 mg, 50 mg, 75 mg</i>	T3	PA-NS
<i>doxepin oral concentrate</i>	T2	PA-NS
<i>doxepin oral tablet</i>	T3	PA
<b>DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG</b>	T4	PA-NS; QL (93 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 30 MG, 60 MG</b>	T4	PA-NS; QL (62 EA per 31 days)
<b>DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG</b>	T4	PA-NS; QL (31 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 60 mg</i>	T2	QL (62 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 30 mg</i>	T2	QL (31 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 40 mg</i>	T3	QL (31 EA per 31 days)
<b>EMGALITY PEN</b>	T3	PA; QL (1 ML per 28 days)
<b>EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML</b>	T3	PA; QL (1 ML per 28 days)
<b>EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)</b>	T3	PA; QL (3 ML per 28 days)
<b>EMSAM</b>	T5	QL (30 EA per 30 days)
<b>ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG</b>	T3	PA; QL (372 EA per 31 days)
<i>entacapone</i>	T3	
<b>EPIDIOLEX</b>	T5	PA-NS
<b>EPITOL</b>	T2	
<b>EPRONTIA</b>	T4	PA-NS; QL (496 ML per 31 days)
<i>ergotamine-caffeine</i>	T2	PA
<i>escitalopram oxalate oral solution</i>	T4	QL (620 ML per 31 days)
<i>escitalopram oxalate oral tablet 10 mg</i>	T2	QL (45 EA per 30 days)
<i>escitalopram oxalate oral tablet 20 mg, 5 mg</i>	T2	QL (30 EA per 30 days)
<i>ethosuximide oral capsule</i>	T3	
<i>ethosuximide oral solution</i>	T4	
<i>etodolac oral capsule</i>	T3	
<i>etodolac oral tablet</i>	T2	
<i>etodolac oral tablet extended release 24 hr 400 mg, 500 mg</i>	T3	
<i>etodolac oral tablet extended release 24 hr 600 mg</i>	T4	
<b>EVRYSDI</b>	T5	PA; QL (240 ML per 31 days)
<b>FANAPT ORAL TABLET</b>	T4	QL (62 EA per 31 days)
<b>FANAPT ORAL TABLETS,DOSE PACK</b>	T4	QL (16 EA per 365 days)
<i>felbamate</i>	T4	
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg</i>	T5	PA; QL (40 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fentanyl citrate buccal lozenge on a handle 1,600 mcg</i>	T5	PA; QL (30 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	T4	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 100 mcg, 200 mcg</i>	T5	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr</i>	T4	PA; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr</i>	T4	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 25 mcg/hr</i>	T2	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 50 mcg/hr</i>	T2	PA; QL (17 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 75 mcg/hr</i>	T4	PA; QL (12 EA per 30 days)
<b>FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG</b>	T5	PA; QL (124 EA per 31 days)
<b>FENTORA BUCCAL TABLET, EFFERVESCENT 400 MCG</b>	T5	PA; QL (119 EA per 31 days)
<b>FENTORA BUCCAL TABLET, EFFERVESCENT 600 MCG</b>	T5	PA; QL (79 EA per 31 days)
<b>FENTORA BUCCAL TABLET, EFFERVESCENT 800 MCG</b>	T5	PA; QL (59 EA per 31 days)
<b>FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK</b>	T4	PA-NS; QL (56 EA per 365 days)
<b>FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG</b>	T4	PA-NS; QL (31 EA per 31 days)
<b>FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG</b>	T4	PA-NS; QL (93 EA per 31 days)
<i>fingolimod</i>	T5	PA; QL (31 EA per 31 days)
<b>FINTEPLA</b>	T5	PA-NS; QL (360 ML per 30 days)
<b>FIRDAPSE</b>	T5	PA; QL (248 EA per 31 days)
<b>FLECTOR</b>	T4	PA; QL (62 EA per 31 days)
<i>fluoxetine (pmd)</i>	T2	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fluoxetine oral capsule</i>	T1	
<i>fluoxetine oral solution</i>	T3	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	T2	
<i>fluphenazine decanoate</i>	T3	
<i>fluphenazine hcl injection</i>	T3	
<i>fluphenazine hcl oral concentrate</i>	T4	
<i>fluphenazine hcl oral tablet</i>	T2	
<i>flurbiprofen oral tablet 100 mg</i>	T2	
<i>fluvoxamine oral capsule, extended release 24hr</i>	T4	
<i>fluvoxamine oral tablet</i>	T2	
<b>FYCOMPA ORAL SUSPENSION</b>	T5	
<b>FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG</b>	T5	
<b>FYCOMPA ORAL TABLET 2 MG</b>	T4	
<i>gabapentin oral capsule 100 mg, 400 mg</i>	T2	PA-NS; QL (270 EA per 30 days)
<i>gabapentin oral capsule 300 mg</i>	T2	PA-NS; QL (360 EA per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	T4	PA-NS; QL (2160 ML per 30 days)
<i>gabapentin oral tablet 600 mg</i>	T2	PA-NS; QL (180 EA per 30 days)
<i>gabapentin oral tablet 800 mg</i>	T2	PA-NS; QL (120 EA per 30 days)
<i>galantamine</i>	T3	
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	T5	QL (31 ML per 31 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	T5	QL (12 ML per 28 days)
<b>GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML</b>	T5	QL (31 ML per 31 days)
<b>GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML</b>	T5	QL (12 ML per 28 days)
<i>guanfacine oral tablet extended release 24 hr</i>	T4	PA
<i>haloperidol</i>	T2	
<i>haloperidol decanoate</i>	T2	
<i>haloperidol lactate injection</i>	T1	
<i>haloperidol lactate oral</i>	T2	
<b>HETLIOZ</b>	T5	PA; QL (31 EA per 31 days)
<b>HETLIOZ LQ</b>	T5	PA; QL (158 ML per 31 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>hydromorphone oral liquid</i>	T4	PA; QL (1550 ML per 31 days)
<i>hydromorphone oral tablet 2 mg, 4 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>hydromorphone oral tablet 8 mg</i>	T3	PA; QL (186 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>IBU ORAL TABLET 600 MG, 800 MG</b>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>imipramine hcl</i>	T2	PA-NS
<b>INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE</b>	T5	PA; QL (300 EA per 30 days)
<i>indomethacin oral</i>	T2	
<b>INGREZZA INITIATION PACK</b>	T5	PA; QL (56 EA per 365 days)
<b>INGREZZA ORAL CAPSULE 40 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>INGREZZA ORAL CAPSULE 60 MG, 80 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML</b>	T4	QL (3.5 ML per 180 days)
<b>INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML</b>	T4	QL (5 ML per 180 days)
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML</b>	T5	QL (0.75 ML per 28 days)
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML</b>	T5	QL (1 ML per 28 days)
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML</b>	T5	QL (1.5 ML per 28 days)
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML</b>	T4	QL (0.25 ML per 28 days)
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML</b>	T5	QL (0.5 ML per 28 days)
<b>INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML</b>	T5	QL (0.875 ML per 84 days)
<b>INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML</b>	T5	QL (1.315 ML per 84 days)
<b>INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML</b>	T5	QL (1.75 ML per 84 days)
<b>INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML</b>	T5	QL (2.625 ML per 84 days)
<b>KESIMPTA PEN</b>	T5	PA; QL (0.4 ML per 28 days)
<b>KLOXXADO</b>	T3	
<b>KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG</b>	T5	PA; QL (155 EA per 31 days)
<i>lacosamide oral</i>	T4	
<i>lamotrigine oral tablet</i>	T2	
<i>lamotrigine oral tablet extended release 24hr</i>	T4	
<i>lamotrigine oral tablet, chewable dispersible</i>	T2	
<b>LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>LATUDA ORAL TABLET 80 MG</b>	T5	PA-NS; QL (62 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>levetiracetam oral solution 100 mg/ml</i>	T2	
<i>levetiracetam oral tablet</i>	T2	
<i>levetiracetam oral tablet extended release 24 hr</i>	T2	
<i>lithium carbonate oral capsule</i>	T1	
<i>lithium carbonate oral tablet</i>	T1	
<i>lithium carbonate oral tablet extended release</i>	T2	
<b>LORAZEPAM INTENSOL</b>	T2	QL (155 ML per 31 days)
<i>lorazepam oral tablet 0.5 mg</i>	T2	QL (124 EA per 31 days)
<i>lorazepam oral tablet 1 mg</i>	T2	QL (186 EA per 31 days)
<i>lorazepam oral tablet 2 mg</i>	T2	QL (155 EA per 31 days)
<i>loxapine succinate</i>	T2	
<b>LUCEMYRA</b>	T5	
<b>LYBALVI</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>MARPLAN</b>	T4	
<b>MAVENCLAD (10 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (4 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (5 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (6 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (7 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (8 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAVENCLAD (9 TABLET PACK)</b>	T5	PA; QL (40 EA per 365 days)
<b>MAYZENT ORAL TABLET 0.25 MG</b>	T5	PA; QL (155 EA per 31 days)
<b>MAYZENT ORAL TABLET 1 MG, 2 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>MAYZENT STARTER(FOR 1MG MAINT)</b>	T4	PA; QL (14 EA per 365 days)
<b>MAYZENT STARTER(FOR 2MG MAINT)</b>	T5	PA; QL (24 EA per 365 days)
<i>meloxicam oral tablet</i>	T1	
<i>memantine oral capsule,sprinkle,er 24hr</i>	T4	
<i>memantine oral solution</i>	T4	
<i>memantine oral tablet</i>	T2	
<i>memantine oral tablets,dose pack</i>	T4	
<i>methadone oral solution 10 mg/5 ml</i>	T2	PA; QL (1033 ML per 31 days)
<i>methadone oral solution 5 mg/5 ml</i>	T2	PA; QL (2066 ML per 31 days)
<i>methadone oral tablet 10 mg</i>	T2	PA; QL (206 EA per 31 days)
<i>methadone oral tablet 5 mg</i>	T2	PA; QL (248 EA per 31 days)
<i>methylphenidate hcl oral capsule, er biphasic 30-70</i>	T4	QL (31 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 10 mg</i>	T4	QL (186 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methylphenidate hcl oral capsule,er biphasic 50-50 20 mg</i>	T4	QL (93 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 40 mg</i>	T4	QL (62 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 60 mg</i>	T4	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 10 mg</i>	T4	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 20 mg</i>	T4	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 18 mg (bx rating), 27 mg, 27 mg (bx rating), 36 mg, 36 mg (bx rating), 54 mg, 54 mg (bx rating)</i>	T4	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet,chewable 10 mg</i>	T2	QL (186 EA per 31 days)
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg</i>	T2	
<i>mirtazapine oral tablet 7.5 mg</i>	T3	
<i>mirtazapine oral tablet,disintegrating</i>	T3	
<i>modafinil</i>	T3	PA; QL (31 EA per 31 days)
<i>molindone</i>	T4	
<i>morphine concentrate oral solution</i>	T2	PA; QL (310 ML per 31 days)
<i>morphine oral capsule, er multiphase 24 hr 120 mg</i>	T4	PA; QL (51 EA per 31 days)
<i>morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg</i>	T4	PA; QL (62 EA per 31 days)
<i>morphine oral solution 10 mg/5 ml</i>	T2	PA; QL (2800 ML per 31 days)
<i>morphine oral solution 20 mg/5 ml (4 mg/ml)</i>	T2	PA; QL (1400 ML per 31 days)
<i>morphine oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<i>morphine oral tablet extended release 100 mg</i>	T3	PA; QL (62 EA per 31 days)
<i>morphine oral tablet extended release 15 mg, 30 mg, 60 mg</i>	T3	PA; QL (100 EA per 31 days)
<i>morphine oral tablet extended release 200 mg</i>	T3	PA; QL (31 EA per 31 days)
<i>nabumetone</i>	T2	
<i>naloxone injection solution</i>	T2	
<i>naloxone injection syringe</i>	T2	
<i>naloxone nasal</i>	T3	
<i>naltrexone</i>	T2	
<b>NAMZARIC</b>	T4	PA
<i>naproxen oral suspension</i>	T2	
<i>naproxen oral tablet</i>	T1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>naproxen oral tablet, delayed release (dr/ec)</i>	T2	
<i>naproxen sodium oral tablet 550 mg</i>	T2	
<i>naratriptan oral tablet 1 mg</i>	T3	QL (20 EA per 28 days)
<i>naratriptan oral tablet 2.5 mg</i>	T3	QL (9 EA per 28 days)
<b>NARCAN</b>	T3	
<b>NAYZILAM</b>	T4	PA-NS; QL (10 EA per 30 days)
<i>nefazodone</i>	T4	
<b>NEUPRO</b>	T4	
<i>nortriptyline</i>	T2	
<b>NOURIANZ</b>	T5	PA; QL (31 EA per 31 days)
<b>NUEDEXTA</b>	T3	PA; QL (62 EA per 31 days)
<b>NUPLAZID</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>NURTEC ODT</b>	T5	QL (18 EA per 28 days)
<i>olanzapine intramuscular</i>	T4	
<i>olanzapine oral tablet</i>	T2	QL (31 EA per 31 days)
<i>olanzapine oral tablet, disintegrating</i>	T4	QL (31 EA per 31 days)
<b>ONGENTYS</b>	T4	PA; QL (31 EA per 31 days)
<i>oxcarbazepine oral suspension</i>	T4	
<i>oxcarbazepine oral tablet</i>	T2	
<i>oxycodone oral capsule</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral concentrate</i>	T4	PA; QL (180 ML per 31 days)
<i>oxycodone oral solution</i>	T2	PA; QL (4133 ML per 31 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral tablet 30 mg</i>	T3	PA; QL (138 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg</i>	T3	PA; QL (372 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	T4	QL (31 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	T4	QL (62 EA per 31 days)
<i>paroxetine hcl oral suspension</i>	T4	
<i>paroxetine hcl oral tablet</i>	T1	
<i>perphenazine</i>	T4	
<b>PERSERIS</b>	T5	QL (1 EA per 28 days)
<i>phenelzine</i>	T2	
<i>phenobarbital</i>	T2	PA-NS
<b>PHENYTEK</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>phenytoin oral suspension 125 mg/5 ml</i>	T2	
<i>phenytoin oral tablet, chewable</i>	T2	
<i>phenytoin sodium extended</i>	T2	
<i>pimozide</i>	T4	
<i>piroxicam</i>	T2	
<b>PONVORY</b>	T5	PA; QL (31 EA per 31 days)
<b>PONVORY 14-DAY STARTER PACK</b>	T5	PA; QL (28 EA per 365 days)
<i>pramipexole oral tablet</i>	T2	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	T2	PA-NS; QL (62 EA per 31 days)
<i>pregabalin oral solution</i>	T2	PA-NS; QL (930 ML per 31 days)
<i>pregabalin oral tablet extended release 24 hr</i>	T4	PA; QL (31 EA per 31 days)
<i>primidone</i>	T2	
<i>protriptyline</i>	T4	
<i>pyridostigmine bromide oral syrup</i>	T3	
<i>pyridostigmine bromide oral tablet</i>	T3	
<i>pyridostigmine bromide oral tablet extended release</i>	T4	
<i>quetiapine oral tablet 100 mg, 50 mg</i>	T2	QL (62 EA per 31 days)
<i>quetiapine oral tablet 200 mg, 300 mg, 400 mg</i>	T3	QL (62 EA per 31 days)
<i>quetiapine oral tablet 25 mg</i>	T1	QL (62 EA per 31 days)
<i>quetiapine oral tablet extended release 24 hr</i>	T3	QL (62 EA per 31 days)
<b>RADICAVA ORS STARTER KIT SUSP</b>	T5	PA; QL (70 ML per 28 days)
<i>ramelteon</i>	T4	QL (31 EA per 31 days)
<i>rasagiline</i>	T4	
<b>REXULTI</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>REYVOW ORAL TABLET 100 MG</b>	T4	QL (8 EA per 28 days)
<b>REYVOW ORAL TABLET 50 MG</b>	T4	QL (4 EA per 28 days)
<b>RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML</b>	T4	QL (2 EA per 28 days)
<b>RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 50 MG/2 ML</b>	T5	QL (2 EA per 28 days)
<i>risperidone oral solution</i>	T2	QL (496 ML per 31 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T2	QL (31 EA per 31 days)
<i>risperidone oral tablet 3 mg</i>	T2	QL (93 EA per 31 days)
<i>risperidone oral tablet 4 mg</i>	T2	QL (124 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T4	QL (31 EA per 31 days)
<i>risperidone oral tablet,disintegrating 3 mg</i>	T4	QL (93 EA per 31 days)
<i>risperidone oral tablet,disintegrating 4 mg</i>	T4	QL (124 EA per 31 days)
<i>rivastigmine</i>	T4	QL (30 EA per 30 days)
<i>rivastigmine tartrate</i>	T3	
<i>rizatriptan oral tablet 10 mg</i>	T2	QL (12 EA per 28 days)
<i>rizatriptan oral tablet 5 mg</i>	T2	QL (24 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 10 mg</i>	T2	QL (12 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 5 mg</i>	T2	QL (24 EA per 28 days)
<i>ropinirole oral tablet</i>	T2	
<b>ROWEEPRA ORAL TABLET 500 MG</b>	T2	
<i>rufinamide</i>	T5	PA-NS
<b>RYTARY</b>	T3	ST
<b>SECUADO</b>	T5	QL (31 EA per 31 days)
<i>selegiline hcl</i>	T2	
<i>sertraline oral concentrate</i>	T2	
<i>sertraline oral tablet</i>	T1	
<b>SPRITAM</b>	T4	
<i>sulindac</i>	T2	
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation</i>	T2	QL (8 EA per 28 days)
<i>sumatriptan nasal spray,non-aerosol 5 mg/actuation</i>	T2	QL (32 EA per 28 days)
<i>sumatriptan succinate oral tablet 100 mg</i>	T2	QL (9 EA per 28 days)
<i>sumatriptan succinate oral tablet 25 mg</i>	T2	QL (36 EA per 28 days)
<i>sumatriptan succinate oral tablet 50 mg</i>	T2	QL (18 EA per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml</i>	T2	QL (6 ML per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	T4	QL (6 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous solution</i>	T2	QL (4 ML per 28 days)
<b>SUNOSI</b>	T4	PA; QL (31 EA per 31 days)
<b>SYMPAZAN ORAL FILM 10 MG, 20 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>SYMPAZAN ORAL FILM 5 MG</b>	T4	PA-NS; QL (62 EA per 31 days)
<b>TEGRETOL ORAL SUSPENSION</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>TEGRETOL ORAL TABLET</b>	T4	
<b>TEGRETOL XR</b>	T4	
<b>TEGSEDI</b>	T5	PA; QL (6 ML per 28 days)
<i>temazepam oral capsule 15 mg, 30 mg</i>	T2	QL (31 EA per 31 days)
<i>temazepam oral capsule 22.5 mg, 7.5 mg</i>	T3	QL (31 EA per 31 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>tetrabenazine oral tablet 25 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>thioridazine</i>	T2	
<i>thiothixene</i>	T3	
<i>tiagabine</i>	T4	
<i>tizanidine oral tablet</i>	T2	
<i>tolcapone</i>	T5	
<i>topiramate oral capsule, sprinkle</i>	T2	
<i>topiramate oral tablet</i>	T2	
<i>tramadol oral tablet 50 mg</i>	T2	PA; QL (240 EA per 30 days)
<i>tramadol-acetaminophen</i>	T2	PA; QL (372 EA per 31 days)
<i>tranylcypromine</i>	T4	
<i>trazodone oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>trifluoperazine</i>	T2	
<i>trimipramine</i>	T3	PA-NS
<b>TRINTELLIX</b>	T3	PA-NS
<b>UBRELVY ORAL TABLET 100 MG</b>	T5	QL (17 EA per 28 days)
<b>UBRELVY ORAL TABLET 50 MG</b>	T5	QL (34 EA per 28 days)
<i>valproic acid</i>	T2	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	T2	
<b>VALTOCO</b>	T4	PA-NS; QL (10 EA per 30 days)
<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg</i>	T2	QL (31 EA per 31 days)
<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	T2	QL (93 EA per 31 days)
<i>venlafaxine oral tablet</i>	T2	
<b>VERSACLOZ</b>	T4	QL (558 ML per 31 days)
<i>vigabatrin</i>	T5	PA-NS
<b>VIGADRONE</b>	T5	PA-NS
<b>VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)</b>	T3	PA-NS; QL (60 EA per 365 days)
<i>vilazodone</i>	T3	PA-NS; QL (31 EA per 31 days)
<b>VIVITROL</b>	T5	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>VRAYLAR ORAL CAPSULE</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>VRAYLAR ORAL CAPSULE,DOSE PACK</b>	T4	PA-NS; QL (14 EA per 365 days)
<b>VUMERITY</b>	T5	PA; QL (124 EA per 31 days)
<b>WAKIX</b>	T5	PA; QL (62 EA per 31 days)
<b>XCOPRI</b>	T5	PA-NS
<b>XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)</b>	T5	PA-NS
<b>XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)</b>	T4	PA-NS
<b>XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)</b>	T5	PA-NS
<b>XYREM</b>	T5	PA; QL (540 ML per 30 days)
<i>zaleplon oral capsule 10 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>zaleplon oral capsule 5 mg</i>	T2	PA; QL (93 EA per 31 days)
<b>ZEPOSIA</b>	T5	PA; QL (31 EA per 31 days)
<b>ZEPOSIA STARTER KIT</b>	T5	PA; QL (74 EA per 365 days)
<b>ZEPOSIA STARTER PACK</b>	T5	PA; QL (14 EA per 365 days)
<i>ziprasidone hcl</i>	T3	QL (62 EA per 31 days)
<i>ziprasidone mesylate</i>	T3	
<i>zolmitriptan oral tablet 2.5 mg</i>	T4	QL (16 EA per 28 days)
<i>zolmitriptan oral tablet 5 mg</i>	T4	QL (8 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 2.5 mg</i>	T4	QL (16 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 5 mg</i>	T4	QL (8 EA per 28 days)
<i>zolpidem oral tablet</i>	T4	PA; QL (31 EA per 31 days)
<i>zonisamide</i>	T2	
<b>ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 2.9-0.71 MG, 8.6-2.1 MG</b>	T3	QL (62 EA per 31 days)
<b>ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG</b>	T3	QL (93 EA per 31 days)
<b>ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 5.7-1.4 MG</b>	T3	QL (31 EA per 31 days)
<b>ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG</b>	T4	QL (2 EA per 28 days)
<b>Cardiovascular, Hypertension / Lipids</b>		
<i>acebutolol</i>	T2	
<i>aliskiren</i>	T4	
<i>amiloride</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>amiloride-hydrochlorothiazide</i>	T2	
<i>amiodarone oral</i>	T2	
<i>amlodipine</i>	T1	
<i>amlodipine-benazepril</i>	T1	
<i>amlodipine-olmesartan</i>	T3	QL (31 EA per 31 days)
<i>amlodipine-valsartan</i>	T2	
<i>aspirin-dipyridamole</i>	T4	
<i>atenolol</i>	T1	
<i>atenolol-chlorthalidone</i>	T2	
<i>atorvastatin</i>	T1	
<i>benazepril</i>	T1	
<i>benazepril-hydrochlorothiazide</i>	T1	
<i>bisoprolol fumarate</i>	T2	
<i>bisoprolol-hydrochlorothiazide</i>	T1	
<b>BRILINTA</b>	T3	
<i>bumetanide oral</i>	T2	
<b>CABLIVI INJECTION KIT</b>	T5	PA; QL (31 EA per 31 days)
<b>CAMZYOS</b>	T5	PA; QL (31 EA per 31 days)
<i>candesartan</i>	T1	
<i>candesartan-hydrochlorothiazid</i>	T1	
<i>captopril</i>	T1	
<b>CARTIA XT</b>	T2	
<i>carvedilol</i>	T1	
<i>carvedilol phosphate</i>	T4	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>cholestyramine (with sugar) oral powder in packet</i>	T2	
<b>CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET</b>	T2	
<i>cilostazol</i>	T2	
<i>clonidine</i>	T3	
<i>clonidine hcl oral tablet</i>	T1	
<i>clopidogrel oral tablet 75 mg</i>	T1	
<i>colesevelam</i>	T4	
<i>colestipol oral packet</i>	T4	
<i>colestipol oral tablet</i>	T3	
<b>CORLANOR ORAL SOLUTION</b>	T4	PA; QL (420 ML per 28 days)
<b>CORLANOR ORAL TABLET 5 MG</b>	T4	PA; QL (93 EA per 31 days)
<b>CORLANOR ORAL TABLET 7.5 MG</b>	T4	PA; QL (62 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>DIGITEK ORAL TABLET 125 MCG (0.125 MG)</b>	T2	QL (62 EA per 31 days)
<b>DIGITEK ORAL TABLET 250 MCG (0.25 MG)</b>	T2	QL (31 EA per 31 days)
<i>digoxin oral solution</i>	T3	QL (155 ML per 31 days)
<i>digoxin oral tablet 125 mcg (0.125 mg)</i>	T1	QL (62 EA per 31 days)
<i>digoxin oral tablet 250 mcg (0.25 mg)</i>	T2	QL (31 EA per 31 days)
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	T2	
<i>diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg</i>	T2	
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	T2	
<i>diltiazem hcl oral tablet</i>	T2	
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg</i>	T2	
<b>DILT-XR</b>	T2	
<i>dofetilide</i>	T4	
<b>DOPTELET (10 TAB PACK)</b>	T5	PA
<b>DOPTELET (15 TAB PACK)</b>	T5	PA
<b>DOPTELET (30 TAB PACK)</b>	T5	PA
<i>doxazosin</i>	T2	
<b>ELIQUIS DVT-PE TREAT 30D START</b>	T3	QL (74 EA per 30 days)
<b>ELIQUIS ORAL TABLET 2.5 MG</b>	T3	QL (60 EA per 30 days)
<b>ELIQUIS ORAL TABLET 5 MG</b>	T3	QL (74 EA per 30 days)
<i>enalapril maleate oral solution</i>	T4	
<i>enalapril maleate oral tablet</i>	T1	
<i>enalapril-hydrochlorothiazide</i>	T1	
<i>enoxaparin subcutaneous syringe</i>	T4	
<b>ENTRESTO ORAL TABLET 24-26 MG</b>	T3	QL (186 EA per 31 days)
<b>ENTRESTO ORAL TABLET 49-51 MG</b>	T3	QL (93 EA per 31 days)
<b>ENTRESTO ORAL TABLET 97-103 MG</b>	T3	QL (62 EA per 31 days)
<i>eplerenone</i>	T4	
<i>ethacrynic acid</i>	T4	
<i>ezetimibe</i>	T2	
<i>ezetimibe-simvastatin</i>	T3	
<i>felodipine</i>	T2	
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg</i>	T2	
<i>fenofibrate nanocrystallized</i>	T2	
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>flecainide</i>	T2	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	T5	
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	T4	
<i>fosinopril</i>	T1	
<i>fosinopril-hydrochlorothiazide</i>	T1	
<i>furosemide injection</i>	T2	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	T2	
<i>furosemide oral tablet</i>	T1	
<i>gemfibrozil</i>	T1	
<i>heparin (porcine) injection solution</i>	T3	
<i>hydralazine oral</i>	T1	
<i>hydrochlorothiazide</i>	T1	
<i>icosapent ethyl oral capsule 0.5 gram</i>	T4	QL (248 EA per 31 days)
<i>icosapent ethyl oral capsule 1 gram</i>	T4	QL (124 EA per 31 days)
<i>indapamide</i>	T1	
<i>irbesartan</i>	T1	QL (31 EA per 31 days)
<i>irbesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<i>isosorbide dinitrate oral tablet</i>	T2	
<i>isosorbide mononitrate</i>	T2	
<i>isradipine</i>	T4	
<b>JANTOVEN</b>	T1	
<b>JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG</b>	T5	PA
<i>labetalol oral</i>	T2	
<i>lisinopril</i>	T1	
<i>lisinopril-hydrochlorothiazide</i>	T1	
<i>losartan oral tablet 100 mg</i>	T1	QL (31 EA per 31 days)
<i>losartan oral tablet 25 mg</i>	T1	QL (93 EA per 31 days)
<i>losartan oral tablet 50 mg</i>	T1	QL (62 EA per 31 days)
<i>losartan-hydrochlorothiazide</i>	T1	
<i>lovastatin</i>	T1	
<i>metolazone</i>	T2	
<i>metoprolol succinate</i>	T2	
<i>metoprolol ta-hydrochlorothiaz</i>	T2	
<i>metoprolol tartrate oral</i>	T1	
<i>metyrosine</i>	T3	
<i>mexiletine</i>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>minoxidil oral</i>	T2	
<i>moexipril</i>	T1	
<b>MULPLETA</b>	T5	PA
<b>MULTAQ</b>	T4	
<i>nadolol</i>	T4	
<i>nebivolol oral tablet 10 mg, 2.5 mg</i>	T4	QL (93 EA per 31 days)
<i>nebivolol oral tablet 20 mg</i>	T4	QL (62 EA per 31 days)
<i>nebivolol oral tablet 5 mg</i>	T4	QL (217 EA per 31 days)
<b>NEXLETOL</b>	T4	PA; QL (31 EA per 31 days)
<b>NEXLIZET</b>	T4	PA; QL (31 EA per 31 days)
<i>niacin oral tablet 500 mg</i>	T5	
<i>niacin oral tablet extended release 24 hr 1,000 mg, 750 mg</i>	T4	
<i>niacin oral tablet extended release 24 hr 500 mg</i>	T4	QL (31 EA per 31 days)
<b>NIACOR</b>	T4	
<i>nicardipine oral</i>	T4	
<i>nifedipine oral tablet extended release</i>	T2	
<i>nifedipine oral tablet extended release 24hr</i>	T2	
<i>nimodipine</i>	T4	
<b>NITRO-BID</b>	T2	
<i>nitroglycerin sublingual</i>	T2	
<i>nitroglycerin transdermal patch 24 hour</i>	T2	
<i>nitroglycerin translingual</i>	T4	
<i>olmesartan oral tablet 20 mg, 40 mg</i>	T2	QL (31 EA per 31 days)
<i>olmesartan oral tablet 5 mg</i>	T2	QL (93 EA per 31 days)
<i>olmesartan-amlodipin-hcthiazyd</i>	T3	
<i>olmesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<i>omega-3 acid ethyl esters</i>	T3	QL (124 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG</b>	T4	PA; QL (93 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG</b>	T4	PA; QL (186 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 1 MG</b>	T5	PA; QL (186 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG</b>	T5	PA; QL (521 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG</b>	T5	PA; QL (261 EA per 31 days)
<b>PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG</b>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pentoxifylline</i>	T2	
<i>perindopril erbumine</i>	T2	
<i>pindolol</i>	T4	
<b>PRALUENT PEN</b>	T4	PA; QL (2 ML per 28 days)
<i>prasugrel</i>	T3	
<i>pravastatin</i>	T1	
<i>prazosin</i>	T2	
<b>PREVALITE ORAL POWDER IN PACKET</b>	T4	
<b>PROMACTA ORAL POWDER IN PACKET 12.5 MG</b>	T5	PA; QL (372 EA per 31 days)
<b>PROMACTA ORAL POWDER IN PACKET 25 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>PROMACTA ORAL TABLET 12.5 MG, 25 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>PROMACTA ORAL TABLET 50 MG, 75 MG</b>	T5	PA; QL (62 EA per 31 days)
<i>propafenone oral capsule, extended release 12 hr</i>	T4	
<i>propafenone oral tablet</i>	T2	
<i>propranolol oral capsule, extended release 24 hr</i>	T2	
<i>propranolol oral tablet</i>	T2	
<i>quinapril</i>	T1	
<i>quinapril-hydrochlorothiazide</i>	T1	
<i>quinidine gluconate oral</i>	T4	
<i>quinidine sulfate oral tablet</i>	T2	
<i>ramipril</i>	T1	
<i>ranolazine</i>	T3	QL (62 EA per 31 days)
<b>REPATHA PUSHTRONEX</b>	T3	PA; QL (7 ML per 28 days)
<b>REPATHA SURECLICK</b>	T3	PA; QL (3 ML per 28 days)
<b>REPATHA SYRINGE</b>	T3	PA; QL (3 ML per 28 days)
<i>rosuvastatin</i>	T1	
<i>simvastatin oral tablet</i>	T1	
<b>SORINE</b>	T2	
<b>SOTALOL AF</b>	T2	
<i>sotalol oral</i>	T2	
<i>spironolactone</i>	T1	
<i>spironolactone-hydrochlorothiazide</i>	T2	
<b>TAVALISSE</b>	T5	PA; QL (62 EA per 31 days)
<b>TAZTIA XT</b>	T2	
<i>telmisartan</i>	T2	
<i>telmisartan-amlodipine</i>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>telmisartan-hydrochlorothiazid</i>	T2	
<i>terazosin</i>	T1	
<b>TIADYLT ER</b>	T2	
<i>timolol maleate oral</i>	T3	
<i>toremide oral</i>	T1	
<i>trandolapril</i>	T1	
<i>triamterene-hydrochlorothiazid</i>	T1	
<b>UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG</b>	T5	PA; QL (62 EA per 31 days)
<b>UPTRAVI ORAL TABLET 200 MCG</b>	T5	PA; QL (224 EA per 28 days)
<b>UPTRAVI ORAL TABLETS,DOSE PACK</b>	T5	PA; QL (400 EA per 365 days)
<i>valsartan oral tablet 160 mg, 40 mg, 80 mg</i>	T1	QL (62 EA per 31 days)
<i>valsartan oral tablet 320 mg</i>	T1	QL (31 EA per 31 days)
<i>valsartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<b>VASCEPA ORAL CAPSULE 0.5 GRAM</b>	T4	QL (248 EA per 31 days)
<b>VASCEPA ORAL CAPSULE 1 GRAM</b>	T4	QL (124 EA per 31 days)
<i>verapamil oral capsule, 24 hr er pellet ct</i>	T2	
<i>verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg</i>	T2	
<i>verapamil oral capsule,ext rel. pellets 24 hr 360 mg</i>	T3	
<i>verapamil oral tablet</i>	T2	
<i>verapamil oral tablet extended release</i>	T2	
<b>VERQUVO</b>	T4	PA; QL (31 EA per 31 days)
<b>VYNDAMAX</b>	T5	PA; QL (31 EA per 31 days)
<b>VYNDAQEL</b>	T5	PA; QL (124 EA per 31 days)
<i>warfarin</i>	T1	
<b>XARELTO DVT-PE TREAT 30D START</b>	T3	QL (51 EA per 30 days)
<b>XARELTO ORAL SUSPENSION FOR RECONSTITUTION</b>	T3	PA; QL (930 ML per 31 days)
<b>XARELTO ORAL TABLET 10 MG, 20 MG</b>	T3	QL (31 EA per 31 days)
<b>XARELTO ORAL TABLET 15 MG</b>	T3	QL (52 EA per 31 days)
<b>XARELTO ORAL TABLET 2.5 MG</b>	T3	QL (62 EA per 31 days)
<b>ZONTIVITY</b>	T4	
<b>Dermatologicals/Topical Therapy</b>		
<b>AC CUTANE ORAL CAPSULE 10 MG</b>	T2	
<b>AC CUTANE ORAL CAPSULE 20 MG, 30 MG, 40 MG</b>	T4	
<i>acitretin</i>	T4	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>acyclovir topical ointment</i>	T3	QL (30 GM per 30 days)
<b>ADBRY</b>	T5	PA; QL (4 ML per 28 days)
<b>ALA-CORT TOPICAL CREAM 1 %</b>	T1	
<b>ALA-CORT TOPICAL CREAM 2.5 %</b>	T1	QL (30 GM per 28 days)
<i>alclometasone</i>	T3	
<i>ammonium lactate</i>	T2	
<b>AMNESTEEM</b>	T4	
<i>betamethasone dipropionate topical cream</i>	T2	
<i>betamethasone dipropionate topical lotion</i>	T2	
<i>betamethasone valerate topical cream</i>	T2	
<i>betamethasone valerate topical lotion</i>	T3	
<i>betamethasone valerate topical ointment</i>	T2	
<i>betamethasone, augmented topical cream</i>	T2	
<i>betamethasone, augmented topical gel</i>	T4	
<i>betamethasone, augmented topical lotion</i>	T4	
<i>betamethasone, augmented topical ointment</i>	T3	
<i>calcipotriene scalp</i>	T3	QL (60 ML per 28 days)
<i>calcipotriene topical cream</i>	T4	QL (60 GM per 28 days)
<i>calcipotriene topical ointment</i>	T3	QL (60 GM per 28 days)
<i>calcitriol topical</i>	T4	ST
<b>CIBINQO</b>	T5	PA; QL (31 EA per 31 days)
<i>ciclopirox topical cream</i>	T2	QL (90 GM per 28 days)
<i>ciclopirox topical gel</i>	T3	QL (45 GM per 28 days)
<i>ciclopirox topical shampoo</i>	T3	QL (120 ML per 28 days)
<i>ciclopirox topical solution</i>	T2	
<i>ciclopirox topical suspension</i>	T3	QL (60 ML per 28 days)
<b>CLARAVIS</b>	T4	
<i>clindamycin phosphate topical foam</i>	T4	QL (100 GM per 28 days)
<i>clindamycin phosphate topical gel</i>	T3	QL (75 GM per 28 days)
<i>clindamycin phosphate topical lotion</i>	T2	QL (60 ML per 28 days)
<i>clindamycin phosphate topical solution</i>	T2	QL (60 ML per 28 days)
<i>clindamycin phosphate topical swab</i>	T2	
<i>clindamycin-tretinoin</i>	T2	PA; QL (60 GM per 28 days)
<i>clotrimazole topical cream</i>	T2	QL (45 GM per 28 days)
<i>clotrimazole topical solution</i>	T3	QL (30 ML per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	T2	QL (45 GM per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	T2	QL (60 ML per 28 days)
<b>COSENTYX (2 SYRINGES)</b>	T5	PA; QL (2 ML per 28 days)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>COSENTYX PEN (2 PENS)</b>	T5	PA; QL (2 ML per 28 days)
<b>COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 28 days)
<b>CROTAN</b>	T4	
<i>dapsone topical</i>	T4	QL (90 GM per 28 days)
<b>DENAVIR</b>	T4	
<i>desoximetasone topical cream</i>	T4	QL (100 GM per 28 days)
<i>desoximetasone topical gel</i>	T4	QL (60 GM per 28 days)
<i>desoximetasone topical spray,non-aerosol</i>	T4	QL (100 ML per 28 days)
<i>diclofenac sodium topical gel 3 %</i>	T4	PA; QL (100 GM per 28 days)
<i>doxepin topical</i>	T4	PA; QL (45 GM per 28 days)
<b>DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML</b>	T5	PA; QL (2.28 ML per 28 days)
<b>DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML</b>	T5	PA; QL (4 ML per 28 days)
<b>DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML</b>	T5	PA; QL (1.34 ML per 28 days)
<b>DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML</b>	T5	PA; QL (2.28 ML per 28 days)
<b>DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML</b>	T5	PA; QL (8 ML per 28 days)
<b>ERY PADS</b>	T3	
<i>erythromycin with ethanol topical gel</i>	T2	QL (60 GM per 28 days)
<i>erythromycin with ethanol topical solution</i>	T2	QL (60 ML per 28 days)
<i>erythromycin-benzoyl peroxide</i>	T4	
<i>fluocinolone and shower cap</i>	T4	QL (118.28 ML per 28 days)
<i>fluocinolone topical cream 0.01 %</i>	T3	QL (60 GM per 28 days)
<i>fluocinolone topical cream 0.025 %</i>	T3	QL (120 GM per 28 days)
<i>fluocinolone topical ointment</i>	T3	QL (120 GM per 28 days)
<i>fluocinolone topical solution</i>	T3	QL (90 ML per 28 days)
<i>fluocinonide topical cream 0.05 %</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical gel</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical ointment</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical solution</i>	T2	QL (60 ML per 28 days)
<b>FLUOCINONIDE-E</b>	T2	QL (60 GM per 28 days)
<i>fluorouracil topical cream 0.5 %</i>	T5	
<i>fluorouracil topical cream 5 %</i>	T3	
<i>fluorouracil topical solution 2 %</i>	T2	
<i>fluorouracil topical solution 5 %</i>	T3	
<i>flurandrenolide topical cream</i>	T4	QL (120 GM per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>flurandrenolide topical lotion</i>	T4	QL (120 ML per 28 days)
<i>fluticasone propionate topical cream</i>	T2	
<i>gentamicin topical</i>	T3	QL (60 GM per 28 days)
<i>halobetasol propionate topical cream</i>	T4	QL (50 GM per 28 days)
<i>halobetasol propionate topical ointment</i>	T4	QL (50 GM per 28 days)
<i>hydrocortisone butyrate topical lotion</i>	T4	QL (118 ML per 28 days)
<i>hydrocortisone butyrate topical ointment</i>	T2	QL (45 GM per 28 days)
<i>hydrocortisone butyrate topical solution</i>	T2	QL (60 ML per 28 days)
<i>hydrocortisone topical cream 1 %</i>	T1	
<i>hydrocortisone topical lotion 2.5 %</i>	T2	QL (118 ML per 28 days)
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	T1	
<i>hydrocortisone valerate topical ointment</i>	T4	QL (60 GM per 28 days)
<i>imiquimod topical cream in packet 5 %</i>	T2	
<i>isotretinoin</i>	T4	
<i>ketoconazole topical cream</i>	T2	QL (60 GM per 28 days)
<i>ketoconazole topical shampoo</i>	T4	
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	T2	PA; QL (50 ML per 28 days)
<i>lidocaine topical adhesive patch,medicated 5 %</i>	T4	PA; QL (93 EA per 31 days)
<i>lidocaine topical ointment</i>	T4	PA; QL (50 GM per 28 days)
<b>LIDOCAINE VISCOUS</b>	T2	
<i>lidocaine-prilocaine topical cream</i>	T2	PA; QL (30 GM per 28 days)
<i>malathion</i>	T4	
<i>metronidazole topical cream</i>	T3	
<i>metronidazole topical gel 0.75 %</i>	T3	
<i>metronidazole topical gel 1 %</i>	T4	
<i>metronidazole topical lotion</i>	T4	
<i>mometasone topical</i>	T2	
<i>mupirocin</i>	T2	
<b>MYORISAN</b>	T4	
<b>NYAMYC</b>	T2	QL (60 GM per 28 days)
<i>nystatin topical cream</i>	T2	QL (30 GM per 28 days)
<i>nystatin topical ointment</i>	T2	QL (30 GM per 28 days)
<i>nystatin topical powder</i>	T2	QL (60 GM per 28 days)
<b>NYSTOP</b>	T2	QL (60 GM per 28 days)
<b>OPZELURA</b>	T5	PA; QL (60 GM per 7 days)
<b>PANRETIN</b>	T5	PA-NS
<i>permethrin</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>podofilox</i>	T4	
<b>REGRANEX</b>	T5	PA
<b>SANTYL</b>	T4	QL (180 GM per 30 days)
<i>selenium sulfide topical lotion</i>	T1	
<b>SILIQ</b>	T5	PA; QL (6 ML per 28 days)
<i>silver sulfadiazine</i>	T1	
<b>SKYRIZI SUBCUTANEOUS PEN INJECTOR</b>	T5	PA; QL (1 ML per 84 days)
<b>SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML</b>	T5	PA; QL (1 ML per 84 days)
<b>SKYRIZI SUBCUTANEOUS SYRINGE KIT</b>	T5	PA; QL (1 EA per 84 days)
<b>SSD</b>	T4	
<b>STELARA SUBCUTANEOUS SOLUTION</b>	T5	PA; QL (0.5 ML per 84 days)
<b>STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 84 days)
<b>STELARA SUBCUTANEOUS SYRINGE 90 MG/ML</b>	T5	PA; QL (1 ML per 56 days)
<i>sulfacetamide sodium (acne)</i>	T2	
<b>SULFAMYLON TOPICAL CREAM</b>	T3	
<i>tacrolimus topical</i>	T4	QL (100 GM per 28 days)
<b>TALTZ AUTOINJECTOR</b>	T5	PA; QL (1 ML per 28 days)
<b>TALTZ SYRINGE</b>	T5	PA; QL (1 ML per 28 days)
<i>tazarotene topical cream</i>	T4	PA; QL (60 GM per 28 days)
<i>tazarotene topical gel</i>	T4	PA; QL (100 GM per 28 days)
<b>TAZORAC TOPICAL CREAM 0.05 %</b>	T4	PA; QL (60 GM per 28 days)
<i>tretinoin topical cream</i>	T2	PA; QL (45 GM per 28 days)
<i>tretinoin topical gel 0.01 %, 0.05 %</i>	T4	PA; QL (45 GM per 28 days)
<i>tretinoin topical gel 0.025 %</i>	T2	PA; QL (45 GM per 28 days)
<i>triamcinolone acetonide topical aerosol</i>	T4	
<i>triamcinolone acetonide topical cream</i>	T2	
<i>triamcinolone acetonide topical lotion</i>	T2	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	T2	
<i>triamcinolone acetonide topical ointment 0.05 %</i>	T4	
<b>TRIDERM TOPICAL CREAM</b>	T2	
<b>TRITOCIN</b>	T4	
<b>VALCHLOR</b>	T5	PA-NS
<b>Diagnostics / Miscellaneous Agents</b>		
<i>acamprosate</i>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>anagrelide</i>	T4	
<b>ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG</b>	T5	PA
<b>AURYXIA</b>	T5	PA; QL (372 EA per 31 days)
<i>bupropion hcl (smoking deter)</i>	T2	QL (62 EA per 31 days)
<i>carglumic acid</i>	T5	PA
<i>cevimeline</i>	T4	
<b>CHEMET</b>	T3	
<b>CLINIMIX 4.25%/D5W SULFIT FREE</b>	T4	PA-BvD
<i>d10 %-0.45 % sodium chloride</i>	T2	
<i>d2.5 %-0.45 % sodium chloride</i>	T2	
<i>d5 % and 0.9 % sodium chloride</i>	T2	
<i>d5 %-0.45 % sodium chloride</i>	T2	
<i>deferasirox oral tablet, dispersible 125 mg</i>	T4	PA
<i>deferasirox oral tablet, dispersible 250 mg, 500 mg</i>	T5	PA
<i>deferiprone</i>	T5	PA
<i>dextrose 10 % in water (d10w)</i>	T2	
<i>dextrose 5 % in water (d5w) intravenous parenteral solution</i>	T2	
<i>disulfiram</i>	T3	
<i>droxidopa</i>	T5	PA
<b>ENDARI</b>	T4	PA; QL (180 EA per 30 days)
<b>EXSERVAN</b>	T5	PA; QL (62 EA per 31 days)
<b>FERRIPROX ORAL SOLUTION</b>	T5	PA
<b>INCRELEX</b>	T5	PA
<i>levocarnitine (with sugar)</i>	T4	PA-BvD
<i>levocarnitine oral tablet</i>	T4	PA-BvD
<b>LOKELMA</b>	T3	PA; QL (93 EA per 31 days)
<i>midodrine</i>	T4	
<b>NICOTROL</b>	T3	
<b>NICOTROL NS</b>	T4	
<i>nitisinone</i>	T5	
<b>NITYR</b>	T5	
<b>ORFADIN ORAL CAPSULE 20 MG</b>	T5	
<b>ORFADIN ORAL SUSPENSION</b>	T5	
<b>OXBRYTA ORAL TABLET FOR SUSPENSION</b>	T5	PA; QL (248 EA per 31 days)
<b>PHEBURANE</b>	T5	PA; QL (620 GM per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pilocarpine hcl oral</i>	T2	
<b>PROLASTIN-C INTRAVENOUS RECON SOLN</b>	T5	PA
<b>PYRUKYND ORAL TABLET 20 MG, 50 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>PYRUKYND ORAL TABLET 5 MG, 5 MG (4-WEEK PACK)</b>	T5	PA
<b>PYRUKYND ORAL TABLETS,DOSE PACK</b>	T5	PA; QL (2 EA per 365 days)
<b>RAVICTI</b>	T5	PA
<b>REVCOVI</b>	T5	
<i>riluzole</i>	T4	
<i>risedronate oral tablet 30 mg</i>	T2	
<i>sevelamer carbonate oral powder in packet</i>	T4	
<i>sevelamer carbonate oral tablet</i>	T3	
<i>sevelamer hcl</i>	T4	
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	T2	
<i>sodium chloride irrigation</i>	T2	
<i>sodium phenylbutyrate</i>	T5	
<i>sodium polystyrene sulfonate oral powder</i>	T2	
<b>SPS (WITH SORBITOL) ORAL</b>	T2	
<b>TAVNEOS</b>	T5	PA; QL (186 EA per 31 days)
<i>trientine</i>	T3	QL (248 EA per 31 days)
<i>varenicline oral tablet</i>	T4	QL (60 EA per 30 days)
<i>varenicline oral tablets,dose pack</i>	T4	QL (106 EA per 365 days)
<b>VELTASSA</b>	T3	PA; QL (30 EA per 30 days)
<b>XURIDEN</b>	T5	PA; QL (124 EA per 31 days)
<b>ZEMAIRA</b>	T5	PA
<b>Ear, Nose / Throat Medications</b>		
<i>acetic acid otic (ear)</i>	T2	
<i>azelastine nasal aerosol,spray</i>	T2	QL (30 ML per 25 days)
<i>azelastine nasal spray,non-aerosol</i>	T3	QL (30 ML per 25 days)
<i>chlorhexidine gluconate mucous membrane</i>	T1	
<b>CIPRO HC</b>	T4	
<i>ciprofloxacin-dexamethasone</i>	T3	
<i>ciprofloxacin-fluocinolone</i>	T4	
<i>fluocinolone acetonide oil</i>	T4	
<i>ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)</i>	T2	QL (30 ML per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ipratropium bromide nasal spray, non-aerosol 42 mcg (0.06 %)</i>	T2	QL (15 ML per 28 days)
<i>neomycin-polymyxin-hc otic (ear)</i>	T3	
<i>ofloxacin otic (ear)</i>	T2	
<i>olopatadine nasal</i>	T3	QL (30.5 GM per 30 days)
<b>PERIOGARD</b>	T1	
<i>triamcinolone acetonide dental</i>	T2	
<b>Endocrine/Diabetes</b>		
<i>acarbose</i>	T2	QL (93 EA per 31 days)
<b>ACTHAR</b>	T5	PA
<b>ALCOHOL PADS</b>	T2	
<b>ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG</b>	T4	PA
<b>ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 1 MG, 2 MG, 5 MG</b>	T5	PA
<b>ANDRODERM</b>	T3	PA
<b>BAQSIMI</b>	T3	
<b>BASAGLAR KWIKPEN U-100 INSULIN</b>	T4	
<i>cabergoline</i>	T3	
<i>calcitonin (salmon) nasal</i>	T3	PA-BvD
<i>calcitriol oral capsule</i>	T2	PA-BvD
<i>calcitriol oral solution</i>	T4	PA-BvD
<b>CERDELGA</b>	T5	PA; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 30 mg</i>	T4	PA-BvD; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 60 mg</i>	T5	PA-BvD; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 90 mg</i>	T5	PA-BvD; QL (124 EA per 31 days)
<b>CORTROPHIN GEL</b>	T5	PA
<i>danazol</i>	T4	
<i>desmopressin nasal spray with pump</i>	T4	
<i>desmopressin oral</i>	T2	
<i>dexamethasone oral elixir</i>	T2	
<i>dexamethasone oral tablet</i>	T1	
<i>diazoxide</i>	T4	
<i>doxercalciferol oral</i>	T4	PA-BvD
<b>EMFLAZA</b>	T5	PA
<b>FIASP FLEXTOUCH U-100 INSULIN</b>	T3	SI
<b>FIASP PENFILL U-100 INSULIN</b>	T3	SI
<b>FIASP U-100 INSULIN</b>	T3	SI

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fludrocortisone</i>	T2	
<b>GALAFOLD</b>	T5	PA; QL (14 EA per 28 days)
<i>glimepiride</i>	T1	
<i>glipizide</i>	T1	
<i>glipizide-metformin</i>	T1	
<b>GLUCAGEN HYPOKIT</b>	T3	
<b>GLUCAGON EMERGENCY KIT (HUMAN)</b>	T3	
<i>glyburide</i>	T2	
<i>glyburide micronized</i>	T2	
<i>glyburide-metformin</i>	T2	
<b>GLYXAMBI</b>	T3	QL (31 EA per 31 days)
<b>GVOKE</b>	T3	
<b>GVOKE HYPOPEN 2-PACK</b>	T3	
<b>GVOKE PFS 1-PACK SYRINGE</b>	T3	
<b>HUMALOG JUNIOR KWIKPEN U-100</b>	T3	SI
<b>HUMALOG KWIKPEN INSULIN</b>	T3	SI
<b>HUMALOG MIX 50-50 INSULN U-100</b>	T3	SI
<b>HUMALOG MIX 50-50 KWIKPEN</b>	T3	SI
<b>HUMALOG MIX 75-25 KWIKPEN</b>	T3	SI
<b>HUMALOG MIX 75-25(U-100)INSULN</b>	T3	SI
<b>HUMALOG U-100 INSULIN</b>	T3	SI
<b>HUMULIN 70/30 U-100 INSULIN</b>	T3	SI
<b>HUMULIN 70/30 U-100 KWIKPEN</b>	T3	SI
<b>HUMULIN N NPH INSULIN KWIKPEN</b>	T3	SI
<b>HUMULIN N NPH U-100 INSULIN</b>	T3	SI
<b>HUMULIN R REGULAR U-100 INSULN</b>	T3	SI
<b>HUMULIN R U-500 (CONC) INSULIN</b>	T3	SI
<b>HUMULIN R U-500 (CONC) KWIKPEN</b>	T3	SI
<i>hydrocortisone oral</i>	T1	
<i>insulin asp prt-insulin aspart</i>	T3	SI
<i>insulin aspart u-100</i>	T3	SI
<i>insulin lispro</i>	T3	SI
<i>insulin lispro protamin-lispro</i>	T3	SI
<b>INVOKAMET</b>	T3	QL (62 EA per 31 days)
<b>INVOKAMET XR</b>	T3	QL (62 EA per 31 days)
<b>INVOKANA ORAL TABLET 100 MG</b>	T3	QL (62 EA per 31 days)
<b>INVOKANA ORAL TABLET 300 MG</b>	T3	QL (31 EA per 31 days)
<b>ISTURISA</b>	T5	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>JANUMET</b>	T3	QL (62 EA per 31 days)
<b>JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG</b>	T3	QL (31 EA per 31 days)
<b>JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG</b>	T3	QL (62 EA per 31 days)
<b>JANUVIA ORAL TABLET 100 MG, 50 MG</b>	T3	QL (31 EA per 31 days)
<b>JANUVIA ORAL TABLET 25 MG</b>	T3	QL (93 EA per 31 days)
<b>JARDIANCE ORAL TABLET 10 MG</b>	T3	QL (62 EA per 31 days)
<b>JARDIANCE ORAL TABLET 25 MG</b>	T3	QL (31 EA per 31 days)
<b>JAVYGTOR ORAL POWDER IN PACKET 100 MG</b>	T5	PA
<b>JENTADUETO</b>	T3	QL (62 EA per 31 days)
<b>JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG</b>	T3	QL (62 EA per 31 days)
<b>JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG</b>	T3	QL (31 EA per 31 days)
<b>JYNARQUE ORAL TABLET</b>	T5	PA; QL (112 EA per 28 days)
<b>JYNARQUE ORAL TABLETS, SEQUENTIAL</b>	T5	PA; QL (56 EA per 28 days)
<b>KORLYM</b>	T5	PA; QL (124 EA per 31 days)
<b>LANTUS SOLOSTAR U-100 INSULIN</b>	T3	SI
<b>LANTUS U-100 INSULIN</b>	T3	SI
<b>LEVEMIR FLEXTOUCH U-100 INSULIN</b>	T3	SI
<b>LEVEMIR U-100 INSULIN</b>	T3	SI
<i>levothyroxine oral tablet</i>	T1	
<b>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</b>	T3	
<i>liothyronine oral</i>	T2	
<i>metformin oral tablet 1,000 mg, 500 mg, 850 mg</i>	T1	
<i>metformin oral tablet extended release 24 hr</i>	T1	
<i>metformin oral tablet extended release 24hr</i>	NF	
<i>metformin oral tablet,er gast.retention 24 hr</i>	NF	
<i>methimazole oral tablet 10 mg, 5 mg</i>	T2	
<i>methylprednisolone</i>	T2	
<i>miglustat</i>	T5	PA; QL (93 EA per 31 days)
<b>MOUNJARO</b>	T3	QL (2 ML per 28 days)
<b>MYALEPT</b>	T5	PA
<i>nateglinide</i>	T1	QL (93 EA per 31 days)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>NATPARA</b>	T5	PA; QL (31 EA per 31 days)
<b>NOVOLIN 70/30 U-100 INSULIN</b>	T3	SI
<b>NOVOLIN 70-30 FLEXPEN U-100</b>	T3	SI
<b>NOVOLIN N FLEXPEN</b>	T3	SI
<b>NOVOLIN N NPH U-100 INSULIN</b>	T3	SI
<b>NOVOLIN R FLEXPEN</b>	T3	SI
<b>NOVOLIN R REGULAR U-100 INSULN</b>	T3	SI
<b>NOVOLOG FLEXPEN U-100 INSULIN</b>	T3	SI
<b>NOVOLOG MIX 70-30 U-100 INSULN</b>	T3	SI
<b>NOVOLOG MIX 70-30FLEXPEN U-100</b>	T3	SI
<b>NOVOLOG PENFILL U-100 INSULIN</b>	T3	SI
<b>NOVOLOG U-100 INSULIN ASPART</b>	T3	SI
<b>ORILISSA ORAL TABLET 150 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>ORILISSA ORAL TABLET 200 MG</b>	T5	PA; QL (62 EA per 31 days)
<i>oxandrolone oral tablet 10 mg</i>	T4	PA
<i>oxandrolone oral tablet 2.5 mg</i>	T3	PA
<b>OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)</b>	T3	QL (3 ML per 28 days)
<b>PALYNZIQ</b>	T5	PA
<i>paricalcitol oral capsule 1 mcg</i>	T2	PA-BvD
<i>paricalcitol oral capsule 2 mcg</i>	T3	PA-BvD
<i>paricalcitol oral capsule 4 mcg</i>	T4	PA-BvD
<i>pioglitazone</i>	T1	QL (31 EA per 31 days)
<i>pioglitazone-metformin</i>	T2	QL (93 EA per 31 days)
<i>prednisolone oral solution</i>	T2	
<i>prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	T2	
<i>prednisone oral solution</i>	T3	
<i>prednisone oral tablet</i>	T1	
<i>prednisone oral tablets,dose pack</i>	T2	
<i>propylthiouracil</i>	T2	
<b>RECORLEV</b>	T5	PA; QL (248 EA per 31 days)
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	T2	QL (124 EA per 31 days)
<i>repaglinide oral tablet 2 mg</i>	T2	QL (248 EA per 31 days)
<b>RYBELSUS</b>	T3	QL (31 EA per 31 days)
<i>sapropterin</i>	T5	PA
<b>SOMAVERT</b>	T5	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>SYMLINPEN 120</b>	T3	QL (10.8 ML per 28 days)
<b>SYMLINPEN 60</b>	T3	QL (6 ML per 28 days)
<b>SYNAREL</b>	T5	
<b>SYNJARDY</b>	T3	QL (62 EA per 31 days)
<b>SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG</b>	T3	QL (62 EA per 31 days)
<b>SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG</b>	T3	QL (31 EA per 31 days)
<b>SYNTHROID</b>	T3	
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)</i>	T2	PA
<i>testosterone enanthate</i>	T3	PA
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	T3	PA
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)</i>	T3	PA
<i>tolvaptan</i>	T5	PA
<b>TOUJEO MAX U-300 SOLOSTAR</b>	T3	SI
<b>TOUJEO SOLOSTAR U-300 INSULIN</b>	T3	SI
<b>TRADJENTA</b>	T3	QL (31 EA per 31 days)
<b>TRESIBA FLEXTOUCH U-100</b>	T3	SI
<b>TRESIBA FLEXTOUCH U-200</b>	T3	SI
<b>TRESIBA U-100 INSULIN</b>	T3	SI
<b>TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG</b>	T3	QL (31 EA per 31 days)
<b>TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG</b>	T3	QL (62 EA per 31 days)
<b>TRULICITY</b>	T3	QL (2 ML per 28 days)
<b>UNITHROID</b>	T3	
<b>VICTOZA 3-PAK</b>	T3	QL (9 ML per 30 days)
<b>XULTOPHY 100/3.6</b>	T3	SI
<b>ZEGALOGUE AUTOINJECTOR</b>	T3	
<b>ZEGALOGUE SYRINGE</b>	T3	
<b>Gastroenterology</b>		
<i>alosetron oral tablet 0.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>alosetron oral tablet 1 mg</i>	T5	PA; QL (62 EA per 31 days)
<i>aprepitant</i>	T4	PA-BvD

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>balsalazide</i>	T4	
<i>betaine</i>	T4	
<i>budesonide oral capsule, delayed, extend. release</i>	T4	
<i>budesonide oral tablet, delayed and ext. release</i>	T5	
<b>CHOLBAM</b>	T5	PA
<b>CIMZIA</b>	T5	PA; QL (2 EA per 28 days)
<b>CIMZIA POWDER FOR RECONST</b>	T5	PA; QL (2 EA per 28 days)
<b>CLENPIQ</b>	T4	
<b>COMPRO</b>	T3	
<b>CONSTULOSE</b>	T2	
<b>CREON</b>	T3	
<i>cromolyn oral</i>	T4	
<i>dicyclomine oral capsule</i>	T2	
<i>dicyclomine oral solution</i>	T2	
<i>dicyclomine oral tablet</i>	T2	
<i>diphenoxylate-atropine oral liquid</i>	T3	
<i>diphenoxylate-atropine oral tablet</i>	T2	
<i>dronabinol</i>	T4	PA-BvD
<b>ENULOSE</b>	T2	
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec)</i>	T2	QL (31 EA per 31 days)
<i>famotidine oral suspension</i>	T2	
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
<b>GATTEX 30-VIAL</b>	T5	PA
<b>GAVILYTE-C</b>	T2	
<b>GAVILYTE-G</b>	T2	
<b>GENERLAC</b>	T2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T2	
<i>granisetron hcl oral</i>	T4	PA-BvD
<i>hydrocortisone rectal</i>	T3	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	T1	
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	T4	
<b>IBSRELA</b>	T5	PA; QL (62 EA per 31 days)
<i>lactulose oral solution 10 gram/15 ml</i>	T2	
<b>LINZESS</b>	T3	QL (31 EA per 31 days)
<i>loperamide oral capsule</i>	T2	
<i>lubiprostone</i>	T3	QL (62 EA per 31 days)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>mesalamine oral capsule (with del rel tablets)</i>	T3	
<i>mesalamine oral capsule, extended release</i>	T3	
<i>mesalamine oral capsule, extended release 24hr</i>	T4	
<i>mesalamine oral tablet, delayed release (dr/ec)</i>	T4	
<i>mesalamine rectal enema</i>	T4	
<i>metoclopramide hcl oral solution</i>	T2	
<i>metoclopramide hcl oral tablet</i>	T2	
<i>misoprostol</i>	T2	
<b>MOVANTI</b>	T3	QL (31 EA per 31 days)
<b>MYTESI</b>	T5	QL (62 EA per 31 days)
<b>OCALIVA</b>	T5	PA; QL (31 EA per 31 days)
<i>omeprazole oral capsule, delayed release (dr/ec)</i>	T1	
<i>ondansetron</i>	T2	PA-BvD
<i>ondansetron hcl oral solution</i>	T3	PA-BvD
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	T2	PA-BvD
<i>pantoprazole oral tablet, delayed release (dr/ec)</i>	T1	
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	T2	
<i>peg3350-sod sul-nacl-kcl-asb-c</i>	T4	
<i>peg-electrolyte soln</i>	T2	
<b>PENTASA</b>	T3	
<i>prochlorperazine</i>	T3	
<i>prochlorperazine maleate</i>	T2	
<b>PROCTO-PAK</b>	T2	
<b>PROCTOSOL HC TOPICAL</b>	T2	
<b>PROCTOZONE-HC</b>	T2	
<i>rabeprazole oral tablet, delayed release (dr/ec)</i>	T2	QL (62 EA per 31 days)
<b>RECTIV</b>	T4	
<b>RELISTOR ORAL</b>	T5	PA; QL (93 EA per 31 days)
<i>scopolamine base</i>	T3	QL (10 EA per 30 days)
<b>SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR</b>	T5	PA; QL (2.4 ML per 56 days)
<b>SUCRAID</b>	T5	
<i>sucralfate</i>	T2	
<i>sulfasalazine</i>	T2	
<b>SUPREP BOWEL PREP KIT</b>	T3	
<b>SYMPROIC</b>	T4	PA; QL (31 EA per 31 days)
<i>ursodiol oral capsule 300 mg</i>	T4	
<i>ursodiol oral tablet</i>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VIBERZI	T5	PA; QL (62 EA per 31 days)
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 3,000-10,000 -14,000-UNIT, 5,000-17,000- 24,000 UNIT	T3	
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 25,000-79,000- 105,000 UNIT, 40,000-126,000- 168,000 UNIT	T5	
<b>Immunology, Vaccines / Biotechnology</b>		
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 25 MCG/ML, 40 MCG/ML	T4	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 200 MCG/ML, 60 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 INTRAMUSCULAR PEN INJECTOR KIT	T5	QL (4 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	QL (4 EA per 28 days)
<i>bcg vaccine, live (pf)</i>	T4	
BESREMI	T5	PA-NS; QL (2 ML per 28 days)
BETASERON SUBCUTANEOUS KIT	T5	QL (14 EA per 28 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T3	
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
EGRIFTA SV	T5	PA
ENGERIX-B (PF)	T3	PA-BvD
ENGERIX-B PEDIATRIC (PF)	T3	PA-BvD

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %</b>	T5	PA
<b>FULPHILA</b>	T5	
<b>GAMMAGARD LIQUID</b>	T5	PA
<b>GAMMAGARD S-D (IGA &lt; 1 MCG/ML)</b>	T5	PA
<b>GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)</b>	T4	PA
<b>GAMMAPLEX</b>	T5	PA
<b>GAMMAPLEX (WITH SORBITOL)</b>	T5	PA
<b>GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)</b>	T3	PA
<b>GARDASIL 9 (PF)</b>	T3	
<b>GRANIX</b>	T5	
<b>GRASTEK</b>	T4	PA
<b>HAVRIX (PF)</b>	T3	
<b>HIBERIX (PF)</b>	T3	
<b>IMOVAX RABIES VACCINE (PF)</b>	T3	PA-BvD
<b>INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE</b>	T3	
<b>INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)</b>	T3	PA-NS
<b>INTRON A INJECTION RECON SOLN 50 MILLION UNIT (1 ML)</b>	T5	PA-NS
<b>IPOL</b>	T3	
<b>IXIARO (PF)</b>	T3	
<b>KINRIX (PF) INTRAMUSCULAR SYRINGE</b>	T3	
<b>LEUKINE INJECTION RECON SOLN</b>	T5	PA
<b>MENACTRA (PF) INTRAMUSCULAR SOLUTION</b>	T3	
<b>MENQUADFI (PF)</b>	T4	
<b>MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT</b>	T3	
<b>M-M-R II (PF)</b>	T3	
<b>NIVESTYM</b>	T5	
<b>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)</b>	T5	PA
<b>NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 5 MG/1.5 ML (3.3 MG/ML)</b>	T4	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NYVEPRIA	T5	
OCTAGAM	T5	PA
ODACTRA	T4	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	T4	PA
PANZYGA	T5	PA
PEDIARIX (PF)	T3	PA-BvD
PEDVAX HIB (PF)	T3	
PEGASYS	T5	PA
PENTACEL (PF)	T3	
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	T5	QL (1 ML per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	T5	QL (1 ML per 28 days)
PREHEVBRIO (PF)	T3	PA-BvD
PRIORIX (PF)	T3	
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	T5	PA-BvD
PROQUAD (PF)	T3	
QUADRACEL (PF)	T3	
RABAVERT (PF)	T3	PA-BvD
RECOMBIVAX HB (PF)	T3	PA-BvD
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
RETACRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	T5	PA-BvD
ROTARIX	T3	
ROTATEQ VACCINE	T3	
SHINGRIX (PF)	T3	QL (2 EA per 999 days)
TDVAX	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>TENIVAC (PF)</b>	T3	
<i>tetanus, diphtheria tox ped(pf)</i>	T4	
<b>TICOVAC</b>	T3	
<b>TRUMENBA</b>	T3	
<b>TWINRIX (PF)</b>	T3	
<b>TYPHIM VI</b>	T3	
<b>UDENYCA</b>	T5	
<b>VAQTA (PF)</b>	T3	
<b>VARIVAX (PF)</b>	T3	
<b>YF-VAX (PF)</b>	T3	
<b>ZARXIO</b>	T5	
<b>ZIEXTENZO</b>	T5	
<b>ZOMACTON</b>	T4	PA
<b>ZORBTIVE</b>	T5	PA
<b>Miscellaneous Supplies</b>		
<b>ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"</b>	T4	
<b>GAUZE PAD TOPICAL BANDAGE 2 X 2 "</b>	T2	
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge</i>	T4	
<i>pen needle, diabetic needle 29 gauge x 1/2"</i>	T4	
<b>Musculoskeletal / Rheumatology</b>		
<b>ACTEMRA ACTPEN</b>	T5	PA; QL (3.6 ML per 28 days)
<b>ACTEMRA SUBCUTANEOUS</b>	T5	PA; QL (3.6 ML per 28 days)
<i>alendronate oral tablet 10 mg, 35 mg, 70 mg</i>	T1	
<i>allopurinol oral tablet 100 mg, 300 mg</i>	T1	
<b>BENLYSTA SUBCUTANEOUS</b>	T5	PA; QL (4 ML per 28 days)
<b>ENBREL MINI</b>	T5	PA; QL (7.84 ML per 28 days)
<b>ENBREL SUBCUTANEOUS SOLUTION</b>	T5	PA; QL (4 ML per 28 days)
<b>ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)</b>	T5	PA; QL (4 ML per 28 days)
<b>ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)</b>	T5	PA; QL (7.84 ML per 28 days)
<b>ENBREL SURECLICK</b>	T5	PA; QL (7.84 ML per 28 days)
<b>EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML ( 105MG/1.17MLX2)</b>	T5	PA; QL (2.34 ML per 28 days)
<b>FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (600MCG/2.4ML)</b>	T5	PA; QL (2.4 ML per 28 days)
<b>HUMIRA PEN</b>	T5	PA; QL (2 EA per 28 days)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>HUMIRA PEN CROHNS-UC-HS START</b>	T5	PA; QL (6 EA per 28 days)
<b>HUMIRA PEN PSOR-UEVETS-ADOL HS</b>	T5	PA; QL (4 EA per 28 days)
<b>HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML</b>	T5	PA; QL (2 EA per 28 days)
<b>HUMIRA(CF)</b>	T5	PA; QL (2 EA per 28 days)
<b>HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML</b>	T5	PA; QL (3 EA per 28 days)
<b>HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML</b>	T5	PA; QL (2 EA per 28 days)
<b>HUMIRA(CF) PEN</b>	T5	PA; QL (2 EA per 28 days)
<b>HUMIRA(CF) PEN CROHNS-UC-HS</b>	T5	PA; QL (3 EA per 28 days)
<b>HUMIRA(CF) PEN PEDIATRIC UC</b>	T5	PA; QL (4 EA per 28 days)
<b>HUMIRA(CF) PEN PSOR-UV-ADOL HS</b>	T5	PA; QL (3 EA per 28 days)
<i>ibandronate oral</i>	T2	
<b>KEVZARA</b>	T5	PA; QL (2.28 ML per 28 days)
<b>KINERET</b>	T5	PA; QL (18.76 ML per 28 days)
<i>leflunomide</i>	T3	
<b>MITIGARE</b>	T3	QL (62 EA per 31 days)
<b>OLUMIANT ORAL TABLET 1 MG, 2 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>ORENCIA CLICKJECT</b>	T5	PA; QL (4 ML per 28 days)
<b>ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML</b>	T5	PA; QL (4 ML per 28 days)
<b>ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML</b>	T5	PA; QL (1.6 ML per 28 days)
<b>ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML</b>	T5	PA; QL (2.8 ML per 28 days)
<b>OTEZLA</b>	T5	PA; QL (62 EA per 31 days)
<b>OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)</b>	T5	PA; QL (55 EA per 28 days)
<i>penicillamine</i>	T5	
<i>probenecid</i>	T2	
<i>probenecid-colchicine</i>	T2	
<b>PROLIA</b>	T4	PA; QL (1 ML per 180 days)
<i>raloxifene</i>	T3	
<b>RIDAURA</b>	T3	
<b>RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG</b>	T5	PA; QL (31 EA per 31 days)
<b>RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG</b>	T5	PA; QL (112 EA per 365 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg</i>	T2	
<i>risedronate oral tablet, delayed release (dr/ec)</i>	T2	
<b>SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML</b>	T5	PA; QL (1 ML per 28 days)
<b>SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 28 days)
<b>SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML</b>	T5	PA; QL (1 ML per 28 days)
<b>SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 28 days)
<i>teriparatide</i>	T5	PA; QL (2.48 ML per 28 days)
<b>TYMLOS</b>	T5	PA; QL (1.56 ML per 30 days)
<b>XELJANZ ORAL SOLUTION</b>	T5	PA; QL (310 ML per 31 days)
<b>XELJANZ ORAL TABLET</b>	T5	PA; QL (62 EA per 31 days)
<b>XELJANZ XR</b>	T5	PA; QL (31 EA per 31 days)
<b>Obstetrics / Gynecology</b>		
<b>ALTAVERA (28)</b>	T2	
<b>ALYACEN 1/35 (28)</b>	T2	
<b>APRI</b>	T2	
<b>ARANELLE (28)</b>	T2	
<b>AVIANE</b>	T2	
<b>BALZIVA (28)</b>	T2	
<b>BLISOVI FE 1.5/30 (28)</b>	T2	
<b>BRIELLYN</b>	T2	
<b>CAMILA</b>	T2	
<i>clindamycin phosphate vaginal</i>	T2	
<b>CLINDESSE</b>	T4	
<b>CRINONE</b>	T4	PA
<b>CRYSELLE (28)</b>	T2	
<b>CYRED EQ</b>	T2	
<i>desog-e.estradiol/e.estradiol</i>	T2	
<i>desogestrel-ethinyl estradiol</i>	T2	
<b>DOLISHALE</b>	T2	
<i>drospirenone-ethinyl estradiol</i>	T2	
<b>EMOQUETTE</b>	T2	
<b>ENPRESSE</b>	T2	
<b>ENSKYCE</b>	T2	
<b>ERRIN</b>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ESTARYLLA</b>	T2	
<i>estradiol oral</i>	T2	
<i>estradiol transdermal patch weekly</i>	T2	
<i>estradiol vaginal</i>	T4	
<i>estradiol-norethindrone acet</i>	T2	
<i>ethynodiol diac-eth estradiol</i>	T2	
<i>etonogestrel-ethinyl estradiol</i>	T3	
<b>FEMYNOR</b>	T2	
<b>HAILEY 24 FE</b>	T2	
<b>ICLEVIA</b>	T2	
<b>INCASSIA</b>	T2	
<b>INTROVALE</b>	T2	
<b>ISIBLOOM</b>	T2	
<b>JASMIEL (28)</b>	T2	
<b>JINTELI</b>	T4	
<b>JULEBER</b>	T2	
<b>JUNEL 1.5/30 (21)</b>	T2	
<b>JUNEL 1/20 (21)</b>	T2	
<b>JUNEL FE 1.5/30 (28)</b>	T2	
<b>JUNEL FE 1/20 (28)</b>	T2	
<b>JUNEL FE 24</b>	T2	
<b>KARIVA (28)</b>	T2	
<b>KELNOR 1/35 (28)</b>	T2	
<b>KELNOR 1-50 (28)</b>	T2	
<b>KURVELO (28)</b>	T2	
<b>LESSINA</b>	T2	
<b>LEVONEST (28)</b>	T2	
<i>levonorgestrel-ethinyl estrad</i>	T2	
<i>levonorg-eth estrad triphasic</i>	T2	
<b>LEVORA-28</b>	T2	
<b>LORYNA (28)</b>	T2	
<b>LOW-OGESTREL (28)</b>	T2	
<b>LUTERA (28)</b>	T2	
<b>LYLEQ</b>	T2	
<b>LYZA</b>	T2	
<b>MARLISSA (28)</b>	T2	
<i>medroxyprogesterone</i>	T2	
<i>metronidazole vaginal</i>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MICONAZOLE-3 VAGINAL SUPPOSITORY</b>	T2	
<b>MICROGESTIN 1.5/30 (21)</b>	T2	
<b>MICROGESTIN 1/20 (21)</b>	T2	
<b>MICROGESTIN FE 1.5/30 (28)</b>	T2	
<b>MICROGESTIN FE 1/20 (28)</b>	T2	
<b>MILI</b>	T2	
<b>MYFEMBREE</b>	T5	PA; QL (31 EA per 31 days)
<b>NECON 0.5/35 (28)</b>	T2	
<i>noreth-ethinyl estradiol-iron</i>	T2	
<i>norethindrone (contraceptive)</i>	T2	
<i>norethindrone acetate</i>	T2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-20 mg-mcg, 1-5 mg-mcg</i>	T2	
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	T2	
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28), 0.25-35 mg-mcg</i>	T2	
<b>NORTREL 0.5/35 (28)</b>	T2	
<b>NORTREL 1/35 (21)</b>	T2	
<b>NORTREL 1/35 (28)</b>	T2	
<b>NORTREL 7/7/7 (28)</b>	T2	
<b>NYLIA 1/35 (28)</b>	T2	
<b>NYLIA 7/7/7 (28)</b>	T2	
<b>NYMYO</b>	T2	
<b>ORIAHNN</b>	T5	PA; QL (56 EA per 28 days)
<b>PIMTREA (28)</b>	T2	
<b>PIRMELLA ORAL TABLET 1-35 MG-MCG</b>	T2	
<b>PORTIA 28</b>	T2	
<b>PREMARIN VAGINAL</b>	T3	
<b>RECLIPSEN (28)</b>	T2	
<b>SETLAKIN</b>	T2	
<b>SPRINTEC (28)</b>	T2	
<b>SRONYX</b>	T2	
<b>SYEDA</b>	T2	
<i>terconazole</i>	T2	
<i>tranexamic acid oral</i>	T3	
<b>TRI-ESTARYLLA</b>	T2	
<b>TRI-MILI</b>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>TRI-NYMYO</b>	T2	
<b>TRI-SPRINTEC (28)</b>	T2	
<b>TRIVORA (28)</b>	T2	
<b>TRI-VYLIBRA</b>	T2	
<b>VANDAZOLE</b>	T3	
<b>VELIVET TRIPHASIC REGIMEN (28)</b>	T2	
<b>VESTURA (28)</b>	T2	
<b>VIENVA</b>	T2	
<b>VYFEMLA (28)</b>	T2	
<b>VYLIBRA</b>	T2	
<b>YUVAFEM</b>	T4	
<b>ZOVIA 1-35 (28)</b>	T2	
<b>Ophthalmology</b>		
<i>acetazolamide</i>	T3	
<b>ALOMIDE</b>	T3	
<b>ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %</b>	T3	
<i>apraclonidine</i>	T3	
<i>azelastine ophthalmic (eye)</i>	T2	
<i>bacitracin ophthalmic (eye)</i>	T2	
<i>bacitracin-polymyxin b</i>	T2	
<b>BESIVANCE</b>	T4	
<i>betaxolol ophthalmic (eye)</i>	T3	
<b>BLEPHAMIDE S.O.P.</b>	T4	
<i>brimonidine ophthalmic (eye) drops 0.15 %</i>	T4	
<i>brimonidine ophthalmic (eye) drops 0.2 %</i>	T2	
<i>brimonidine-timolol</i>	T3	
<i>brinzolamide</i>	T4	
<i>carteolol</i>	T2	
<b>CILOXAN OPHTHALMIC (EYE) OINTMENT</b>	T4	
<i>ciprofloxacin hcl ophthalmic (eye)</i>	T2	
<b>COMBIGAN</b>	T3	
<i>cromolyn ophthalmic (eye)</i>	T2	
<i>cyclosporine ophthalmic (eye)</i>	T3	QL (60 EA per 30 days)
<b>CYSTADROPS</b>	T5	PA; QL (20 ML per 28 days)
<b>CYSTARAN</b>	T5	PA; QL (60 ML per 28 days)
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diclofenac sodium ophthalmic (eye)</i>	T2	
<i>difluprednate</i>	T3	
<i>dorzolamide</i>	T2	
<i>dorzolamide-timolol</i>	T2	
<i>erythromycin ophthalmic (eye)</i>	T2	
<i>fluorometholone</i>	T3	
<i>flurbiprofen sodium</i>	T2	
<i>gatifloxacin</i>	T4	
<b>GENTAK OPHTHALMIC (EYE) OINTMENT</b>	T2	
<i>gentamicin ophthalmic (eye) drops</i>	T2	
<b>ILEVRO</b>	T3	
<i>ketorolac ophthalmic (eye) drops 0.4 %</i>	T3	
<i>ketorolac ophthalmic (eye) drops 0.5 %</i>	T2	
<b>LACRISERT</b>	T4	
<i>latanoprost</i>	T1	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	T1	
<i>levofloxacin ophthalmic (eye) drops 0.5 %</i>	T2	
<b>LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %</b>	T3	QL (5 ML per 31 days)
<i>methazolamide</i>	T4	
<i>moxifloxacin ophthalmic (eye) drops</i>	T3	
<b>NATACYN</b>	T4	
<i>neomycin-bacitracin-poly-hc</i>	T3	
<i>neomycin-bacitracin-polymyxin</i>	T2	
<i>neomycin-polymyxin b-dexameth</i>	T2	
<i>neomycin-polymyxin-gramicidin</i>	T3	
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	T3	
<i>ofloxacin ophthalmic (eye)</i>	T2	
<i>olopatadine ophthalmic (eye) drops 0.2 %</i>	T3	
<b>OXERVATE</b>	T5	PA; QL (112 ML per 56 days)
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T3	
<i>polymyxin b sulf-trimethoprim</i>	T1	
<i>prednisolone acetate</i>	T2	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	T2	
<b>RESTASIS</b>	T3	QL (60 EA per 30 days)
<b>RESTASIS MULTIDOSE</b>	T3	QL (5.5 ML per 27 days)
<b>SIMBRINZA</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sulfacetamide sodium ophthalmic (eye)</i>	T2	
<i>sulfacetamide-prednisolone</i>	T2	
<i>timolol maleate ophthalmic (eye) drops</i>	T1	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	T3	
<b>TOBRADEX OPHTHALMIC (EYE) OINTMENT</b>	T3	
<i>tobramycin ophthalmic (eye)</i>	T1	
<i>tobramycin-dexamethasone</i>	T3	
<b>TOBREX OPHTHALMIC (EYE) OINTMENT</b>	T4	
<i>travoprost</i>	T3	
<i>trifluridine</i>	T3	
<b>XIIDRA</b>	T3	QL (60 EA per 30 days)
<b>ZIRGAN</b>	T4	ST
<b>Respiratory And Allergy</b>		
<i>acetylcysteine</i>	T2	PA-BvD
<b>ADEMPAS</b>	T5	PA; QL (93 EA per 31 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	T3	QL (17 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)</i>	T3	QL (13.4 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)</i>	NF	
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml</i>	T2	PA-BvD
<i>albuterol sulfate oral syrup</i>	T1	
<b>ALYQ</b>	T5	PA; QL (62 EA per 31 days)
<i>ambrisentan</i>	T5	PA; QL (31 EA per 31 days)
<b>ANORO ELLIPTA</b>	T3	QL (60 EA per 30 days)
<b>ASMANEX HFA</b>	T3	QL (13 GM per 30 days)
<b>ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)</b>	T3	QL (1 EA per 30 days)
<b>ATROVENT HFA</b>	T4	QL (25.8 GM per 30 days)
<i>azelastine-fluticasone</i>	T4	
<b>BECONASE AQ</b>	T4	
<b>BERINERT INTRAVENOUS KIT</b>	T5	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>bosentan</i>	T5	PA; QL (62 EA per 31 days)
<b>BREO ELLIPTA</b>	T3	QL (60 EA per 30 days)
<b>BRONCHITOL</b>	T5	PA; QL (560 EA per 28 days)
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	T3	PA-BvD
<i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i>	T4	PA-BvD
<b>CINRYZE</b>	T5	PA; QL (20 EA per 28 days)
<b>COMBIVENT RESPIMAT</b>	T4	QL (4 GM per 30 days)
<i>cromolyn inhalation</i>	T2	PA-BvD
<i>cyproheptadine</i>	T2	PA
<b>DALIRESP</b>	T4	QL (31 EA per 31 days)
<i>desloratadine oral tablet</i>	T2	QL (31 EA per 31 days)
<i>desloratadine oral tablet, disintegrating</i>	T3	QL (31 EA per 31 days)
<i>epinephrine injection auto-injector</i>	T3	
<b>ESBRIET ORAL CAPSULE</b>	T5	PA; QL (279 EA per 31 days)
<b>ESBRIET ORAL TABLET 267 MG</b>	T5	PA; QL (279 EA per 31 days)
<b>ESBRIET ORAL TABLET 801 MG</b>	T5	PA; QL (93 EA per 31 days)
<b>FASENRA</b>	T5	PA; QL (1 ML per 56 days)
<b>FASENRA PEN</b>	T5	PA; QL (1 ML per 56 days)
<i>flunisolide</i>	T3	QL (50 ML per 25 days)
<i>fluticasone propionate nasal</i>	T1	QL (16 GM per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated</i>	T3	QL (1 EA per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	T3	QL (60 EA per 30 days)
<b>HAEGARDA</b>	T5	PA
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	T2	PA
<i>hydroxyzine hcl oral tablet</i>	T2	PA
<i>icatibant</i>	T5	PA; QL (18 ML per 30 days)
<b>INCRUSE ELLIPTA</b>	T3	QL (30 EA per 30 days)
<i>ipratropium bromide inhalation</i>	T2	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
<b>KALYDECO ORAL GRANULES IN PACKET 25 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG</b>	T5	PA; QL (56 EA per 28 days)
<b>KALYDECO ORAL TABLET</b>	T5	PA; QL (62 EA per 31 days)
<i>levalbuterol hcl inhalation solution for nebulization 1.25 mg/3 ml</i>	T2	PA-BvD



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>levalbuterol tartrate</i>	T3	QL (30 GM per 30 days)
<i>levocetirizine oral solution</i>	T3	QL (310 ML per 31 days)
<i>levocetirizine oral tablet</i>	T1	QL (31 EA per 31 days)
<i>mometasone nasal</i>	T3	QL (34 GM per 30 days)
<i>montelukast</i>	T2	QL (31 EA per 31 days)
<b>NUCALA SUBCUTANEOUS AUTO-INJECTOR</b>	T5	PA; QL (3 ML per 28 days)
<b>NUCALA SUBCUTANEOUS RECON SOLN</b>	T5	PA; QL (3 EA per 28 days)
<b>NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML</b>	T5	PA; QL (3 ML per 28 days)
<b>NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML</b>	T5	PA; QL (0.4 ML per 28 days)
<b>OFEV</b>	T5	PA; QL (62 EA per 31 days)
<b>OMNARIS</b>	T4	
<b>OPSUMIT</b>	T5	PA; QL (31 EA per 31 days)
<b>ORKAMBI ORAL GRANULES IN PACKET 100-125 MG, 150-188 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>ORKAMBI ORAL TABLET</b>	T5	PA; QL (124 EA per 31 days)
<b>ORLADEYO</b>	T5	PA; QL (31 EA per 31 days)
<i>pirfenidone oral tablet 267 mg</i>	T5	PA; QL (279 EA per 31 days)
<i>pirfenidone oral tablet 801 mg</i>	T5	PA; QL (93 EA per 31 days)
<b>PULMOZYME</b>	T5	PA
<b>QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION</b>	T3	QL (10.6 GM per 30 days)
<b>QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION</b>	T3	QL (21.2 GM per 30 days)
<b>SAJAZIR</b>	T5	PA; QL (18 ML per 30 days)
<b>SEREVENT DISKUS</b>	T3	QL (60 EA per 30 days)
<i>sildenafil (pulm.hypertension) oral suspension for reconstitution</i>	T4	PA; QL (224 ML per 31 days)
<i>sildenafil (pulm.hypertension) oral tablet</i>	T3	PA; QL (93 EA per 31 days)
<b>SPIRIVA RESPIMAT</b>	T3	QL (4 GM per 30 days)
<b>SPIRIVA WITH HANDIHALER</b>	T3	QL (30 EA per 30 days)
<b>STIOLTO RESPIMAT</b>	T3	QL (4 GM per 30 days)
<b>STRIVERDI RESPIMAT</b>	T4	QL (4 GM per 30 days)
<b>SYMBICORT</b>	T3	QL (10.2 GM per 30 days)
<b>SYMDEKO</b>	T5	PA; QL (56 EA per 28 days)
<i>tadalafil (pulm. hypertension)</i>	T5	PA; QL (62 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>TAKHZYRO</b>	T5	PA; QL (4 ML per 28 days)
<i>terbutaline oral</i>	T4	
<b>THEO-24</b>	T4	
<i>theophylline oral solution</i>	T2	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	T2	
<i>theophylline oral tablet extended release 24 hr</i>	T2	
<b>TRACLEER ORAL TABLET FOR SUSPENSION</b>	T5	PA; QL (124 EA per 31 days)
<b>TRELEGY ELLIPTA</b>	T3	QL (60 EA per 30 days)
<b>TRIKAFTA</b>	T5	PA; QL (84 EA per 28 days)
<b>TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG (112)- 32 MCG (84)</b>	T5	PA; QL (392 EA per 365 days)
<b>TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 32 MCG, 32-48 MCG, 48 MCG, 64 MCG</b>	T5	PA
<b>TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16(112)-32(112) -48(28) MCG</b>	T5	PA; QL (504 EA per 365 days)
<b>VENTAVIS</b>	T5	PA
<b>VENTOLIN HFA</b>	T3	QL (36 GM per 30 days)
<b>WIXELA INHUB</b>	T3	QL (60 EA per 30 days)
<b>XOLAIR</b>	T5	PA
<b>YUPELRI</b>	T5	PA-BvD
<i>zafirlukast oral tablet 10 mg</i>	T4	QL (93 EA per 31 days)
<i>zafirlukast oral tablet 20 mg</i>	T4	QL (62 EA per 31 days)
<b>Urologicals</b>		
<i>alfuzosin</i>	T2	QL (31 EA per 31 days)
<i>bethanechol chloride</i>	T2	
<b>CIALIS ORAL TABLET 2.5 MG</b>	T4	PA; QL (62 EA per 31 days)
<b>CIALIS ORAL TABLET 5 MG</b>	T4	PA; QL (31 EA per 31 days)
<b>CYSTAGON</b>	T4	
<i>darifenacin</i>	T3	QL (31 EA per 31 days)
<i>dutasteride</i>	T2	QL (31 EA per 31 days)
<i>dutasteride-tamsulosin</i>	T3	QL (31 EA per 31 days)
<b>ELMIRON</b>	T4	
<i>finasteride oral tablet 5 mg</i>	T2	
<b>MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON</b>	T3	QL (300 ML per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR</b>	T3	QL (31 EA per 31 days)
<i>oxybutynin chloride oral syrup</i>	T2	
<i>oxybutynin chloride oral tablet</i>	T2	
<i>oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg</i>	T2	QL (31 EA per 31 days)
<i>oxybutynin chloride oral tablet extended release 24hr 15 mg</i>	T3	QL (62 EA per 31 days)
<i>potassium citrate oral tablet extended release</i>	T3	
<b>PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET</b>	T5	PA
<i>silodosin</i>	T4	
<i>solifenacin</i>	T4	QL (31 EA per 31 days)
<i>tadalafil oral tablet 2.5 mg</i>	T4	PA; QL (62 EA per 31 days)
<i>tadalafil oral tablet 5 mg</i>	T4	PA; QL (31 EA per 31 days)
<i>tamsulosin</i>	T1	
<i>tolterodine oral capsule, extended release 24hr</i>	T3	QL (31 EA per 31 days)
<i>tolterodine oral tablet</i>	T3	QL (62 EA per 31 days)
<i>trospium oral capsule, extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>trospium oral tablet</i>	T2	QL (93 EA per 31 days)
<b>Vitamins, Hematinics / Electrolytes</b>		
<i>calcium acetate(phosphat bind)</i>	T2	
<b>CLINIMIX 5%/D15W SULFITE FREE</b>	T4	PA-BvD
<b>CLINIMIX 4.25%/D10W SULF FREE</b>	T4	PA-BvD
<b>CLINIMIX 5%-D20W(SULFITE-FREE)</b>	T4	PA-BvD
<i>fluoride (sodium) oral tablet</i>	T2	
<b>INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %</b>	T4	PA-BvD
<b>ISOLYTE S PH 7.4</b>	T3	PA-BvD
<b>ISOLYTE-P IN 5 % DEXTROSE</b>	T3	PA-BvD
<b>KLOR-CON</b>	T3	
<b>KLOR-CON M10</b>	T2	
<b>KLOR-CON M15</b>	T2	
<b>KLOR-CON M20</b>	T2	
<i>magnesium sulfate injection</i>	T2	
<b>PLENAMINE</b>	T3	PA-BvD
<i>potassium chlorid-d5-0.45%nacl</i>	T2	
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml</i>	T2	
<i>potassium chloride intravenous</i>	T2	
<i>potassium chloride oral capsule, extended release</i>	T2	
<i>potassium chloride oral liquid</i>	T2	
<i>potassium chloride oral tablet extended release</i>	T2	
<i>potassium chloride oral tablet,er particles/crystals</i>	T2	
<i>potassium chloride-0.45 % nacl</i>	T2	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride-d5-0.9%nacl</i>	T2	
<b>PRENATAL VITAMIN PLUS LOW IRON</b>	T2	PA
<b>PROSOL 20 %</b>	T4	PA-BvD
<i>sodium chloride 0.45 % intravenous parenteral solution</i>	T2	
<i>sodium chloride 3 % hypertonic</i>	T2	
<i>sodium chloride 5 % hypertonic</i>	T2	
<b>TRAVASOL 10 %</b>	T3	PA-BvD
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<b>PLENAMINE</b> .....	67	<b>PROCTOSOL HC</b> .....	52	<b>RETEVMO</b> .....	16
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<i>polymyxin b sulf-trimethoprim</i> ....	62	<b>PROCYSBI</b> .....	67	<b>REXULTI</b> .....	30

<b>REYATAZ</b> .....	11	<i>sirolimus</i> .....	17	<b>SUPRAX</b> .....	12
<b>REYVOW</b> .....	30	<b>SIRTURO</b> .....	11	<b>SUPREP BOWEL PREP KIT</b> .....	52
<i>ribavirin</i> .....	11	<b>SIVEXTRO</b> .....	11	<b>SYEDA</b> .....	60
<b>RIDAURA</b> .....	57	<b>SKYRIZI</b> .....	43, 52	<b>SYMBICORT</b> .....	65
<i>rifabutin</i> .....	11	<i>sodium chloride</i> .....	45	<b>SYMDEKO</b> .....	65
<i>rifampin</i> .....	11	<i>sodium chloride 0.45 %</i> .....	68	<b>SYMFI</b> .....	12
<i>riluzole</i> .....	45	<i>sodium chloride 0.9 %</i> .....	45	<b>SYMFI LO</b> .....	12
<i>rimantadine</i> .....	11	<i>sodium chloride 3 % hypertonic</i> .....	68	<b>SYMLINPEN 120</b> .....	50
<b>RINVOQ</b> .....	57	<i>sodium chloride 5 % hypertonic</i> .....	68	<b>SYMLINPEN 60</b> .....	50
<i>risedronate</i> .....	45, 58	<i>sodium phenylbutyrate</i> .....	45	<b>SYMPAZAN</b> .....	31
<b>RISPERDAL CONSTA</b> .....	30	<i>sodium polystyrene sulfonate</i> .....	45	<b>SYMPROIC</b> .....	52
<i>risperidone</i> .....	30, 31	<i>sofosbuvir-velpatasvir</i> .....	11	<b>SYMTUZA</b> .....	12
<i>ritonavir</i> .....	11	<i>solifenacin</i> .....	67	<b>SYNAREL</b> .....	50
<i>rivastigmine</i> .....	31	<b>SOLTAMOX</b> .....	17	<b>SYNJARDY</b> .....	50
<i>rivastigmine tartrate</i> .....	31	<b>SOMAVERT</b> .....	49	<b>SYNJARDY XR</b> .....	50
<i>rizatriptan</i> .....	31	<i>sorafenib</i> .....	17	<b>SYNRIBO</b> .....	17
<i>ropinirole</i> .....	31	<b>SORINE</b> .....	38	<b>SYNTHROID</b> .....	50
<i>rosuvastatin</i> .....	38	<i>sotalol</i> .....	38	<b>TABLOID</b> .....	17
<b>ROTARIX</b> .....	55	<b>SOTALOL AF</b> .....	38	<b>TABRECTA</b> .....	17
<b>ROTATEQ VACCINE</b> .....	55	<b>SOVALDI</b> .....	11	<i>tacrolimus</i> .....	17, 43
<b>ROWEEPRA</b> .....	31	<b>SPIRIVA RESPIMAT</b> .....	65	<i>tadalafil</i> .....	67
<b>ROZLYTREK</b> .....	16	<b>SPIRIVA WITH</b>		<i>tadalafil (pulm. hypertension)</i> ....	65
<b>RUBRACA</b> .....	16	<b>HANDIHALER</b> .....	65	<b>TAFINLAR</b> .....	17
<i>rufinamide</i> .....	31	<i>spironolactone</i> .....	38	<b>TAGRISO</b> .....	17
<b>RUKOBIA</b> .....	11	<i>spironolacton-hydrochlorothiaz.</i>	38	<b>TAKHZYRO</b> .....	66
<b>RYBELSUS</b> .....	49	<b>SPRINTEC (28)</b> .....	60	<b>TALTZ AUTOINJECTOR</b> .....	43
<b>RYDAPT</b> .....	17	<b>SPRITAM</b> .....	31	<b>TALTZ SYRINGE</b> .....	43
<b>RYTARY</b> .....	31	<b>SPRYCEL</b> .....	17	<b>TALZENNA</b> .....	17
<b>SAJAZIR</b> .....	65	<b>SPS (WITH SORBITOL)</b> .....	45	<i>tamoxifen</i> .....	17
<b>SANDIMMUNE</b> .....	17	<b>SRONYX</b> .....	60	<i>tamsulosin</i> .....	67
<b>SANTYL</b> .....	43	<b>SSD</b> .....	43	<b>TASIGNA</b> .....	17
<i>sapropterin</i> .....	49	<b>STELARA</b> .....	43	<b>TAVALISSE</b> .....	38
<b>SCSEMBLIX</b> .....	17	<b>STIOLTO RESPIMAT</b> .....	65	<b>TAVNEOS</b> .....	45
<i>scopolamine base</i> .....	52	<b>STIVARGA</b> .....	17	<i>tazarotene</i> .....	43
<b>SECUADO</b> .....	31	<i>streptomycin</i> .....	11	<b>TAZORAC</b> .....	43
<i>selegiline hcl</i> .....	31	<b>STRIBILD</b> .....	11	<b>TAZTIA XT</b> .....	38
<i>selenium sulfide</i> .....	43	<b>STRIVERDI RESPIMAT</b> .....	65	<b>TAZVERIK</b> .....	17
<b>SELZENTRY</b> .....	11	<b>SUCRAID</b> .....	52	<b>TDVAX</b> .....	55
<b>SEREVENT DISKUS</b> .....	65	<i>sucralfate</i> .....	52	<b>TEFLARO</b> .....	12
<i>sertraline</i> .....	31	<i>sulfacetamide sodium</i> .....	63	<b>TEGRETOL</b> .....	31, 32
<b>SETLAKIN</b> .....	60	<i>sulfacetamide sodium (acne)</i> .....	43	<b>TEGRETOL XR</b> .....	32
<i>sevelamer carbonate</i> .....	45	<i>sulfacetamide-prednisolone</i> .....	63	<b>TEGSEDI</b> .....	32
<i>sevelamer hcl</i> .....	45	<i>sulfadiazine</i> .....	11	<i>telmisartan</i> .....	38
<b>SHINGRIX (PF)</b> .....	55	<i>sulfamethoxazole-trimethoprim</i>		<i>telmisartan-amlodipine</i> .....	38
<b>SIGNIFOR</b> .....	17	.....	11, 12	<i>telmisartan-hydrochlorothiazid</i> ..	39
<i>sildenafil (pulm.hypertension)</i> ....	65	<b>SULFAMYLON</b> .....	43	<i>temazepam</i> .....	32
<b>SILIQ</b> .....	43	<i>sulfasalazine</i> .....	52	<b>TENIVAC (PF)</b> .....	56
<i>silodosin</i> .....	67	<i>sulindac</i> .....	31	<i>tenofovir disoproxil fumarate</i> ....	12
<i>silver sulfadiazine</i> .....	43	<i>sumatriptan</i> .....	31	<b>TEPMETKO</b> .....	17
<b>SIMBRINZA</b> .....	62	<i>sumatriptan succinate</i> .....	31	<i>terazosin</i> .....	39
<b>SIMPONI</b> .....	58	<i>sunitinib</i> .....	17	<i>terbinafine hcl</i> .....	12
<i>simvastatin</i> .....	38	<b>SUNOSI</b> .....	31	<i>terbutaline</i> .....	66

<i>terconazole</i> .....	60	<b>TRESIBA FLEXTOUCH U-100</b> .....	50	<i>valsartan-hydrochlorothiazide</i> ...	39
<i>teriparatide</i> .....	58	<b>TRESIBA FLEXTOUCH U-200</b> .....	50	<b>VALTOCO</b> .....	32
<i>testosterone</i> .....	50	<b>TRESIBA U-100 INSULIN</b> .....	50	<i>vancomycin</i> .....	12
<i>testosterone cypionate</i> .....	50	<i>tretinoin</i> .....	43	<b>VANDAZOLE</b> .....	61
<i>testosterone enanthate</i> .....	50	<i>tretinoin (antineoplastic)</i> .....	17	<b>VAQTA (PF)</b> .....	56
<i>tetanus, diphtheria tox ped(pf)</i> .....	56	<i>triamcinolone acetonide</i> .....	43, 46	<i>varenicline</i> .....	45
<i>tetrabenazine</i> .....	32	<i>triamterene-hydrochlorothiazid</i> ..	39	<b>VARIVAX (PF)</b> .....	56
<i>tetracycline</i> .....	12	<b>TRIDERM</b> .....	43	<b>VASCEPA</b> .....	39
<b>THALOMID</b> .....	17	<i>trientine</i> .....	45	<b>VELIVET TRIPHASIC REGIMEN (28)</b> .....	61
<b>THEO-24</b> .....	66	<b>TRI-ESTARYLLA</b> .....	60	<b>VELTASSA</b> .....	45
<i>theophylline</i> .....	66	<i>trifluoperazine</i> .....	32	<b>VEMLIDY</b> .....	12
<i>thioridazine</i> .....	32	<i>trifluridine</i> .....	63	<b>VENCLEXTA</b> .....	18
<i>thiothixene</i> .....	32	<b>TRIJARDY XR</b> .....	50	<b>VENCLEXTA STARTING PACK</b> .....	18
<b>TIADYL ER</b> .....	39	<b>TRIKAFTA</b> .....	66	<i>venlafaxine</i> .....	32
<i>tiagabine</i> .....	32	<i>trimethoprim</i> .....	12	<b>VENTAVIS</b> .....	66
<b>TIBSOVO</b> .....	17	<b>TRI-MILI</b> .....	60	<b>VENTOLIN HFA</b> .....	66
<b>TICOVAC</b> .....	56	<i>trimipramine</i> .....	32	<i>verapamil</i> .....	39
<i>tigecycline</i> .....	12	<b>TRINTELLIX</b> .....	32	<b>VERQUOVO</b> .....	39
<i>timolol maleate</i> .....	39, 63	<b>TRI-NYMYO</b> .....	61	<b>VERSACLOZ</b> .....	32
<b>TIVICAY</b> .....	12	<b>TRI-SPRINTEC (28)</b> .....	61	<b>VERZENIO</b> .....	18
<b>TIVICAY PD</b> .....	12	<b>TRITOCIN</b> .....	43	<b>VESTURA (28)</b> .....	61
<i>tizanidine</i> .....	32	<b>TRIUMEQ</b> .....	12	<b>VIBERZI</b> .....	53
<b>TOBI PODHALER</b> .....	12	<b>TRIUMEQ PD</b> .....	12	<b>VICTOZA 3-PAK</b> .....	50
<b>TOBRADEX</b> .....	63	<b>TRIVORA (28)</b> .....	61	<b>VIENVA</b> .....	61
<i>tobramycin</i> .....	12, 63	<b>TRI-VYLIBRA</b> .....	61	<i>vigabatrin</i> .....	32
<i>tobramycin in 0.225 % nacl</i> .....	12	<b>TRIZIVIR</b> .....	12	<b>VIGADRONE</b> .....	32
<i>tobramycin sulfate</i> .....	12	<b>TROPHAMINE 10 %</b> .....	68	<b>VIIBRYD</b> .....	32
<i>tobramycin-dexamethasone</i> .....	63	<i>trospium</i> .....	67	<b>VIJOICE</b> .....	18
<b>TOBREX</b> .....	63	<b>TRULICITY</b> .....	50	<i>vilazodone</i> .....	32
<i>tolcapone</i> .....	32	<b>TRUMENBA</b> .....	56	<b>VIRACEPT</b> .....	12
<i>tolterodine</i> .....	67	<b>TRUSELTIQ</b> .....	18	<b>VIREAD</b> .....	12
<i>tolvaptan</i> .....	50	<b>TUKYSA</b> .....	18	<b>VITRAKVI</b> .....	18
<i>topiramate</i> .....	32	<b>TURALIO</b> .....	18	<b>VIVITROL</b> .....	32
<i>toremifene</i> .....	17	<b>TWINRIX (PF)</b> .....	56	<b>VIVJOA</b> .....	13
<i>torseamide</i> .....	39	<b>TYBOST</b> .....	12	<b>VIZIMPRO</b> .....	18
<b>TOUJEO MAX U-300 SOLOSTAR</b> .....	50	<b>TYMLOS</b> .....	58	<b>VONJO</b> .....	18
<b>TOUJEO SOLOSTAR U-300 INSULIN</b> .....	50	<b>TYPHIM VI</b> .....	56	<i>voriconazole</i> .....	13
<b>TRACLEER</b> .....	66	<b>TYVASO DPI</b> .....	66	<b>VOSEVI</b> .....	13
<b>TRADJENTA</b> .....	50	<b>UBRELVY</b> .....	32	<b>VOTRIENT</b> .....	18
<i>tramadol</i> .....	32	<b>UDENYCA</b> .....	56	<b>VRAYLAR</b> .....	33
<i>tramadol-acetaminophen</i> .....	32	<b>UNITHROID</b> .....	50	<b>VUMERITY</b> .....	33
<i>trandolapril</i> .....	39	<b>UPTRAVI</b> .....	39	<b>VYFEMLA (28)</b> .....	61
<i>tranexamic acid</i> .....	60	<i>ursodiol</i> .....	52	<b>VYLIBRA</b> .....	61
<i>tranylcypromine</i> .....	32	<b>VABOMERE</b> .....	12	<b>VYNDAMAX</b> .....	39
<b>TRAVASOL 10 %</b> .....	68	<i>valacyclovir</i> .....	12	<b>VYENDAQEL</b> .....	39
<i>travoprost</i> .....	63	<b>VALCHLOR</b> .....	43	<b>WAKIX</b> .....	33
<i>trazodone</i> .....	32	<i>valganciclovir</i> .....	12	<i>warfarin</i> .....	39
<b>TRECTOR</b> .....	12	<i>valproic acid</i> .....	32	<b>WELIREG</b> .....	18
<b>TRELEGY ELLIPTA</b> .....	66	<i>valproic acid (as sodium salt)</i> .....	32	<b>WIXELA INHUB</b> .....	66
<b>TRELSTAR</b> .....	17	<i>valsartan</i> .....	39	<b>XALKORI</b> .....	18

<b>XARELTO</b> .....	39	<b>ZORBTIVE</b> .....	56
<b>XARELTO DVT-PE TREAT</b>		<b>ZORTRESS</b> .....	19
<b>30D START</b> .....	39	<b>ZOVIA 1-35 (28)</b> .....	61
<b>XATMEP</b> .....	18	<b>ZUBSOLV</b> .....	33
<b>XCOPRI</b> .....	33	<b>ZYDELIG</b> .....	19
<b>XCOPRI MAINTENANCE</b>		<b>ZYKADIA</b> .....	19
<b>PACK</b> .....	33	<b>ZYPREXA RELPREVV</b> .....	33
<b>XCOPRI TITRATION PACK</b>	33		
<b>XELJANZ</b> .....	58		
<b>XELJANZ XR</b> .....	58		
<b>XENLETA</b> .....	13		
<b>XERMELO</b> .....	18		
<b>XGEVA</b> .....	18		
<b>XIFAXAN</b> .....	13		
<b>XIIDRA</b> .....	63		
<b>XOFLUZA</b> .....	13		
<b>XOLAIR</b> .....	66		
<b>XOSPATA</b> .....	18		
<b>XPOVIO</b> .....	18		
<b>XTANDI</b> .....	18, 19		
<b>XULTOPHY 100/3.6</b> .....	50		
<b>XURIDEN</b> .....	45		
<b>XYREM</b> .....	33		
<b>YF-VAX (PF)</b> .....	56		
<b>YONSA</b> .....	19		
<b>YUPELRI</b> .....	66		
<b>YUVAFEM</b> .....	61		
<i>zafirlukast</i> .....	66		
<i>zaleplon</i> .....	33		
<b>ZARXIO</b> .....	56		
<b>ZEGALOGUE</b>			
<b>AUTOINJECTOR</b> .....	50		
<b>ZEGALOGUE SYRINGE</b> .....	50		
<b>ZEJULA</b> .....	19		
<b>ZELBORAF</b> .....	19		
<b>ZEMAIRA</b> .....	45		
<b>ZENPEP</b> .....	53		
<b>ZEPATIER</b> .....	13		
<b>ZEPOSIA</b> .....	33		
<b>ZEPOSIA STARTER KIT</b> .....	33		
<b>ZEPOSIA STARTER PACK</b> .....	33		
<i>zidovudine</i> .....	13		
<b>ZIEXTENZO</b> .....	56		
<i>ziprasidone hcl</i> .....	33		
<i>ziprasidone mesylate</i> .....	33		
<b>ZIRGAN</b> .....	63		
<b>ZOLINZA</b> .....	19		
<i>zolmitriptan</i> .....	33		
<i>zolpidem</i> .....	33		
<b>ZOMACTON</b> .....	56		
<i>zonisamide</i> .....	33		
<b>ZONTIVITY</b> .....	39		

# acitretin

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## Products Affected

- *acitretin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# actemra

## Products Affected

- **ACTEMRA ACTPEN**
- **ACTEMRA SUBCUTANEOUS**

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For rheumatoid arthritis, patients must have an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide). For giant cell arteritis, patients must have an adequate trial or intolerance to one systemic corticosteroid (e.g., prednisone). For polyarticular juvenile idiopathic arthritis, patients must have an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For systemic sclerosis-associated interstitial lung disease (SSc-ILD), patients must have an adequate trial or intolerance to one immunosuppressant (e.g., mycophenolate mofetil, corticosteroids, azathioprine, cyclophosphamide). Documentation of systemic juvenile idiopathic arthritis.
<b>Age Restrictions</b>	Deny if less than 18 years of age for systemic sclerosis-associated interstitial lung disease (SSc-ILD), Rheumatoid Arthritis, and Giant Cell Arteritis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Systemic Juvenile Idiopathic Arthritis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# acthar h.p.

## Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Covered for the following indications: 1. Infantile spasms (West syndrome) in children less than 2 years of age. 2. Acute exacerbations of multiple sclerosis (MS) for patients receiving concurrent immunomodulator therapy (e.g., interferon beta, glatiramer acetate, dimethyl fumarate, fingolimod, teriflunomide) 3. Rheumatic disorders for patients receiving maintenance therapy with at least one NSAID, DMARD (e.g. leflunomide) or biologic (e.g. adalimumab) 4. Collagen diseases for members receiving maintenance therapy with at least one antimalarial (e.g. hydroxychloroquine) or immunosuppressant (e.g. azathioprine) 5. Dermatologic diseases 6. Allergic states (i.e. serum sickness and transfusion reaction due to serum protein reaction 7. Ophthalmic diseases 8. Respiratory diseases 9. Gout and unable to take first-line therapies. 10. Pediatric acquired epileptic aphasia. 11. Proteinuria in nephrotic syndrome and trial/failure or contraindication to two therapies from any of the following different classes: corticosteroids (e.g., cortisone or dexamethasone), calcineurin inhibitors (e.g., cyclosporine or tacrolimus, per DRUGDEX). 12. Diagnosis for adrenal insufficiency with trial/failure or contraindication to cosyntropin. For covered indications 2 through 10, limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (i.e. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	For reauthorization, the following (1. 2. and 3.) must be met. 1) Prescriber attestation that the member cannot use corticosteroids (e.g. IV methylprednisolone, high dose oral corticosteroids) due to unsatisfactory response, intolerance (e.g. severe anaphylaxis) or experienced a severe adverse event to corticosteroids (e.g. psychosis). 2) If the reauthorization is for the treatment of multiple sclerosis, a rheumatic disorder, dermatologic disease, or nephrotic syndrome, the prescriber attests that H.P. Acthar is being used for a new acute exacerbation and not on a routine basis to prevent an exacerbation as supported by Compendia. 3) If the reauthorization is for treatment of multiple sclerosis, a rheumatic disorder, or collagen disease, the member continues to receive maintenance therapy.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off Label Uses</b>	Gout

# actimmune

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## Products Affected

- ACTIMMUNE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Adbry

## Products Affected

- ADBRY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe atopic dermatitis, documentation of all of the following (1-2): 1) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- atopic dermatitis of the face or anogenital involvement -OR- the member has severe atopic dermatitis evidenced by the extent of the member's body surface area affected which makes topical therapy impractical to apply - OR- severe atopic dermatitis evidenced by severely damaged skin 2) trial & failure, intolerance, or contraindication to topical tacrolimus or topical pimecrolimus -OR- the member has severe atopic dermatitis evidenced by the extent of the member's body surface area affected which makes topical therapy impractical to apply -OR- severe atopic dermatitis evidenced by severely damaged skin
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For Atopic Dermatitis, patients must have an adequate trial/failure, intolerance, or contraindication to both preferred products: Dupixent and Rinvoq. For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen. For reauthorization, attestation of positive clinical response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ADHD Drugs

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## Products Affected

- *guanfacine oral tablet extended release 24 hr*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of ADHD -AND- trial/failure, intolerance or contraindication to a stimulant
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# afinitor

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## Products Affected

- *everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) HR mutation status and HER2 mutation status 2) Alternatives tried/failed 3) Concomitant therapy 4) Candidacy for surgical resection
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# aimovig

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## Products Affected

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

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



# ajovy

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## Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, the following criteria will apply (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in average monthly migraine days or number of migraine episodes is required.
Indications	All FDA-approved Indications.
Off Label Uses	

# alecensa

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## Products Affected

- ALECENSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# alkindi

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## Products Affected

- **ALKINDI SPRINKLE**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of adrenocortical insufficiency -AND- Therapeutic failure or intolerance to oral generic hydrocortisone tablets.
<b>Age Restrictions</b>	Deny if greater than 17 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ALPHA1-PROTEINASE INHIBITORS

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Covered under Part B when furnished incident to a physician service and is not self-administered.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# alunbrig

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ampyra

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## Products Affected

- *dalfampridine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	History of seizure disorder, Cr Cl less than 50ml/min
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, documentation supporting improvement in walking impairment from baseline is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# anabolic steroids

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## Products Affected

- *oxandrolone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- For the diagnosis of osteoporosis the trial/failure, intolerance or contraindication to at least 2 federal legend drugs indicated for use in osteoporosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# apokyn

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## Products Affected

- *apomorphine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Parkinson's disease -AND- for use in acute, intermittent treatment of hypomobility off episodes -AND- experiencing off episodes despite the use of oral carbidopa/levodopa -AND- Therapeutic failure, intolerance, or contraindication to the following (1. and 2.): 1) a generic pramipexole containing product or a generic ropinirole containing product. 2) generic entacapone, selegiline or rasagiline.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# arikayce

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## Products Affected

- ARIKAYCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Mycobacterium avium complex lung disease -AND- attestation of not achieving negative sputum cultures despite at least 6 months with a multidrug background regimen containing a macrolide - AND- Arikayce will be used in conjunction with a background multidrug regimen.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	18 months
<b>Other Criteria</b>	For reauthorization, attestation of positive sputum cultures -OR- negative sputum cultures for insufficient period of time (e.g. less than 12 months).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## attr-cm drugs

### Products Affected

- VYNDAMAX
- VYNDAQEL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) with amyloid deposits on cardiac biopsy or scintigraphy with heart contralateral greater than 1.5 (Grade III) -AND- Cardiac involvement supported by cardiac magnetic resonance, echocardiography or serum cardiac biomarker (e.g. B-type natriuretic peptide, cardiac troponin) - AND- Primary (light chain) amyloidosis has been ruled out by immunohistochemistry, mass spectrometry or scintigraphy.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of improvement or delayed disease progression from baseline demonstrated by 6-minute walk test, cardiac function (e.g. LVEF, NYHA class), Kansas City Cardiomyopathy Questionnaire-Overall Summary, number of cardiovascular-related hospitalizations or serum cardiac biomarkers (e.g. B-type natriuretic peptide, cardiac troponin)
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# atypical antipsychotics

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## Products Affected

- *aripiprazole*
- **REXULTI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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). For Rexulti, trial, intolerance, or contraindication to one other formulary generic atypical antipsychotic (e.g. quetiapine).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# aubagio

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## Products Affected

- AUBAGIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of Aubagio and other disease modifying agents such as fingolimod, interferons, Copaxone, Tysabri
<b>Required Medical Information</b>	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# auryxia

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## Products Affected

- AURYXIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Treatment of iron deficiency anemia
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ayvakit

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## Products Affected

- **AYVAKIT**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For unresectable or metastatic Gastrointestinal Stromal Tumor (GIST), PDGFRA exon 18 mutation status. For Advanced Systemic Mastocytosis (AdvSM), platelet count greater than or equal to $50 \times 10^9/L$ AND aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm (SM-AHN), or Mast cell leukemia (MCL).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# bafiertam

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## Products Affected

- **BAFIERTAM**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
<b>Required Medical Information</b>	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- Therapeutic failure or intolerance to generic dimethyl fumarate
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# balversa

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## Products Affected

- **BALVERSA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) FGFR3 or FGFR2 mutation status as detected by an FDA approved test 2) alternatives tried/failed within labelled time frame
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# banzel

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## Products Affected

- **BANZEL ORAL SUSPENSION**
- *rufinamide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Patients with familial short QT syndrome
<b>Required Medical Information</b>	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- an adequate trial or intolerance of a previous antiepileptic therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# benlysta

## Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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) -OR- Documentation of active lupus nephritis -AND- documentation of positive ANA titer (greater than or equal to 1:80) or anti-dsDNA greater than or equal to 30 IU/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 which includes corticosteroids (e.g. prednisone) with at least one of the following: 1.) mycophenolate for induction followed by mycophenolate for maintenance 2.) cyclophosphamide for induction followed by azathioprine for maintenance</p>
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	For reauthorization, attestation of positive clinical response is required. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# berinert

## Products Affected

- **BERINERT INTRAVENOUS KIT**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Member should not be on two acute therapies simultaneously and acute therapy should not be used as prophylactic therapy
<b>Required Medical Information</b>	For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type I & II with the following (1-4): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. 4) Documentation of member's weight. For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type III with the following (5-9): 5) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 6) Documentation of family history of HAE or FXII mutation 7) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 8) Medications known to cause angioedema have been evaluated and discontinued. 9) Documentation of member's weight.
<b>Age Restrictions</b>	Deny if less than 5 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For 18 years of age or older, therapeutic failure, intolerance or contraindication to icatibant.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Besremi

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## Products Affected

- **BESREMI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of polycythemia vera
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# **bosulif**

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## **Products Affected**

- **BOSULIF**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis AND all of the following, if applicable to diagnosis: 1) phase of CML 2) Philadelphia chromosome status 3) alternatives tried/failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# braftovi

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## Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Use in wild-type BRAF melanoma or wild-type BRAF CRC
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) BRAF V600E or V600K mutation status 2) alternatives tried/failed 3) concomitant therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# bronchitol

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## Products Affected

- **BRONCHITOL**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cystic fibrosis -AND- Passed a Bronchitol Tolerance Test -AND- Used in conjunction with standard therapies for the management of cystic fibrosis to improve pulmonary function (e.g. bronchodilators, antibiotics, anti-inflammatory therapy).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of increase in FEV1
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# brukinsa

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## Products Affected

- **BRUKINSA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- if applicable to diagnosis, alternatives tried/failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# butrans

## Products Affected

- *buprenorphine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Documentation of moderate to severe chronic pain -AND- trial and failure of at least two previous federal legend medications for pain, including NSAIDs, tramadol, or opioid analgesics. For concomitant use of an opiate agonist and substance abuse therapy, documentation that the member has an acute pain condition (e.g. acute traumatic injury) in which treatment with other agents would cause insufficient pain control or if the member requires treatment for pain related to a terminal illness. For concomitant use of an opiate agonist, benzodiazepine and a centrally acting skeletal muscle relaxant, documentation that the member has tried/failed at least 2 other skeletal muscle relaxant (e.g. methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients AND attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For concomitant use of an opiate agonist and other opiate potentiators (e.g. gabapentinoids, benzodiazepines) attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For long acting (e.g. extended release) opioid medications, the following apply (1-5). 1)Pain is severe enough to require daily, around-the-clock, long-term opioid treatment. 2)Patient is not long acting opioid naive. 3)Attestation that non-opiate alternative therapies have been explored (e.g. NSAIDs). 4)Attestation that controlled substance Rx history has been reviewed in the state Prescription Drug Monitoring Program. 5)Attestation of counseling on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# **cablivi**

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## **Products Affected**

- **CABLIVI INJECTION KIT**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of acquired thrombocytopenic purpura (aTTP) -AND- Used in conjunction with plasma exchange and immunosuppressive therapy (i.e. systemic corticosteroids or rituximab)
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	75 days initial authorization, 28 days reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of remaining signs and symptoms of persistent disease (e.g. suppressed ADAMTS 13 activity level remain present)
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# **cabometryx**

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## **Products Affected**

- **CABOMETRYX**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) alternatives tried/failed 2) attestation of first line use 3) concomitant therapy 4) radioactive iodine refractory status
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# calquence

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## Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- if applicable to diagnosis, alternatives tried/failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Camzyos

## Products Affected

- CAMZYOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy -AND- Left ventricular ejection fraction of greater than or equal to 55% -AND- Valsalva left ventricular outflow tract peak gradient of greater than or equal to 50 mmHg at rest or after provocation -AND- Therapeutic failure or intolerance to one of the following (1 or 2) or contraindication to all: 1) Non-vasodilating beta blocker (e.g. metoprolol) 2) non-dihydropyridine calcium channel blocker (e.g. diltiazem) -AND- Not currently treated with and attestation Camzyos will not be used concomitantly with disopyramide, ranolazine, or combination therapy of beta-blocker and calcium channel blocker
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of improvement in pV02 by greater than or equal to 1.5 mL/kg/min plus at least 1 NYHA class reduction or improvement in pV02 by greater than or equal to 3.0 mL/kg/min without NYHA class worsening -AND- Not currently treated with and attestation Camzyos will not be used concomitantly with disopyramide, ranolazine, or combination therapy of beta-blocker and calcium channel blocker
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# caplyta

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## Products Affected

- CAPLYTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- trial, intolerance, or contraindication to one other formulary generic atypical antipsychotic (e.g. quetiapine).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# caprelsa

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## Products Affected

- CAPRELSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# carbaglu

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## Products Affected

- *carglumic acid*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use as an adjunct therapy for acute hyperammonemia due to hepatic enzyme N-acetylglutamate synthase (NAGS) deficiency, propionic acidemia (PA), or methylmalonic acidemia (MMA) -OR- maintenance therapy for chronic hyperammonemia due to hepatic enzyme N-acetylglutamate synthase (NAGS) deficiency
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

# CERDELGA

## Products Affected

- CERDELGA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of type 1 Gaucher disease confirmed by the following A. or B. A) With one of the following symptoms (1, 2, 3, 4, or, 5): 1)Hepatomegaly. 2)Splenomegaly. 3)Bone disease (i.e. osteonecrosis, osteopenia, secondary pathologic fractures, bone infarct). 4)Bone marrow complications as defined by anemia with hemoglobin less than or equal to 11.5 g/dL for females or 12.5 g/dL for males or thrombocytopenia with platelet count less than or equal to 120,000/mm <sup>3</sup> . 5)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). -OR- B) Attestation of deficiency in glucocerebrosidase activity in peripheral leukocytes or genetic testing confirms mutant alleles -AND- Documentation of CYP2D6 metabolizer status (e.g. intermediate metabolizer).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# CF drugs

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis. For Bethkis: failure on, intolerance to, or contraindication to generic tobramycin inhalation solution
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Inhalation solutions covered under Part B when administered in the home setting using a covered nebulizer (i.e. DME). For reauthorization of tobramycin products, attestation of decrease in sputum density of pseudomonas aeruginosa, increase in FEV1 or decrease in number of hospitalizations or pulmonary exacerbations. For reauthorization of Pulmozyme, attestation of increase in FEV1 or decrease in number of hospitalizations or pulmonary exacerbations.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# chloroquine

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## Products Affected

- *chloroquine phosphate oral tablet 250 mg, 500 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. If using for diagnosis of malaria prophylaxis, documentation of duration of travel is required.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Malaria tx and amebiasis: 1 month. Malaria prophylaxis: Travel duration plus 10 wks
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# cholbam

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## Products Affected

- **CHOLBAM**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of bile acid synthesis disorders due to single enzyme defects (e.g. AKR1D1, CTX, CYP7A1) -OR- documentation of use as adjunctive therapy for peroxisomal disorders (PDs), including Zellweger spectrum disorders, in patients who exhibit manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# cialis

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For brand Cialis, trial and failure of generic tadalafil is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# Cibinqo

## Products Affected

- CIBINQO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe refractory atopic dermatitis whose disease is not adequately controlled with other systemic drug products, documentation of all of the following (1-2): 1) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- atopic dermatitis of the face or anogenital involvement -OR- the member has severe atopic dermatitis evidenced by the extent of the member's body surface area affected which makes topical therapy impractical to apply -OR- severe atopic dermatitis evidenced by severely damaged skin, 2) trial & failure, intolerance, or contraindication to topical tacrolimus or topical pimecrolimus -OR- the member has severe atopic dermatitis evidenced by the extent of the member's body surface area affected which makes topical therapy impractical to apply -OR- severe atopic dermatitis evidenced by severely damaged skin.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For Atopic Dermatitis, patients must have an adequate trial/failure, intolerance, or contraindication to both preferred products: Dupixent and Rinvoq. For reauthorization, attestation of positive clinical response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## **cimzia**

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### **Products Affected**

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide). For moderate to severe Crohn's disease, inadequate response or intolerance to at least two immunosuppressants (e.g. corticosteroids, azathioprine). For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to two nonsteroidal anti-inflammatory drugs (NSAIDs). For moderate to severe psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>For Crohn's disease, patients must have an adequate trial or intolerance to both preferred biologic products, Humira and Stelara. For Rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra, Xeljanz/Xeljanz XR and Rinvoq. For plaque psoriasis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Cosentyx, Otezla, Stelara, Skyrizi and Enbrel. For ankylosing spondylitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel and Cosentyx. For Psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Cosentyx, Enbrel, Humira, Xeljanz/Xeljanz XR, Otezla, and Stelara. For initial and induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended initial and induction therapy dosing regimens per indication.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# cinryze

## Products Affected

- CINRYZE

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	

## cometriq

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### Products Affected

- COMETRIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of progressive, metastatic medullary thyroid cancer
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# copiktra

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## Products Affected

- **COPIKTRA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- if applicable to diagnosis, alternatives tried/failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# corlanor

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis AND all of the following: 1) Normal sinus rhythm. 2) Resting heart rate greater than or equal to 70 beats per minute. 3) Left ventricular ejection fraction less than or equal to 35 percent, when applicable. 4) In adult patients (greater than or equal to 18 years), trial/failure of maximum tolerated dose of one beta-blocker used for treatment of heart failure (e.g., bisoprolol, carvedilol, metoprolol succinate) OR contraindication to beta-blocker use.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For oral solution, attestation of inability to swallow tablets is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# Cosentyx

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs. For enthesitis-related arthritis, inadequate response or intolerance to at least 1 non-biologic disease modifying anti-rheumatic drugs (DMARD), or all are contraindicated.
<b>Age Restrictions</b>	Deny if less than 6 years of age for moderate to severe plaque psoriasis -OR- less than 2 years of age for psoriatic arthritis -OR- less than 4 years of age for enthesitis-related arthritis -OR- less than 18 years of age for all other indications
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# cotellic

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## Products Affected

- COTELLIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) BRAF V600E or V600K mutation status 2) Concomitant therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# crinone

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## Products Affected

- CRINONE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Use to promote fertility
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## **cystamine ophthalmic drops**

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### **Products Affected**

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cystinosis -AND- Attestation of accumulation of corneal cystine crystals
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# daraprim

## Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For primary prophylaxis of toxoplasmosis gondii infection, CD4 count less than 100 cells/mm <sup>3</sup> -AND- Toxoplasma IgG positive -AND- failure, intolerance or contraindication to trimethoprim-sulfamethoxazole. For secondary prophylaxis of toxoplasmosis gondii infection, CD4 count less than 200 cells/mm <sup>3</sup> . For secondary prophylaxis of cystoisosporiasis with CD4 count less than 200 cells/mm <sup>3</sup> or acute cystoisosporiasis infection: failure, intolerance or contraindication to trimethoprim-sulfamethoxazole. For primary prophylaxis of Pneumocystis jirovecii pneumonia: diagnosis of HIV - AND- CD4 count less than 200 cells/mm <sup>3</sup> -AND- failure, intolerance or contraindication to trimethoprim-sulfamethoxazole.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

# daurismo

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## Products Affected

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

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

# deferasirox

## Products Affected

- *deferasirox oral tablet, dispersible*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For chronic iron overload due to blood transfusions, transfusion history of greater than or equal to 100 mL/kg of packed red blood cells (i.e. at least 20 units of packed red blood cells for a 40 kg person or more in individuals weighing more than 40 kg) -And- history of serum ferritin consistently greater than 1,000 mcg/L or liver iron concentration (LIC) greater than or equal to 7 iron per gram of liver dry weight (mg Fe/g dw). For Chronic Iron Overload in Non-Transfusion-Dependent Thalassemia (NTDT) Syndrome, LIC of at least 5 mg Fe/g dw -AND- serum ferritin greater than 300 mcg/L.
<b>Age Restrictions</b>	Deny if less than 2 years of age for chronic iron overload or less than 10 years of age chronic iron overload in NTDT
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization of chronic iron overload due to blood transfusion, continued requirement for regular blood transfusions -AND- serum ferritin level greater than or equal to 500mcg/L or LIC greater than or equal to 3 mg Fe/g dw. For reauthorization of chronic iron overload in NTDT syndrome, LIC greater than or equal to 3 mg Fe/g dw.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# diacomit

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Dravets syndrome - AND- Used in combination with clobazam
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation supporting reduction in seizure frequency
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# dihydroergotamine

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## Products Affected

- *dihydroergotamine nasal*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of acute migraine headaches with or without aura -AND- requires non-oral route of administration -AND- therapeutic failure or intolerance to generic sumatriptan nasal spray.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# doptelet

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of thrombocytopenia and chronic liver disease - AND- beneficiary is scheduled to undergo a procedure -OR- Documentation of chronic immune thrombocytopenia -AND- Trial, intolerance, or inadequate response to corticosteroid therapy, immunoglobulin therapy or splenectomy -AND- One of the following (1 or 2): 1) Platelet count less than or equal to $50 \times 10^9/L$ and has significant mucous member bleeding or at least one risk factor for bleeding (e.g. hypertension, peptic ulcer disease). 2) Platelets count of less than or equal to $30 \times 10^9/L$
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	For thrombocytopenia with chronic liver disease- 1 mo. For chronic immune thrombocytopenia- 12 mo.
<b>Other Criteria</b>	Platelet count is provided for applicable dosing.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# doxepin cream

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## Products Affected

- *doxepin topical*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- course of therapy will not exceed 8 days -AND- experienced therapeutic failure, intolerance, or contraindication to one of the following (1 or 2): 1) at least 2 generic formulary topical corticosteroids. 2) generic topical tacrolimus or pimecrolimus for topic dermatitis with the facial or anogenital involvement.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# drizalma

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- inability to swallow capsules. For fibromyalgia, members must also have widespread bilateral pain above and below the waist for greater than 3 months duration -AND- At least one (1) fibromyalgia-related symptom (e.g., cognitive impairment, fatigue, sleep disturbance, neurologic symptoms, exercise intolerance).
<b>Age Restrictions</b>	Deny if less than 18 years of age in the treatment of fibromyalgia, major depressive disorder, diabetic peripheral neuropathy and chronic musculoskeletal pain -OR- if less than 7 years of age in generalized anxiety disorder
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# dupixent

## Products Affected

- **DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML**
- **DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML, 200 MG/1.14 ML, 300 MG/2 ML**

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Documentation of all of the following (1-3): 1) moderate to severe atopic dermatitis 2) trial &amp; failure, intolerance, or contraindication to at least one topical corticosteroid -OR- atopic dermatitis of the face or anogenital involvement -OR- the member has severe atopic dermatitis evidenced by a large proportion of the member's body surface area is affected making topical therapy impractical to apply -OR- severe atopic dermatitis evidenced by severely damaged skin 3) if 2 years or older: trial &amp; failure, intolerance, or contraindication to topical tacrolimus or topical pimecrolimus -OR- the member has severe atopic dermatitis evidenced by a large proportion of the member's body surface area is affected making topical therapy impractical to apply -OR- severe atopic dermatitis evidenced by severely damaged skin -OR- Documentation of the following (4-7): 4) moderate-to-severe asthma 5) documented pretreatment FEV1 less than 80 percent predicted in adults or FEV1 less than 90 percent predicted in adolescents or FEV1 reversibility of at least 12% after albuterol administration 6) Blood eosinophils greater than or equal to 150 cells/uL -OR- patient is currently taking daily or alternate-day oral corticosteroids 7) using a medium- or high-dose inhaled corticosteroid and a long acting beta agonist -OR- Documentation of the following (8-9): 8) chronic rhinosinusitis with nasal polyposis (CRSwNP) 9) trial &amp; failure, intolerance or contraindication to intra-nasal corticosteroid and 14 day course of oral corticosteroids -OR- Documentation of the following (10-13): 10) eosinophilic esophagitis 11) weight at least 40 kg 12) esophageal eosinophil count greater than or equal to 15 eos/hpf on esophageal biopsy 13) clinical symptoms of esophageal dysfunction.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For reauthorization, attestation of positive clinical response to therapy, for atopic dermatitis -OR- attestation of decreased in rescue medication or oral corticosteroid use, decrease in frequency of severe asthma exacerbation, increase in pulmonary function from baseline (e.g. FEV1) or reduction in reported asthma related symptoms, for asthma -OR- attestation of decrease in nasal polyp score or reduction in nasal congestion/obstruction severity score, for CRSwNP -OR- attestation of histological remission (less than 15 eos/hpf) on esophageal biopsy or reduced severity or frequency of clinical symptoms of esophageal dysfunction, for EoE
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## egfr tyrosine kinase inhibitors

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### Products Affected

- *erlotinib*
- **EXKIVITY**
- **GILOTRIF**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Afatinib products: tumors with resistant EGFR mutations. Erlotinib products: use in NSCLC tumors with mutations other than those in FDA-approved indications. Use in combination with platinum based chemotherapy.
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis 1) Epidermal growth factor receptor (EGFR) mutations, including exon 19 deletions or exon 21 (L858R) substitution mutations 2) Alternatives tried/failed 3) Concomitant therapy 4) Line of therapy in which medication will be used
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# egrifta

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## Products Affected

- EGRIFTA SV

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# emflaza

## Products Affected

- EMFLAZA

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

# emgality

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes. For episodic cluster headaches, characterized by severe or very severe unilateral orbital, supraorbital, and/or temporal pain lasting 15 to 180 minutes when left untreated -AND- Attack frequency of at least one attack every other day during the cluster period.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For reauthorization, attestation of reduction in average monthly migraine days or number of migraine episodes is required -OR- attestation of reduction in the number of mean weekly cluster headaches from baseline is required.
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	

# enbrel

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Rheumatoid Arthritis, Psoriatic Arthritis and Ankylosing Spondylitis or less than 2 years of age for Juvenile Idiopathic Arthritis or Less than 4 years of age for Plaque Psoriasis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# endari

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## Products Affected

- **ENDARI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Sickle Cell Disease with 2 or more sickle cell acute complications (e.g. vaso-occlusive crisis, acute anemia, acute chest syndrome, etc.) -AND-documentation of previous trial of hydroxyurea or plans of continued therapy while taking Endari
<b>Age Restrictions</b>	Deny if less than 5 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of stability in sickle cell acute complications or decrease in number of sickle cell acute complications is required (e.g. vaso-occlusive crisis, acute anemia, acute chest syndrome, etc.)
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# enspryng

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## Products Affected

- ENSPRYNG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of neuromyelitis optica spectrum disorder (NMOSD) - AND- Attestation of anti-aquaporin-4 (AQP4) antibody positive -AND- Not used in combination with another monoclonal antibody used for the treatment of NMOSD.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of decrease in number of NMOSD relapses. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# epclusa

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 3 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# epidiolex

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## Products Affected

- EPIDIOLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Lennox-Gastaut, Dravet syndromes or Tuberous Sclerosis Complex. For Lennox-Gastaut, trial and failure or intolerance of at least two standard of care treatments (e.g. lamotrigine, clobazam). For Lennox-Gastaut and Dravet syndromes, treatment is in combination with other conventional agents.
<b>Age Restrictions</b>	Deny if less than 1 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation supporting reduction in seizure frequency
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# Eprontia

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## Products Affected

- **EPRONTIA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- inability to swallow pills or food. For migraine, therapeutic failure, intolerance, or contraindication to two generic preventive migraine therapies. For partial onset seizures, primary generalized tonic-clonic seizures, or adjunctive treatment of Lennox-Gastaut Syndrome, therapeutic failure, contraindication, or intolerance to two generic anti-epileptic drugs.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# erivedge

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## Products Affected

- ERIVEDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of advanced basal cell carcinoma (BCC), which includes metastatic -OR- locally advanced basal cell carcinoma, for whom surgery is inappropriate or in whom recurrence after surgery is documented - AND- is not a candidate for radiation
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# erleada

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## Products Affected

- ERLEADA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- the member meets one of the following (1 or 2) 1. Documentation of use in combination with a GnRH analog -OR- 2. The member has had a bilateral orchiectomy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# evenity

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- Postmenopausal woman at high risk for fracture, meeting one of the following (1. thru 3.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Covered under Part B for patients eligible for home health services when provider certifies that patient sustained bone fracture related to post-menopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug. A cumulative lifetime approval of romosozumab will be limited to a coverage duration of 12 months.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# evrysdi

## Products Affected

- EVRYSDI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of spinal muscular atrophy -AND- Baseline motor function test results (e.g. MFM, CHOP, HINE, RULM, HFMSE, 6MWT) -AND- Not using concomitantly with Spinraza -AND- Molecular genetic testing of 5q SMA showing Homozygous gene deletion, Homozygous conversion mutation or Compound heterozygote
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	For reauthorization, attestation of stable or clinically significant improvement in Spinal Muscular Atrophy associated symptoms (e.g. stabilization or decreased decline in motor function compared to the predicted natural history trajectory of disease) -OR- Stable or improved motor function results compared to baseline (e.g. MFM, CHOP, HINE, RULM, HFMSE, 6MWT).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Exservan

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## Products Affected

- **EXSERVAN**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of amyotrophic lateral sclerosis (ALS) -AND- Inability to swallow tablets.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of stability or improvement in symptoms of ALS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# fasenra

## Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of severe asthma -AND- history of at least one asthma exacerbations requiring oral or systemic corticosteroid treatment in the past 12 months -AND- documented pretreatment FEV1 less than 80 percent predicted in adults or FEV1 less than 90 percent predicted in adolescents or FEV1 reversibility of at least 12% after albuterol administration 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
<b>Age Restrictions</b>	Deny if less than 12 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Blood eosinophil count (in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection) greater than or equal to 150 cells/microliter within 6 weeks of initiation of therapy. For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ferriprox

## Products Affected

- *deferiprone*
- **FERRIPROX ORAL SOLUTION**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of transfusional iron overload due to thalassemia syndromes, sickle cell disease and other anemias -AND- transfusion history of greater than or equal to 100 mL/kg of packed red blood cells (i.e. at least 20 units of packed red blood cells for a 40 kg person or more in individuals weighing more than 40 kg) -AND- history of serum ferritin consistently greater than 1,000 mcg/L or liver iron concentration (LIC) greater than or equal to 7 iron per gram of liver dry weight (mg Fe/g dw)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Trial and failure of deferasirox (generic Exjade) is required. For reauthorization, continued requirement for regular blood transfusions - AND- serum ferritin level greater than or equal to 500mcg/L or LIC greater than or equal to 3 mg Fe/g dw
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	



# fetzima

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of major depressive disorder and trial and failure of two other antidepressants.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# fintepla

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## Products Affected

- FINTEPLA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Dravet syndrome or Lennox-Gastaut syndrome. For Lennox-Gastaut syndrome, therapeutic failure, contraindication, or intolerance to at least 2 standard of care treatments (e.g. lamotrigine, clobazam).
<b>Age Restrictions</b>	Deny if less than 2 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# firazyr

## Products Affected

- *icatibant*
- SAJAZIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Member should not be on two acute therapies simultaneously and acute therapy should not be used as prophylactic therapy
<b>Required Medical Information</b>	For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type I & II with the following (1-3): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type III with the following (4-7): 4) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 5) Documentation of family history of HAE or FXII mutation 6) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 7) Medications known to cause angioedema have been evaluated and discontinued.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# firdapse

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## Products Affected

- **FIRDAPSE**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of positive clinical response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# flector

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## Products Affected

- *diclofenac epolamine*
- **FLECTOR**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis AND one of the following (1,2 or 3): 1) trial/failure, intolerance, or contraindication to 2 oral generic NSAIDs one of which must be diclofenac 2) hypersensitivity to oral NSAIDs 3) history or high risk for adverse gastrointestinal effects associated with oral NSAID use.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# forteo

## Products Affected

- **FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (600MCG/2.4ML)**
- *teriparatide*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- at high risk for fracture, meeting one of the following (1. thru 4.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 40 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	Documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Additional documentation of trial/failure, intolerance or contraindication to preferred parathyroid hormone analog Tymlos is required for applicable indication. Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Forteo/teriparatide will be limited to a coverage duration of 24 months in the absence of provider attestation that the member remains at or has returned to having a high risk for fracture
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Fotivda

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## Products Affected

- FOTIVDA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- if applicable to diagnosis, previous therapies tried/failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# **gabapentin**

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## **Products Affected**

- *gabapentin oral capsule 100 mg, 300 mg, 400 mg*
- *gabapentin oral solution 250 mg/5 ml*
- *gabapentin oral tablet 600 mg, 800 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# galafold

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## Products Affected

- GALAFOLD

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Fabry disease confirmed by biochemical or genetic test -AND- Presence of an amenable GLA variant causing Fabry disease in the clinical context of the patient -AND- Will not be used concomitantly with enzyme replacement therapy (ERT) e.g. Fabrazyme.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of positive clinical response to therapy - AND- Will not be used concomitantly with enzyme replacement therapy (ERT) e.g. Fabrazyme.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# **gattex**

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## **Products Affected**

- **GATTEX 30-VIAL**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of short bowel syndrome (SBS) having less than 200 cm of functional small bowel AND if age 18 and older, dependence on parenteral nutrition or intravenous nutritional support for at least 12 months AND requiring parenteral nutrition at least 3 times per week -OR- Documentation of SBS having less than 200 cm of functional small bowel AND age 1 to 17 years of age AND Dependence on parenteral nutrition AND weight of at least 10 kg.
<b>Age Restrictions</b>	Deny if less than 1 year of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, continued dependence on parenteral nutrition/intravenous nutritional support -AND- attestation of increase in weight from baseline or decrease in intravenous parenteral nutrition requirements from baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## **gavreto**

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### **Products Affected**

- **GAVRETO**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis 1) RET mutant or fusion status 2) Radioactive iodine-refractory (if radioactive iodine is appropriate)
<b>Age Restrictions</b>	Deny if less than 18 years of age for NSCLC or less than 12 years of age for thyroid cancer
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# gilenya

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## Products Affected

- *fingolimod*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of Gilenya and other disease modifying agents such as interferons, Copaxone, Tysabri
<b>Required Medical Information</b>	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# gleevec

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## Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis and all of the following, if applicable to diagnosis 1) Alternatives tried 2) Concomitant therapy 3) mutation status, if applicable to diagnosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# grastek

## Products Affected

- **GRASTEK**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy
<b>Required Medical Information</b>	Documentation of allergic rhinitis and use for Timothy grass pollen or cross reactive grass pollens (Sweet Vernal, Orchard, Perennial Rye, Timothy, Kentucky Blue Grass pollen, Redtop, or meadow fescue) -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
<b>Age Restrictions</b>	Deny if less than 5 years of age or greater than 65 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Member must also be prescribed an epinephrine auto injector. For reauthorization, attestation of improved allergy symptoms is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# growth hormone

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## Products Affected

- **NORDITROPIN FLEXPRO**
- **OMNITROPE**
- **ZOMACTON**
- **ZORBTIVE**

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

# haegarda

## Products Affected

- HAEGARDA

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



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	

# HARVONI

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## Products Affected

- **HARVONI ORAL PELLETS IN PACKET**
- **HARVONI ORAL TABLET 90-400 MG**
- *ledipasvir-sofosbuvir*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 3 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# HETLIOZ

## Products Affected

- HETLIOZ

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

# Hetlioz LQ

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## Products Affected

- HETLIOZ LQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Smith-Magenis Syndrome as confirmed by chromosome analysis -AND- patient is experiencing nighttime sleep disturbances (e.g. difficulty falling asleep, shortened sleep cycles, inability to enter REM sleep, or frequent awaking during the night and early in the morning)
<b>Age Restrictions</b>	Deny if less than 3 or greater than 15 years of age.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of positive clinical response to therapy with minimal side effects for Smith-Magenis Syndrome -AND- member is between 3 and 15 years of age
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# high-risk meds

## Products Affected

- *amitriptyline*
- *benztropine oral*
- *clomipramine*
- *cyclobenzaprine oral tablet 10 mg, 5 mg*
- *cypheptadine*
- *doxepin oral capsule*
- *doxepin oral concentrate*
- *doxepin oral tablet*
- *ergotamine-caffeine*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *imipramine hcl*
- *trimipramine*

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

# High-risk meds phenobarbital

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## Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Coverage is not provided for use in sedation/insomnia
<b>Required Medical Information</b>	For use in seizures the following are required: 1. Explanation of risk-benefit profile favoring use of the high-risk medication 2. Attestation of an intent to monitor and address treatment-related adverse events. 3. For new starts, the trial and failure or documentation of intolerance or contraindication to at least 2 non-high risk alternative drugs used for seizures (e.g. carbamazepine, lamotrigine) is required.
<b>Age Restrictions</b>	Automatic approval if less than 65 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off Label Uses</b>	Seizure disorders

# homozygous fh

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of homozygous familial hypercholesterolemia (HoFH) supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene -OR- untreated LDL-C greater than 400mg/dL or TC greater than 500mg/dl with cutaneous or tendon xanthoma before age 10 yrs or HeFH in both parents -AND- The member has a current LDL-C greater than 100mg/dL despite use of maximally tolerated statin OR statin intolerance -AND- The member will continue to receive concurrent lipid-lowering therapies for the treatment of HoFH
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Patients must have an adequate trial/failure or contraindication to the preferred product Repatha. For reauthorization, documentation showing an LDL-C reduction on Juxtapid therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# humira

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For uveitis, inadequate response or intolerance to 2 immunosuppressants.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, and Ankylosing Spondylitis or less than 12 years of age for Hidradenitis Suppurative or Less than 6 years of age for Crohn's disease or Less than 5 years of age for Ulcerative Colitis or less than 2 years of age for Juvenile Idiopathic Arthritis and Uveitis
Prescriber Restrictions	
Coverage Duration	12 months



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>For Crohn's disease in adults (18 years or older), trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine) or monotherapy with infliximab is required. For Crohn's disease in pediatrics, trial of 1 immunosuppressant (e.g. corticosteroids, azathioprine) or monotherapy with infliximab is required. For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis therapy without concomitant methotrexate, doses above plan quantity limit will be approved aligned with recommended weekly dosing regimen. For pediatric ulcerative colitis and hidradenitis suppurativa, doses above plan quantity limit will be approved to align with recommended dosing regimen. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Ibrance

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## Products Affected

- **IBRANCE**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of HR-positive, HER2-negative advanced or metastatic breast cancer -AND- meets one of the following (1 or 2): 1) documentation of use with an aromatase inhibitor as initial endocrine-based therapy in postmenopausal women or men -OR- 2) documentation of use with fulvestrant in patients with disease progression following endocrine therapy.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Ibsrela

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## Products Affected

- **IBSRELA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of irritable bowel syndrome with constipation -AND- failure or intolerance to Linzess -AND- if member is female, failure or intolerance to lubiprostone.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# iclusig

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## Products Affected

- ICLUSIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Treatment of newly-diagnosed chronic phase CML
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) Philadelphia chromosome status 2) T315I status 3) Alternatives tried/failed 4) Candidacy for other tyrosine kinase inhibitor therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# idhifa

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA approved test
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

**Products Affected**

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Documentation of diagnosis. For select diagnoses the following apply- 1) For Myasthenia Gravis Syndrome, documentation that the patient is refractory to other standard therapies (e.g., cholinesterase inhibitors, corticosteroids, azathioprine) given in therapeutic doses over at least 3 months OR is intolerant of/has a contraindication to those standard therapies. 2) For Multiple Sclerosis, patient is refractory to other standard therapies (e.g., interferons) given in therapeutic doses over at least 3 months OR is intolerant of/has a contraindication to those standard therapies. 3) For Inflammatory Myopathies, the patient is refractory to corticosteroids given in therapeutic doses over at least 4 months OR is intolerant of/has a contraindication to corticosteroids or immunosuppressants. 4) For CLL with Associated Hypogammaglobulinemia, IgG level less than 600mg/dL or evidence of a specific antibody deficiency or recurrent bacterial infections. 5) For Bone Marrow Transplantation, the member is 20 years of age or older and within the first 100 days after transplantation. 6) For Dermatomyositis/Polymyositis, trial and failure, intolerance, or contraindication to standard first line therapy (i.e. corticosteroids or immunosuppressants). 7) For Pediatric HIV, the patient is less than 13 y.o. who have entry CD4 lymphocyte count greater than or equal to 200/mm<sup>3</sup> and IgG less than 400mg/dL OR recurrent bacterial infections. 8) For Guillain-Barre syndrome, impaired function by objective assessment and/or objective findings on physical exam at the time of initial therapy and IVIG therapy must be initiated within 2 weeks of symptom onset. 9) For Autoimmune Mucocutaneous Blistering Diseases (e.g. Stevens-Johnson Syndrome), trial and failure, intolerance, or contraindication to conventional therapy (e.g. corticosteroids) or the patient has rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents.</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Covered under Part B when administered in the home to a member with a diagnosis of primary immunodeficiency disease
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off Label Uses</b>	Myasthenia Gravis syndrome, Multiple Sclerosis, Inflammatory Myopathies, Polymyositis, Dermatomyositis, Bone Marrow Transplant, Pediatric HIV, Guillain-Barre syndrome, Autoimmune Mucocutaneous Blistering Diseases

# imbruvica

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) 17p deletion status 2) Alternatives tried/failed 3) concomitant therapy. For suspension, members must also have an inability to swallow oral tablets or oral capsules.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# inbrija

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use for the treatment of intermittent off episodes of Parkinson's disease while on carbidopa/levodopa
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of positive clinical response
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# increlex

## Products Affected

- INCRELEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of severe primary IGF-1 deficiency and all of the following: 1) Normal or elevated response (greater than 10 ng/ml) to two (2) of the following standard growth hormone stimulation tests: arginine, clonidine, glucagon, insulin, levodopa, propranolol. 2) Serum IGF-1 concentration that is less than or equal to three (3) standard deviations below the normal value based on laboratory reference range. 3) Height less than or equal to three (3) standard deviations below normal (at or below the third percentile for gender and age). 4) If female, bone age less than or equal to 14 years. If male, bone age less than or equal to 16. - OR- Documentation of diagnosis of growth hormone deficiency caused by gene deletion and all of the following: 1) Growth velocity at least 2 standard deviations below the age-appropriate mean or height at least 2.25 standard deviations below the age-appropriate mean. 2) Subnormal response (less than 10 ng/mL) to two (2) of the following standard growth hormone stimulation tests: arginine, clonidine, glucagon, insulin, levodopa, propranolol. 3) Development of neutralizing antibodies to growth hormone product(s). 4) If female, bone age of less than or equal to 14 years. If male, bone age less than or equal to 16.
<b>Age Restrictions</b>	Deny if greater than 17 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of growth velocity and bone age, as applicable to meet standard continuation of therapy guidelines
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ingrezza

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## Products Affected

- **INGREZZA INITIATION PACK**
- **INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of tardive dyskinesia
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# inlyta

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## Products Affected

- INLYTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) Alternatives tried/failed 2) Concomitant therapy 3) Line of therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# inqovi

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## Products Affected

- INQOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation chronic myelomonocytic leukemia. Documentation of de novo or secondary myelodysplastic syndrome -AND- One of the following (1 or 2): 1) French American-British MDS subtypes of refractory anemia, refractory anemia with ringed sideroblasts or refractory anemia with excess blasts. 2) International Prognostic Scoring System group of intermediate-1, intermediate-2 or high-risk.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# inrebic

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## Products Affected

- **INREBIC**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of intermediate-2 or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis per an accepted risk stratification tool for myelofibrosis (e.g., International Prognostic Scoring System [IPSS]) -AND- If a new start, baseline platelet count of greater than $50 \times 10^9/L$
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Baseline platelet count to be provided.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# interferon alfa

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## Products Affected

- **INTRON A INJECTION RECON SOLN  
10 MILLION UNIT (1 ML), 50 MILLION  
UNIT (1 ML)**
- **PEGASYS**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# interleukin-1b blockers

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## Products Affected

- ARCALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For Deficiency of Interleukin-1 Receptor Antagonist (DIRA), documentation of need for maintenance of remission. For Recurrent Pericarditis (RP), documentation of trial/failure or intolerance to one, or contraindication to all of the following: oral nonsteroidal anti-inflammatory drug (NSAID), systemic corticosteroid, or colchicine.
<b>Age Restrictions</b>	Deny if less than 12 years of age for Recurrent Pericarditis and Cryopyrin-Associated Periodic Syndromes
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For DIRA: patient must weigh 10kg or more
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# IPF AGENTS

## Products Affected

- **ESBRIET ORAL CAPSULE**
  - **ESBRIET ORAL TABLET 267 MG, 801 MG**
  - **OFEV**
- *pirfenidone oral tablet 267 mg, 801 mg*

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	

# iressa

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## Products Affected

- **IRESSA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Use in tumors with EGFR mutations other than exon 19 deletions or exon 21 (L858R) substitution mutations.
<b>Required Medical Information</b>	Documentation of diagnosis -AND- the following: 1) EGFR exon 19 deletion mutations or exon 21 (L858R) mutations as detected by an FDA-approved test
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# isturisa

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## Products Affected

- **ISTURISA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Cushing's disease AND patient is not a candidate for pituitary surgery or surgery has not been curative
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of mean urine free cortisol (mUFC) less than starting baseline value.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# itraconazole

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## Products Affected

- *itraconazole*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Onychomycosis: 3 months. All other indications: 3 months initial, 12 months reauth
<b>Other Criteria</b>	Documentation of trial/failure or intolerance of amphotericin b must be provided for approval in patients with aspergillosis.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# jakafi

## Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis per an accepted risk stratification tool for myelofibrosis (e.g., International Prognostic Scoring System [IPSS]) and if a new start, baseline platelet count of greater than $50 \times 10^9/L$ -OR- documentation of polycythemia vera and inadequate response or intolerance to hydroxyurea -OR- Documentation of steroid refractory acute graft-versus-host disease and prior therapy with at least one systemic corticosteroid -OR- Documentation of chronic graft-versus-host disease with prior failure of at least one systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Baseline platelet count to be provided.
Indications	All FDA-approved Indications.
Off Label Uses	

# jynarque

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## Products Affected

- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of rapidly progressing autosomal dominant polycystic kidney disease defined by one of the following: 1.) Historical decline in eGFR greater than or equal to 5mL/min/1.73 m*2 within a 12 month period. 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	For reauthorization, prescriber attestation of slowed decline of kidney function
Indications	All FDA-approved Indications.
Off Label Uses	

# kalydeco

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	Granules- Deny if less than 4 months or greater than 5 years of age. Tablets- Deny if less than 6 years of age.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# kesimpta

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## Products Affected

- **KESIMPTA PEN**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# kevzara

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## Products Affected

- **KEVZARA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For rheumatoid arthritis, patients must have an adequate trial or intolerance to two of the following preferred products Humira, Enbrel, Actemra, Xeljanz/Xeljanz XR and Rinvoq.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# kineret

## Products Affected

- **KINERET**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For Deficiency of Interleukin-1 Receptor Antagonist (DIRA), therapeutic failure or intolerance to at least one (1) corticosteroid, or all corticosteroids are contraindicated.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Rheumatoid Arthritis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra, Rinvoq and Xeljanz/Xeljanz XR.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# kisqali

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## 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)**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following. 1) HR mutation status and HER2 mutation status 2) Alternatives tried/failed 3) Concomitant therapy, if applicable to diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# klisyri

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## Products Affected

- **KLISYRI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of actinic keratosis of the face or scalp -AND- Therapeutic failure or intolerance to 2 of the following 1) generic imiquimod 5% cream 2) fluorouracil 5% topical cream 3) fluorouracil topical solution
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# korlym

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## Products Affected

- **KORLYM**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hyperglycemia secondary to hypercortisolism in patients with endogenous Cushing's syndrome -AND- Patient is not a candidate for surgery or where surgery has failed -AND- one of the following (1 or 2): 1) Diagnosis of diabetes with trial and failure, intolerance, or contraindication to one previous therapy for Type 2 Diabetes (e.g. metformin, sulfonylureas, insulin) or using in addition to a therapy for Type 2 diabetes. 2) Glucose intolerance
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# koselugo

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## Products Affected

- **KOSELUGO ORAL CAPSULE 10 MG, 25 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- for neurofibromatosis type 1 (NF1), documentation of symptomatic, inoperable plexiform neurofibromas (PN)
<b>Age Restrictions</b>	Deny if less than 2 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# kuvan

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## Products Affected

- **JAVYGTOR ORAL POWDER IN PACKET 100 MG**
- *sapropterin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of PKU -AND- documented baseline Phe level greater than 6 mg/dL -AND- clinical documentation of current weight -AND- sapropterin dihydrochloride dose does not exceed 20 mg/kg/day
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, initial therapy has resulted in decrease in phenylalanine levels from baseline or current phenylalanine levels within the range of 120-360 micromol/L -AND- clinical documentation of current weight is required -AND- sapropterin dihydrochloride dose does not exceed 20 mg/kg/day.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# kynmobi

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## Products Affected

- **KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Parkinson's disease -AND- for use in acute, intermittent treatment of hypomobility off episodes -AND- experiencing off episodes despite the use of oral carbidopa/levodopa -AND- Therapeutic failure, intolerance, or contraindication to the following (1. and 2.): 1) a generic pramipexole containing product or a generic ropinirole containing product. 2) generic entacapone, selegiline or rasagiline.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# latuda

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. If medication is being used for bipolar 1 disorder, documentation of trial and failure or intolerance to one other formulary medication indicated in bipolar 1 disorder (e.g. quetiapine)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# lenvima

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## Products Affected

- LENVIMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following if applicable to diagnosis: 1) Radioactive iodine refractory status 2) Microsatellite instability-high status or mismatch repair deficient status 3) Alternatives tried/failed or attestation of first line use 4) Concomitant therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# leukine

## Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis: following induction chemotherapy in patients who are 55 years or older with acute myelogenous leukemia (AML) -OR- mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis and autologous transplantation -OR- acceleration of myeloid reconstitution following autologous bone marrow or peripheral blood progenitor cell transplantation -OR- acceleration of myeloid reconstitution following allogeneic BMT -OR- treatment of delayed neutrophil recovery or graft failure after autologous or allogeneic BMT -OR- following acute exposure to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS]).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# lidoderm

## Products Affected

- *lidocaine topical adhesive patch, medicated 5 %*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of postherpetic neuralgia (PHN) -AND- trial and failure of 1 other agent used to treat PHN (e.g. gabapentin), inability to swallow oral medication or unable to take an oral medication due to potential adverse events (e.g. sedation) -OR- documentation of diabetic peripheral neuropathy (DPN) -AND- trial and failure of one other agent used to treat DPN (e.g. duloxetine), inability to swallow oral medication or unable to take an oral medication due to potential adverse events (e.g. sedation)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off Label Uses</b>	diabetic peripheral neuropathy

# Livtencity

## Products Affected

- LIVTENCITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Diagnosis of CMV prophylaxis.
<b>Required Medical Information</b>	Documentation of refractory cytomegalovirus infection or disease as evidenced by antigenemia or polymerase chain reaction (PCR) test -AND- all of the following (1-3): 1) member weighs at least 35 kg, 2) member is a recipient of hematopoietic stem cell transplant -OR- solid organ transplant. 3) member has experienced therapeutic failure to one of the following: ganciclovir, valganciclovir, cidofovir, or foscarnet.
<b>Age Restrictions</b>	Deny if less than 12 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	For reauthorization, attestation of a previous reduction in CMV DNA level -AND- documentation of one of the following (1-2): 1) new onset symptomatic CMV infection -OR- 2) virologic relapse with treatment-emergent maribavir resistance.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Lokelma

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## Products Affected

- LOKELMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hyperkalemia as defined by serum potassium level between 5.1 and 7.4 mmol/L on at least two (2) screenings -AND- Modification of medications to reduce serum potassium levels were not successful, when applicable
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of reduction in serum potassium levels following Lokelma administration and continued treatment for hyperkalemia is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Ionsurf

## Products Affected

- LONSURF

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic colorectal cancer in patients who have previously been treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy -OR- documentation of metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least two prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# lorbrena

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of ALK-positive metastatic non-small cell lung cancer (NSCLC)
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Iotronex

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## Products Affected

- *alosetron oral tablet 0.5 mg, 1 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	For irritable bowel syndrome (IBS): Exclude if male gender
<b>Required Medical Information</b>	Documentation of chronic severe diarrhea-predominant IBS -AND- trial & failure, intolerance, or contraindication to a generic anti-diarrheal agent (e.g. loperamide)
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initial: 12 weeks. Reauth: 6 months
<b>Other Criteria</b>	For reauthorization, attestation that symptoms of IBS continue to persist AND positive clinical response.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Lumakras

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## Products Affected

- LUMAKRAS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis and all of the following, if applicable to diagnosis 1) KRAS G12C mutation status, as detected by an FDA-approved test 2) Alternatives tried
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# lupkynis

## Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of active lupus nephritis -AND- Concurrent systemic lupus erythematosus documented by positive ANA titer (greater than or equal to 1:80) or anti-dsDNA greater than or equal to 30 IU/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 corticosteroids (e.g. prednisone) and mycophenolate mofetil.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 weeks initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of disease stability or disease improvement
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Lybalvi

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## Products Affected

- LYBALVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of schizophrenia or bipolar I disorder -AND- One of the following (1 or 2): 1) Therapeutic failure, intolerance or contraindication to generic risperidone and generic quetiapine 2) Currently stable and responding to olanzapine but experiencing weight gain from the medication
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# lynparza

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## Products Affected

- LYNPARZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) BRCA mutations 2) Genomic instability status 3) Homologous recombinant repair gene mutations 4) HER2 status 5) Alternatives tried/failed 6) Concomitant therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# lyrica

## Products Affected

- *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg*
- *pregabalin oral solution*
- *pregabalin oral tablet extended release 24 hr*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For immediate release and controlled release tablets, documentation of DPN and trial/failure or intolerance to duloxetine -OR- PHN and trial/failure or intolerance to gabapentin. For immediate release capsules, documentation of seizures and trial/failure or intolerance to two AEDS - OR- neuropathic pain associated with spinal cord injury -OR- documentation to support a diagnosis of fibromyalgia and trial/failure or intolerance to duloxetine. When using pregabalin products concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# mavenclad

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use of Mavenclad and other disease modifying agents such as interferons, Copaxone, Tysabri. Treatment duration greater than 24 months.
<b>Required Medical Information</b>	Documentation of diagnosis of relapse-remitting multiples sclerosis or active secondary progressive disease -AND- therapeutic failure or intolerance to one other disease modifying therapy (e.g. Avonex, Gilenya, Copaxone)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	Coverage beyond 24 months will not be approved.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# mavyret

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## Products Affected

- MAVYRET ORAL PELLETS IN PACKET
- MAVYRET ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 3 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# mayzent

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use of Mayzent and other disease modifying agents such as interferons, Copaxone, Tysabri.
<b>Required Medical Information</b>	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- Testing for CYP2C9 variants has confirmed member does not have CYP2C9*3/*3 genotype
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# megace

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# mekinist

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## Products Affected

- MEKINIST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# mektovi

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## Products Affected

- MEKTOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) BRAF mutation status 2) Concomitant therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# mulpleta

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## Products Affected

- **MULPLETA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of thrombocytopenia and chronic liver disease - AND- beneficiary is scheduled to undergo a procedure -AND- trial and failure or intolerance to Doptelet
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# myalept

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## Products Affected

- MYALEPT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of congenital or acquired generalized lipodystrophy - AND- Leptin levels less than 8 ng/mL for males or less than 12 ng/mL for females -AND- the member has a diagnosis of diabetes or fasting insulin levels greater than 30uU/mL or fasting hypertriglyceridemia greater than 200mg/dL -AND- Therapeutic failure to one previous diabetes therapy (e.g. metformin, insulin) or hypertriglyceridemia therapy (e.g. statin, fibrate)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, decrease in HbA1c from baseline, decrease in fasting plasma glucose from baseline or decrease in fasting triglycerides from baseline
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## mycapssa

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### Products Affected

- MYCAPSSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of acromegaly -AND- High pretreatment insulin-like growth factor-1 (IGF-1) based on laboratory reference range -AND- Previous response to and tolerated treatment with octreotide or lanreotide.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of decreased or normalized IGF-1 from baseline
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# Myfembree

## Products Affected

- MYFEMBREE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Diagnosis of severe hepatic impairment or osteoporosis.
<b>Required Medical Information</b>	Documentation of Diagnosis. For premenopausal woman with uterine leiomyomas, experiencing heavy menstrual bleeding -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist in combination with estrogen and progestin does not exceed 24 months. For moderate to severe pain associated with endometriosis in premenopausal woman, if the patient is a female of childbearing age, the patient is not pregnant - AND - Therapeutic failure, contraindication, or intolerance to 2 standard of care treatments (i.e. generic NSAID, combined hormonal contraceptive, progestin, GnRH agonist) -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist in combination with estrogen and progestin does not exceed 24 months
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 18 months reauthorization
<b>Other Criteria</b>	For reauthorization of uterine leiomyomas, attestation of continued experience of heavy menstrual bleeding -AND- Attestation of decrease in menstrual blood loss -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist in combination with estrogen and progestin does not exceed 24 months. For reauthorization of endometriosis, continued pain associated with endometriosis -AND- attestation of reduction in pain -AND- For women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist in combination with estrogen and progestin does not exceed 24 months
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	

## **namzarin**

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### **Products Affected**

- **NAMZARIC**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis and trial/failure of generic memantine and generic donepezil
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# natpara

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## Products Affected

- NATPARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use as an adjunct to control hypocalcemia in patients with hypoparathyroidism -AND- Serum calcium concentration is greater than 7.5mg/dL -AND- Attestation of sufficient 25-hydroxyvitamin D stores
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, total serum calcium level is greater than 7.5 mg/dL and less than or equal to 10.6 mg/dL
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# nayzilam

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## Products Affected

- NAYZILAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of seizure clusters or acute repetitive seizures -AND- Therapeutic failure, contraindication or intolerance to generic diazepam rectal gel delivery system
<b>Age Restrictions</b>	Deny if less than 12 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# nerlynx

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## Products Affected

- **NERLYNX**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following. 1) HER2 mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## nexavar

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### Products Affected

- *sorafenib*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For locally recurrent or metastatic, progressive, differentiated thyroid carcinoma, refractory to radioactive iodine treatment
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# nexletol

## Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>1.HeFH supported by presence of causal mutation of FH by genetic testing OR untreated LDL-C greater than or equal to 190 mg/dL or untreated LDL-C greater than or equal to 160 mg/dL before 20 years of age with physical signs of FH (e.g. xanthomas, xanthelasma) OR diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or definite Simon Broome register criteria, or definite on the Make Early Diagnosis to Prevent Early Deaths tool AND LDL-C greater than 100 mg/dL despite use of maximally tolerated statin or statin intolerance AND therapeutic failure, intolerance or contraindication to ezetimibe AND must be used with maximally tolerated statin dose or documentation of statin intolerance.</p> <p>2.Hypercholesterolemia ASCVD AND LDL-C greater than 70 mg/dL despite use of maximally tolerated statin or statin intolerance AND therapeutic failure, intolerance or contraindication to ezetimibe AND must be used with maximally tolerated statin dose or documentation of statin intolerance.</p>
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	For reauthorization, documentation showing an LDL-C reduction from baseline AND attestation of continued use of Nexletol or Nexlizet with a maximally tolerated statin, unless statin intolerant. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statin which resolved upon discontinuation of statin or documentation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ninlaro

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## Products Affected

- NINLARO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of multiple myeloma -AND- previous treatment with at least 1 prior therapy -AND- used in combination with lenalidomide and dexamethasone
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# NORTHERA

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## Products Affected

- *droxidopa*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of neurogenic orthostatic hypotension caused by primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency or non-diabetic autonomic neuropathy -AND- Documentation of inadequate response, intolerance or contraindication to preferred generic alternative midodrine.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# nourianz

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## Products Affected

- NOURIANZ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Parkinson's disease experiencing off episodes -AND- trial/failure, contraindication or intolerance to two (2) of the following generic products: ropinirole, pramipexole, entacapone, selegiline, or rasagiline -AND- Used as adjunct to levodopa/carbidopa.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# nubeqa

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## Products Affected

- NUBEQA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following if applicable to diagnosis: 1. Concomitant therapy 2. History of a bilateral orchiectomy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# nucala

## Products Affected

- NUCALA SUBCUTANEOUS AUTO-INJECTOR
- NUCALA SUBCUTANEOUS RECON SOLN
- NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Documentation of diagnosis of severe asthma evidenced by pretreatment FEV1 less than 80 percent predicted in adults or FEV1 less than 90 percent predicted in adolescents or FEV1 reversibility of at least 12% after albuterol administration -AND- 1.) A history of 2 or more exacerbations in the previous year or inadequate symptom control with inhaled corticosteroid in combination with 3 months of controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline), unless intolerant of or contraindication to all agents -AND- 2 or 3. 2) Greater than or equal to 150 cells/uL screening within 6 weeks of dosing. 3) Greater than or equal to 300 cells/uL within 12 months of screening. -OR- Documentation of eosinophilic granulomatosis with polyangitis (EGPA) in patients who have a history of relapsing or refractory disease and will be receiving concomitant glucocorticoid treatment with or without immunosuppressive therapy -OR- Documentation of hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause for greater than or equal to 6 months -AND- At least 2 HES flares (HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy) within the past 12 months -AND- Stable on HES therapy for at least 4 weeks (chronic or episodic oral corticosteroids, immunosuppressive or cytotoxic therapy) -OR- Documentation of chronic rhinosinusitis with nasal polyps (CRSwNP) and trial/failure, contraindication, or intolerance to an intranasal corticosteroid.</p>
<b>Age Restrictions</b>	Deny if less than 6 years old for asthma or less than 12 years old for hypereosiniphilic syndrome
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# nuedexta

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## Products Affected

- NUEDEXTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation supporting improvement in symptoms is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# nuplazid

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## Products Affected

- NUPLAZID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hallucinations and delusions associated with Parkinson's disease psychosis
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# nuvigil

## Products Affected

- *armodafinil*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of shift work sleep disorder (SWSD) as defined by a minimum of 5 night shifts per month and the shift is 6 to 12 hours in duration occurring between 10pm and 8am. Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range - OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography as established in accordance with ICSD or DSM V criteria acceptable for all indications
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, provider attestation of improvement in daytime sleepiness is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ocaliva

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## Products Affected

- OCALIVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# octreotide

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## Products Affected

- *octreotide acetate injection solution*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For acromegaly, high pretreatment insulin-like growth factor-1 (IGF-1) based on laboratory reference range -AND- therapeutic failure or cannot be treated with surgical resection, pituitary irradiation or bromocriptine mesylate at maximally tolerated doses.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization of acromegaly, decreased or normalized IGF-1 from baseline
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# odactra

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## Products Affected

- ODACTRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy
<b>Required Medical Information</b>	Documentation of allergic rhinitis due to house dust mites -AND- allergic rhinitis with or without conjunctivitis has been confirmed by skin testing for licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to D. pteronyssinus or D. Farina -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
<b>Age Restrictions</b>	Deny if less than 18 years of age or greater than 65 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Member must also be prescribed an epinephrine auto injector. For reauthorization, attestation of improved allergy symptoms is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## odomzo

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### Products Affected

- ODOMZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# olumiant

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## Products Affected

- **OLUMIANT ORAL TABLET 1 MG, 2 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Part A covered for Covid-19 in hospitalized patients
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe rheumatoid arthritis an inadequate response or intolerance to at least one non-biologic DMARD (e.g., methotrexate, leflunomide). For severe alopecia areata, inadequate response or intolerance to an intralesional corticosteroid or high potency topical corticosteroid, or contraindication to all.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Rheumatoid Arthritis and Alopecia Areata
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra, Rinvoq and Xeljanz/Xeljanz XR, with at least 1 being a tumor necrosis factor blocker.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# onfi

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## Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- adequate trial or intolerance of a previous antiepileptic therapy
<b>Age Restrictions</b>	Deny if less than 2 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# ongentys

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## Products Affected

- **ONGENTYS**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Parkinson's disease experiencing off episodes -AND- Used as adjunct to levodopa/carbidopa -AND- trial/failure, contraindication or intolerance to the following (1. and 2.): 1) entacapone 2) one of the following generic products: rasagiline, pramipexole, ropinirole, selegiline
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## onureg

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### Products Affected

- ONUREG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of acute myeloid leukemia that has achieved first complete remission or complete remission with incomplete blood count recovery following intensive induction chemotherapy -AND- Inability to complete intensive curative therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Opzelura

## Products Affected

- OPZELURA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of all of the following (1-4): 1) mild to moderate atopic dermatitis (AD), 2) attestation of up to 20 percent of body surface area (excluding scalp) with AD involvement, 3) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- documentation of facial or anogenital involvement, 4) trial & failure, intolerance, or contraindication to topical generic tacrolimus or topical generic pimecrolimus -OR- Documentation of all of the following (5-7): 5) Nonsegmental vitiligo, 6) body surface area with vitiligo involvement does not exceed 10 percent, 7) trial & failure or intolerance to at least 1 generic, formulary high or ultrahigh potency topical corticosteroid -OR- vitiligo with facial or anogenital involvement
<b>Age Restrictions</b>	Deny if less than 12 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initial authorization: 8 weeks for AD, 24 weeks for vitiligo. Reauthorization: 12 months
<b>Other Criteria</b>	For reauthorization, attestation of positive clinical response to therapy for atopic dermatitis -OR- meaningful repigmentation of affected areas for vitiligo
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# oralair

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## Products Affected

- **ORALAIR SUBLINGUAL TABLET 300  
INDX REACTIVITY**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
<b>Required Medical Information</b>	Documentation of allergic rhinitis and use for Sweet Vernal, Orchard, Perennial Rye, Timothy or Kentucky Blue Grass pollens -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
<b>Age Restrictions</b>	Deny if less than 5 years of age or greater than 65 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Member must also be prescribed an epinephrine auto injector. For reauthorization, attestation of improved allergy symptoms is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# orencia

## Products Affected

- **ORENCIA CLICKJECT**
- **ORENCIA SUBCUTANEOUS SYRINGE**  
125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Rheumatoid Arthritis, and Psoriatic Arthritis or less than 2 years of age for Juvenile Idiopathic Arthritis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra, Rinvoq and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Cosentyx, Xeljanz/Xeljanz XR, Otezla and Stelara. For juvenile idiopathic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Xeljanz/Xeljanz solution and Actemra.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## orgovyx

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### Products Affected

- **ORGOVYX**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of advanced prostate cancer -AND- the member is appropriate to receive androgen deprivation therapy by meeting one of the following (1, 2, or 3) 1. Biochemical (prostate specific antigen) or clinical relapse following local primary intervention 2. Newly diagnosed castration-sensitive metastatic disease 3. Advanced local disease
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# oriahnn

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## Products Affected

- **ORIAHNN**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Diagnosis of severe hepatic impairment or osteoporosis.
<b>Required Medical Information</b>	Documentation of premenopausal woman with uterine leiomyomas - AND- Experiencing heavy menstrual bleeding -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist in combination with estrogen and progestin does not exceed 24 months.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 18 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of continued experience of heavy menstrual bleeding -AND- Attestation of decrease in menstrual blood loss -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist in combination with estrogen and progestin does not exceed 24 months.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# orilissa

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Diagnosis of severe hepatic impairment or osteoporosis.
<b>Required Medical Information</b>	Documentation of female with diagnosis of endometriosis with moderate to severe pain -AND- For women of childbearing age, attestation of not pregnant -AND- Inadequate response, failure or contraindication to 2 standard of care treatments (e.g. NSAIDS, combined hormonal contraceptives, progestin, GnRH agonist, Danazol) -AND- Treatment with Orilissa does not exceed 24 months
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 18 months reauthorization
<b>Other Criteria</b>	For reauthorization, Orilissa is continued to be used for pain associated with endometriosis -AND- attestation of reduction in pain -AND- Total cumulative duration of therapy does not exceed 24 months.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# orkambi

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## Products Affected

- **ORKAMBI ORAL TABLET**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cystic fibrosis and homozygous F508del mutation
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# orkambi granules

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## Products Affected

- **ORKAMBI ORAL GRANULES IN PACKET 100-125 MG, 150-188 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cystic fibrosis and homozygous F508del mutation
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# orladeyo

## Products Affected

- ORLADEYO

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

# OTEZLA

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For oral ulcers associated with Behcet's Disease, inadequate response or intolerance to topical triamcinolone for acute flare-up of oral ulcers -AND- inadequate response or intolerance to colchicine for prevention of recurrent oral ulcers
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Oxbryta for Suspension

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## Products Affected

- **OXBRYTA ORAL TABLET FOR SUSPENSION**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of sickle cell disease -AND- Failure, intolerance or contraindication to hydroxyurea -AND- one of the following (1 or 2): 1) is eleven years of age or younger -OR- 2) has an inability to swallow tablets
<b>Age Restrictions</b>	Deny if less than 4 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of improvement of sickle cell disease signs, symptoms or complications
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## oxervate

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### Products Affected

- **OXERVATE**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Treatment duration greater than 8 weeks per eye
<b>Required Medical Information</b>	Documentation of diagnosis -AND- affected eye (e.g. right eye, both eyes).
<b>Age Restrictions</b>	Deny if less than 2 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	8 weeks
<b>Other Criteria</b>	Coverage beyond 8 weeks per eye will not be approved
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# palynziq

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## Products Affected

- PALYNZIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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) -AND- 3.) Has a prescription for epinephrine agent unless contraindicated.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of reduction in baseline pretreatment Phe levels -OR- blood Phe levels are less than or equal to 600 micrometers/L -OR- attestation that additional therapy with Palynziq is needed to allow adequate trial of maximum dose of 60mg per day for 16 weeks or member is not currently on 60mg per day dose.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Panretin

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## Products Affected

- PANRETIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cutaneous lesions in patients with AIDS-related Kaposi Sarcoma (KS) who are not receiving systemic therapy for KS.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# pemazyre

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## Products Affected

- PEMAZYRE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) FGFR2 fusion or other rearrangement as detected by an FDA-approved test 2) Previous therapies tried/failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Pheburane

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## Products Affected

- PHEBURANE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- therapeutic failure or intolerance to generic sodium phenylbutyrate
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# piqray

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## Products Affected

- **PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of HR-positive, HER2-negative advanced or metastatic breast cancer in men and postmenopausal women with disease progression on or after endocrine-based therapy -AND- Used in combination with fulvestrant - AND- PI3K mutation positive as detected by an FDA approved test.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# pomalyst

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## Products Affected

- POMALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of multiple myeloma, and combination use with dexamethasone, and previous trial of at least 2 therapies including lenalidomide and a proteasome inhibitor, and disease progression on or within 60 days of completion of the last therapy -OR- Documentation of AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV negative
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Ponvory

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## Products Affected

- **PONVORY**
- **PONVORY 14-DAY STARTER PACK**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
<b>Required Medical Information</b>	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# praluent

## Products Affected

- PRALUENT PEN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>1.HoFH supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene OR untreated LDL-C greater than 400mg/dL or TC greater than 500mg/dl with cutaneous or tendon xanthoma before age 10 yrs or HeFH in both parents AND The member has a current LDL-C of greater than 135 mg/dL (if 17 years of age or younger) or greater than 100mg/dL (18 years of age or older) despite use of maximally tolerated statin or statin intolerance AND The member will continue to receive concurrent lipid-lowering therapies for the treatment of HoFH. 2.HeFH supported by presence of causal mutation of FH by genetic testing OR untreated LDL-C greater than or equal to 190 mg/dL or untreated LDL-C greater than or equal to 160 mg/dL before 20 years of age with physical signs of FH (e.g. xanthomas, xanthelasma) OR diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or definite on Simon Broome register, or definite on the Make Early Diagnosis to Prevent Early Deaths tool AND LDL-C greater than 100 mg/dL despite use of maximally tolerated statin or statin intolerance. 3.Hypercholesterolemia ASCVD or Primary Hyperlipidemia AND LDL-C greater than 70 mg/dL despite use of maximally tolerated statin or statin intolerance</p>
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>Patients must have an adequate trial/failure or contraindication to the preferred product Repatha. Do not used with another PCSK9 inhibitor. For reauthorization, documentation showing an LDL-C reduction on Praluent therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# prenatal vitamins

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## Products Affected

- **PRENATAL VITAMIN PLUS LOW IRON**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of nutritional supplementation required in a female of child-bearing potential during pre-conception, pregnancy, or lactation
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# prescription drug combo

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## Products Affected

- acetaminophen-codeine oral solution 120-12 mg/5 ml
- acetaminophen-codeine oral tablet
- alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg
- **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 tablet 10-325 mg, 5-325 mg, 7.5-325 mg
- hydromorphone oral liquid
- hydromorphone oral tablet
- methadone oral solution 10 mg/5 ml, 5 mg/5 ml
- methadone oral tablet 10 mg, 5 mg
- morphine concentrate oral solution
- morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg
- morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)
- morphine oral tablet
- morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg
- oxycodone oral capsule
- oxycodone oral concentrate
- oxycodone oral solution
- oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg
- oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg
- tramadol oral tablet 50 mg
- tramadol-acetaminophen
- zaleplon oral capsule 10 mg, 5 mg
- zolpidem oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	

# procysbi

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## Products Affected

- **PROCYSBI ORAL GRANULES DEL  
RELEASE IN PACKET**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- previous trial and failure, intolerance, or contraindication to Cystagon (cysteamine bitartrate immediate-release)
<b>Age Restrictions</b>	Deny if less than 1 year of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For granules, attestation of inability to swallow capsules or gastrostomy tube (g-tube) placement is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# prolia

## Products Affected

- PROLIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -And- For osteoporosis at high risk for fracture, meeting one of the following (1. thru 4.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 (i.e. osteopenia) -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 40 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For osteoporosis and osteopenia, documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Covered under Part B for patients eligible for home health services when provider certifies that patient sustained bone fracture related to post-menopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug.
Indications	All FDA-approved Indications.
Off Label Uses	

# provigil

## Products Affected

- *modafinil*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of shift work sleep disorder (SWSD) as defined by a minimum of 5 night shifts per month with at least 3 of those nights occurring consecutively and the shift is 6 to 12 hours in duration occurring between 10pm and 8am. Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) - AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B)Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography as established in accordance with ICSD or DSM V criteria acceptable for all indications. Diagnosis of fatigue associated with Multiple Sclerosis (MS)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, provider attestation of improvement in daytime sleepiness is required.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off Label Uses</b>	Fatigue associated with Multiple Sclerosis (MS)

# pulmonary arterial hypertension

## Products Affected

- **ADEMPAS**
- **ALYQ**
- *ambrisentan*
- *bosentan*
- **OPSUMIT**
- **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG**
- *sildenafil (pulm.hypertension) oral suspension for reconstitution*
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*
- **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**
- **VENTAVIS**

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization (RHC), defined as a mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than or equal to 3 Wood units -AND- WHO Group. For Bosentan in pediatric individuals, an exception to RHC will be allowed when the risk of RHC outweighs the benefit -AND- prescriber attests alternative studies have been completed (i.e. CT, MRI or specified test ruling out other causes of pulmonary hypertension). For Adempas, additional diagnosis of CTEPH as documented by right heart catheterization and V/Q scan substantiating mPAP greater than 20 mmHg at rest and PWP less than or equal to 15 mmHg and documented presence of occlusive thrombi within the pulmonary arteries will be approved.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Ventavis covered under Part B when using via nebulizer in the home setting.
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	



# Purified Cortrophin Gel

## Products Affected

- CORTROPHIN GEL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Covered for the following indications: 1. Acute exacerbations of multiple sclerosis (MS) for patients receiving concurrent immunomodulator therapy (e.g., interferon beta, glatiramer acetate, dimethyl fumarate, fingolimod, teriflunomide) 2. Rheumatic disorders for patients receiving maintenance therapy with at least one NSAID, DMARD (e.g. leflunomide) or biologic (e.g. adalimumab) 3. Collagen diseases for members receiving maintenance therapy with at least one antimalarial (e.g. hydroxychloroquine) or immunosuppressant (e.g. azathioprine) 4. Dermatologic diseases, if using for severe psoriasis, then the member is concurrently receiving maintenance therapy with phototherapy, systemic therapy (e.g., methotrexate), or a biologic (e.g. adalimumab). 5. Allergic states (i.e. serum sickness and transfusion reaction due to serum protein reaction), if using for atopic dermatitis, then the member is concurrently receiving maintenance therapy with a topical corticosteroid, topical calcineurin inhibitor, topical PDE-4 inhibitor, or dupilumab. 6. Ophthalmic diseases 7. Respiratory diseases 8. Gout and unable to take first-line therapies. 9. Pediatric acquired epileptic aphasia. 10. Proteinuria in nephrotic syndrome and trial/failure or contraindication to two therapies from any of the following different classes: corticosteroids (e.g., cortisone or dexamethasone), calcineurin inhibitors (e.g., cyclosporine or tacrolimus, per DRUGDEX). For covered indications 1 through 9, limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (i.e. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	For reauthorization, the following (1. 2. and 3.) must be met. 1) Prescriber attestation that the member cannot use corticosteroids (e.g. IV methylprednisolone, high dose oral corticosteroids) due to unsatisfactory response, intolerance (e.g. severe anaphylaxis) or experienced a severe adverse event to corticosteroids (e.g. psychosis). 2) If the reauthorization is for the treatment of multiple sclerosis, a rheumatic disorder, dermatologic disease, or nephrotic syndrome, the prescriber attests that H.P. Acthar is being used for a new acute exacerbation and not on a routine basis to prevent an exacerbation as supported by Compendia. 3) If the reauthorization is for treatment of multiple sclerosis, a rheumatic disorder, or collagen disease, the member continues to receive maintenance therapy.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off Label Uses</b>	Epileptic Aphasia

# Pyrukynd

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## Products Affected

- **PYRUKYND ORAL TABLET 20 MG, 5 MG, 5 MG (4-WEEK PACK), 50 MG**
- **PYRUKYND ORAL TABLETS,DOSE PACK**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hemolytic anemia with pyruvate kinase deficiency, as supported by one of the following (1-2): 1) mutations in the PKLR gene, 2) reduced activity of the pyruvate kinase enzyme.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 weeks initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of increase in hemoglobin level from baseline -OR- decrease in transfusion burden from baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# qinlock

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## Products Affected

- QINLOCK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of advanced gastrointestinal stromal tumor -AND- Prior treatment with imatinib and 2 other kinase inhibitors.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# quinine

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## Products Affected

- *quinine sulfate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Treatment or prevention of leg cramps
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	10 days
<b>Other Criteria</b>	Doses for duration greater than 10 days will not be approved
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Radicava

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## Products Affected

- **RADICAVA ORS STARTER KIT SUSP**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of amyotrophic lateral sclerosis (ALS)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ravicti

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## Products Affected

- RAVICTI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Urea cycle disorders due to N-acetylglutamate synthetase deficiency, Treatment of acute hyperammonemia in urea cycle disorders
<b>Required Medical Information</b>	Documentation of chronic management of a urea cycle disorders (UCDs)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Recorlev

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## Products Affected

- **RECORLEV**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of endogenous Cushing's syndrome AND patient is not a candidate for pituitary surgery or surgery has not been curative
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of mean urine free cortisol (mUFC) less than starting baseline value.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# regranex

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## Products Affected

- **REGRANEX**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	20 weeks
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# relistor

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## Products Affected

- **RELISTOR ORAL**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of opioid induced constipation (OIC) due to any of the following (1-2): 1) chronic non-cancer pain, or 2) chronic pain related to prior cancer or its treatment who do not require frequent (e.g. weekly) opioid dosage escalation -AND- documentation of opioid medication use for at least one month -AND- trial and failure, contraindication, or intolerance to 2 of the following (3-5): 3) Laxatives, 4) lubiprostone, 5) Movantik
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# repatha

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>1.HoFH supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene OR untreated LDL-C greater than 400mg/dL or TC greater than 500mg/dl with cutaneous or tendon xanthoma before age 10 yrs or HeFH in both parents AND The member has a current LDL-C of greater than 135 mg/dL (if 17 years of age or younger) or greater than 100mg/dL (18 years of age or older) despite use of maximally tolerated statin or statin intolerance AND The member will continue to receive concurrent lipid-lowering therapies for the treatment of HoFH. 2.HeFH supported by presence of causal mutation of FH by genetic testing OR untreated LDL-C greater than or equal to 190 mg/dL or untreated LDL-C greater than or equal to 160 mg/dL before 20 years of age with physical signs of FH (e.g. xanthomas, xanthelasma) OR diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or definite on Simon Broome register, or definite on the Make Early Diagnosis to Prevent Early Deaths tool, AND LDL-C greater than 100 mg/dL if 18 and older or LDL-C greater than 130 if 17 and younger despite use of maximally tolerated statin or statin intolerance. If 17 and younger will continue to receive concurrent lipid-lowering therapies. 3.Hypercholesterolemia ASCVD or Primary Hyperlipidemia AND LDL-C greater than 70 mg/dL despite use of maximally tolerated statin or statin intolerance</p>
<b>Age Restrictions</b>	Deny if less than 18 years of age for ASCVD and Primary Hyperlipidemia, or less than 10 years of age for HoFH and HeFH.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	Do not used with another PCSK9 inhibitor. For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## retevmo

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### Products Affected

- **RETEVMO ORAL CAPSULE 40 MG, 80 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis 1) RET fusion status 2) Radioactive iodine-refractory (if radioactive iodine is appropriate)
<b>Age Restrictions</b>	Deny if less than 18 years of age for NSCLC or less than 12 years of age for thyroid cancer
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# revlimid

## Products Affected

- *lenalidomide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Documentation of chronic lymphocytic leukemia outside of a controlled clinical trial
<b>Required Medical Information</b>	Diagnosis of multiple myeloma in combination with dexamethasone -OR- diagnosis of multiple myeloma, as maintenance following autologous hematopoietic stem cell transplant (auto-HSCT) -OR- diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities -OR- diagnosis of mantle cell lymphoma (MCL) in which disease has relapsed or progressed after two prior therapies, one of which included bortezomib -OR- diagnosis of follicular lymphoma in combination with a rituximab product -OR- diagnosis of marginal zone lymphoma in combination with a rituximab product after previous treatment.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

# rinvoq

## Products Affected

- **RINVOQ ORAL TABLET EXTENDED  
RELEASE 24 HR 15 MG, 30 MG, 45 MG**

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of moderate to severe Rheumatoid Arthritis, moderate to severe Refractory Atopic Dermatitis, Ankylosing Spondylitis, Psoriatic Arthritis, or Ulcerative Colitis. For moderate to severe rheumatoid arthritis, an inadequate response or intolerance to at least one non-biologic DMARD (e.g., leflunomide, methotrexate). For moderate to severe refractory atopic dermatitis whose disease is not adequately controlled with other systemic drug products, documentation of all of the following (1-2): 1) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- atopic dermatitis of the face or anogenital involvement -OR- the member has severe atopic dermatitis evidenced by the extent of the member's body surface area affected which makes topical therapy impractical to apply -OR- severe atopic dermatitis evidenced by severely damaged skin, 2) trial & failure, intolerance, or contraindication to topical tacrolimus or topical pimecrolimus -OR- the member has severe atopic dermatitis evidenced by the extent of the member's body surface area affected which makes topical therapy impractical to apply -OR- severe atopic dermatitis evidenced by severely damaged skin. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For diagnoses in which tumor necrosis factor (TNF) blockers are also indicated (e.g., Rheumatoid Arthritis, Psoriatic Arthritis), the member has experienced therapeutic failure or intolerance to at least 1 TNF blocker.
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	



# rozlytrek

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For metastatic non-small cell lung cancer, the tumor status is ROS1-positive. For solid tumors with NTRK gene fusion without a known acquired resistance mutation, the tumors are metastatic or surgical resection is likely to result in severe morbidity - AND- There are no satisfactory alternative treatments or the tumors have progressed following treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# rubraca

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## Products Affected

- RUBRACA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following. 1) BRCA mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# rydapt

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## Products Affected

- RYDAPT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Use as single agent induction therapy for AML
<b>Required Medical Information</b>	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) FLT3 mutations 2) Concomitant therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# sabril

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## Products Affected

- *vigabatrin*
- **VIGADRONE**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Deny if less than 2 years of age in treatment of refractory complex partial seizures -OR- if less than 1 month old and greater than 2 years of age in treatment of infantile spasms
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# samsca

## Products Affected

- *tolvaptan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of symptomatic hypervolemic or euvolemic hyponatremia evidenced by (1. or 2.): 1.) Serum Na less than 125 mEq/L -OR- 2.) Serum NA less than 135mEq/L with symptoms (e.g. nausea, malaise, lethargy, headache, seizures)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	Doses must be initiated in the hospital setting to closely monitor serum sodium. Treatment should be limited to 30 days to minimize risk of liver injury. For reauthorization, treatment is for a new episode of a clinically significant euvolemic or hypervolemic hyponatremia -AND- on of the following (1. or 2.) 1.) Serum Na less than 125 mEq/L -OR- 2.) Serum NA less than 135mEq/L with symptoms (e.g. nausea, malaise, lethargy, headache, seizures)
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Scemblix

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## Products Affected

- **SCSEMBLIX ORAL TABLET 20 MG, 40 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) T3151 mutation status 2) Philadelphia chromosome status 3) Alternatives tried/failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# signifor

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## Products Affected

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Cushing's disease AND patient is not a candidate for pituitary surgery or surgery has not been curative
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of decrease in urinary free cortisol levels from baseline
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# siliq

## Products Affected

- SILIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	4 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	If on Siliq therapy greater than or equal to 4 months or reauthorization, provider must attest to improvement in the physician's global assessment score, psoriasis area severity index score, or a decrease in the affected body surface area of psoriatic plaque lesions. For psoriasis, patients must have an adequate trial or intolerance to 2 preferred products Humira, Cosentyx, Otezla, Stelara, Enbrel, and Skyrizi. For psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# 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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. Simponi 50mg: For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide) and Simponi will be used in combination with methotrexate. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). Diagnosis of psoriatic arthritis Simponi 100mg: Diagnosis of moderate to severe ulcerative colitis.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For Rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra, Xeljanz/Xeljanz XR and Rinvoq. For psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Cosentyx, Xeljanz/Xeljanz XR, Otezla, and Stelara. For ankylosing spondylitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel and Cosentyx. For ulcerative colitis, patients must have an adequate trial or intolerance to the preferred products Humira, Stelara and Xeljanz/Xeljanz XR. For ulcerative colitis indication therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# skyrizi

## Products Affected

- SKYRIZI SUBCUTANEOUS PEN INJECTOR
- SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML
- SKYRIZI SUBCUTANEOUS SYRINGE KIT
- SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For Crohn's disease, attestation of clinical response or remission following IV administration of Skyrizi within 3 months of initiating therapy with Skyrizi SC.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# solaraze

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## Products Affected

- *diclofenac sodium topical gel 3 %*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- trial and failure, intolerance, or contraindication to topical fluorouracil
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	For reauthorization, attestation of 30 day washout period since optimal therapeutic effect may not be evident until 30 days following cessation of therapy AND attestation of previous response to diclofenac sodium 3% topical gel therapy
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# somavert

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## Products Affected

- SOMAVERT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For acromegaly, high pretreatment insulin-like growth factor-1 (IGF-1) based on laboratory reference range -AND- inadequate or partial response to surgery or radiotherapy or not a candidate for surgery or radiotherapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization of acromegaly, decreased or normalized IGF-1 from baseline
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# sovaldi

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## Products Affected

- SOVALDI ORAL PELLETS IN PACKET
- SOVALDI ORAL TABLET 400 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member has a contraindication to or is otherwise not a candidate for all regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
<b>Age Restrictions</b>	Deny if less than 3 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# sprycel

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## Products Affected

- SPRYCEL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) Philadelphia Chromosome status (e.g. positive) 2) Alternatives tried/failed 3) Concomitant therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# stelara

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- documentation of member weight and prescribed dose. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For Crohn's Disease, inadequate response or intolerance to two immunosuppressants (e.g. corticosteroids, azathioprine) -OR- intolerance to a TNF inhibitor (e.g. Humira) -OR- Contraindication to a TNF inhibitor due to demyelinating disease or heart failure -OR- attestation of clinical response or remission following IV administration of Stelara within 2 months of initiating therapy with Stelara SC. For Ulcerative colitis, attestation of clinical response or remission following IV administration of Stelara within 2 months of initiating therapy with Stelara SC
<b>Age Restrictions</b>	Deny if less than 18 years of age for Crohn's Disease and Ulcerative Colitis or less than 6 years of age for Plaque Psoriasis and Psoriatic Arthritis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>Must follow recommended dosing guidelines based upon weight.</p> <p>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. Induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# stivarga

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## Products Affected

- **STIVARGA**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic colorectal cancer and trial of a fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy, AND an anti-VEGF therapy AND if RAS wild-type, an anti-EGFR therapy -OR- documentation of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) after treatment with both imatinib and sunitinib -OR- documentation of hepatocellular cancer AND previous treatment with sorafenib
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# **sunosi**

## **Products Affected**

- **SUNOSI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography as established in accordance with ICSD or DSM V criteria acceptable for all indications
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For narcolepsy and OSAHS, documentation of trial and failure, contraindication or intolerance to modafinil and armodafinil. For reauthorization, provider attestation of improvement in daytime sleepiness is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# sutent

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## Products Affected

- *sunitinib*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) disease progression on or intolerance to imatinib mesylate 2) high risk of recurrent RCC following nephrectomy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# symdeko

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## Products Affected

- **SYMDEKO**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cystic fibrosis (CF) in patients who have either the homozygous F508del mutation or another mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to tezacaftor/ivacaftor based on clinical and/or in vitro assay (e.g. E56K, R117C, A455E)
<b>Age Restrictions</b>	Deny if less than 6 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# sympazan

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## Products Affected

- SYMPAZAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- adequate trial or intolerance of a previous antiepileptic therapy -AND- unable to tolerate generic clobazam
<b>Age Restrictions</b>	Deny if less than 2 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# symproic

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## Products Affected

- SYMPROIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of opioid induced constipation (OIC) due to any of the following (1-2): 1) chronic non-cancer pain, or 2) chronic pain related to prior cancer or its treatments who do not require frequent (e.g., weekly) opioid dosage escalation -AND- documentation of opioid medication use for at least one month -AND- trial and failure, contraindication, or intolerance to at least 2 of the following (3-5): 3) Laxatives, 4) lubiprostone, 5) Movantik
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tabrecta

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## Products Affected

- TABRECTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic non-small cell lung cancer with MET exon 14 skipping mutation as detected by an FDA approved test.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tagrisso

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## Products Affected

- TAGRISSO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following. 1) EGFR mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# takhzyro

## Products Affected

- TAKHZYRO

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

# taltz

## Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs.
<b>Age Restrictions</b>	Deny if less than 18 years of age for Psoriatic Arthritis, Ankylosing Spondylitis and non-radiographic axial spondyloarthritis or less than 6 years of age for Plaque Psoriasis
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Cosentyx, Xeljanz/Xeljanz XR, Otezla, and Stelara. For plaque psoriasis patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Cosentyx, Otezla, Stelara, Enbrel and Skyrizi. For ankylosing spondylitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel and Cosentyx. For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# talzenna

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## Products Affected

- **TALZENNA ORAL CAPSULE 0.25 MG, 0.5 MG, 0.75 MG, 1 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of deleterious or suspected deleterious gBRCAm, HER2-negative locally advanced or metastatic breast cancer
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# targretin

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## Products Affected

- *bexarotene oral*
- *bexarotene topical*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cutaneous manifestations of cutaneous T-cell lymphoma in patients who are refractory to at least one prior systemic therapy.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tasigna

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## Products Affected

- TASIGNA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) Philadelphia Chromosome status (e.g. positive) 2) Alternatives tried/failed
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tavalisse

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## Products Affected

- TAVALISSE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For diagnosis of ITP, the following criteria apply (1 and 2): 1) trial, intolerance, or inadequate response to a corticosteroid, immunoglobulin, or splenectomy. 2) One of the following (A or B): A) Platelet count less than or equal to $50 \times 10^9/L$ and has significant mucous member bleeding or at least one risk factor for bleeding (e.g. hypertension, peptic ulcer disease). B) Platelet count of less than or equal to $30 \times 10^9/L$ .
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Tavneos

## Products Affected

- TAVNEOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of severe active granulomatosis with polyangiitis or severe active microscopic polyangiitis -AND- Prescriber attests to positive test for anti-PR3 or positive test for anti-MPO -AND- Member will continue to receive concomitant standard of care treatment with systemic glucocorticoids (e.g. prednisone) and immunosuppressives (e.g. mycophenolate mofetil, azathioprine).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of therapeutic response defined by disease stability or disease improvement -AND- Member will continue to receive concomitant standard of care treatment with glucocorticoids (e.g. prednisone) and immunosuppressives (e.g. mycophenolate mofetil, azathioprine).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tazorac

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## Products Affected

- *tazarotene topical cream*
- *tazarotene topical gel*
- **TAZORAC TOPICAL CREAM 0.05 %**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of 1 of the following (A or B). A) Documentation of plaque psoriasis -AND- trial and failure or intolerance to at least one topical corticosteroid (e.g. fluocinonide, mometasone, triamcinolone, betamethasone). B) Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two topical acne medications (e.g. adapalene, clindamycin, sulfacetamide, erythromycin) one of which must be generic topical tretinoin
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# tazverik

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## Products Affected

- TAZVERIK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of locally advanced or metastatic epithelioid sarcoma - AND- Disease is not eligible for complete resection. Documentation of relapsed or refractory follicular lymphoma -AND-Tumors are EZH2 mutation positive, as detected by FDA approved test, in a member that has received at least 2 prior systemic therapies -OR- Prescriber attests there are no satisfactory alternative treatment options.
<b>Age Restrictions</b>	Deny if less than 16 years of age for epithelioid sarcoma or deny if less than 18 years of age for follicular lymphoma
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tecfidera

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## Products Affected

- *dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
<b>Required Medical Information</b>	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tegsedi

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## Products Affected

- **TEGSEDI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of polyneuropathy associated with hereditary TTR (hATTR) amyloidosis with mutation in TTR gene confirmed by genetic testing -AND- Neurologic examination shows clinical signs and symptoms of the disease (e.g. peripheral/autonomic neuropathy, motor disability, carpal tunnel, etc.) -AND- Not simultaneously utilizing other gene targeted therapy for polyneuropathy of hATTR
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of positive clinical response
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tepmetko

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## Products Affected

- **TEPMETKO**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic non-small cell lung cancer with a MET exon 14 skipping alteration
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## testosterone (androgens)

### Products Affected

- **ANDRODERM**
- *testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 total testosterone level below the normal range for the laboratory -OR- a total testosterone level near the lower limit of the normal range with a low free testosterone level which is less than normal based upon the laboratory reference range -OR- the member is not producing any testosterone. Additional approvable indications include female patients with metastatic breast cancer (testosterone enanthate only), primary or secondary hypogonadism in males with testicular failure due to double orchidectomy, and delayed puberty in males (testosterone enanthate only).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	HIV Wasting

# thalomid

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Use as monotherapy for ENL treatment in the presence of moderate to severe neuritis
<b>Required Medical Information</b>	Documentation of multiple myeloma in combination with dexamethasone -OR- documentation for use in the treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) -OR- documentation of therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## thrombopoiesis stimulating agents

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### Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of chronic immune idiopathic thrombocytopenia purpura and trial and failure of corticosteroid or immunoglobulin therapy or splenectomy -OR- documentation of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy (eltrombopag only)-OR- severe aplastic anemia who have had an insufficient response to immunosuppressive therapy -OR- documentation of first line treatment for severe aplastic anemia and used in combination with at least two immunosuppressive therapies.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Platelet count to be provided
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# tibsovo

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## Products Affected

- TIBSOVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) IDH1 mutation status, 2) alternatives tried/failed, 3) comorbidity that precludes use of intensive induction chemotherapy (i.e. age greater than or equal to 75 years, severe cardiac or pulmonary comorbidity, reduced renal function, hepatic impairment, or physician attestation)
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# topical lidocaine

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# transmucosal fentanyl citrate

## Products Affected

- *fentanyl citrate buccal lozenge on a handle*  
1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg
- *fentanyl citrate buccal tablet, effervescent*  
100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg
- *FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of therapeutic use and the member is currently receiving and tolerant to long acting opioid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# trelstar

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## Products Affected

- **TRELSTAR INTRAMUSCULAR  
SUSPENSION FOR RECONSTITUTION**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tretinoin

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## Products Affected

- *clindamycin-tretinoin*
- *tretinoin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Cosmetic use
<b>Required Medical Information</b>	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two topical acne medications (e.g. clindamycin, sulfacetamide, erythromycin)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# trikafta

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## Products Affected

- TRIKAFTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cystic fibrosis (CF) in patients who have at least one F508del mutation or another mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to elexacaftor/tezacaftor/ivacaftor based on in vitro assay (e.g. E56K, R117C, A455E)
<b>Age Restrictions</b>	Deny if less than 6 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Truseltiq

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## Products Affected

- **TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1), 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2), 75 MG/DAY (25 MG X 3)**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) FGFR2 fusion or other rearrangement as detected by an FDA-approved test 2) Previous therapies tried/failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tukysa

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## Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) HER2 mutations 2) Alternatives tried/failed 3) Concomitant therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# turalio

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## Products Affected

- TURALIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of symptomatic tenosynovial giant cell tumor associated with severe morbidity and functional limitations -AND- patient is not amenable to improvement with surgery or not a candidate for surgery
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tykerb

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## Products Affected

- *lapatinib*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) HER2 mutations 2) Alternatives tried/failed 3) Concomitant therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tymlos

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## Products Affected

- TYMLOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Treatment duration greater than 24 months.
<b>Required Medical Information</b>	Documentation of diagnosis -AND- at high risk for fracture, meeting one of the following (1. thru 3.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	Documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Tymlos will be limited to a coverage duration of 24 months.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# tyvaso dpi

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## Products Affected

- **TYVASO DPI INHALATION  
CARTRIDGE WITH INHALER 16  
MCG, 16 MCG (112)- 32 MCG (84),  
16(112)-32(112) -48(28) MCG, 32 MCG,  
32-48 MCG, 48 MCG, 64 MCG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- results of a right heart catheterization (RHC) meeting all of the following (1., 2., and 3.): 1) mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg at rest, 2) pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, 3) PVR greater than or equal to 3 Wood units -AND- WHO Group
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# VALCHLOR

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## Products Affected

- VALCHLOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received prior skin-directed therapy (e.g. topical corticosteroids, topical chemotherapy, local radiation and topical retinoids).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# valtoco

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## Products Affected

- VALTOCO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of seizure clusters or acute repetitive seizures -AND- Therapeutic failure, contraindication or intolerance to generic diazepam rectal gel delivery system
<b>Age Restrictions</b>	Deny if less than 6 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# veltassa

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## Products Affected

- VELTASSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hyperkalemia as defined by serum potassium level between 5.1 and 6.4 mmol/L on at least two (2) screenings -AND- Modification of medications to reduce serum potassium levels were not successful, when applicable.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, attestation of reduction in serum potassium levels following Veltassa administration and continued treatment for hyperkalemia is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# venclexta

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## Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis and concomitant therapy, if applicable to diagnosis. For newly-diagnosed AML, presence of at least one comorbidity that precludes use of intensive induction chemotherapy (i.e. age greater than or equal to 75 years, severe cardiac or pulmonary comorbidity, reduced renal function, hepatic impairment, or physician attestation) is required.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



## verquvo

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### Products Affected

- VERQUVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of heart failure (NYHA Class II to IV) -AND- Left ventricular ejection fraction less than 45% -AND- Hospitalization for heart failure or received outpatient IV diuretics for heart failure -AND- Used in combination with a angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker or Entresto -AND- Used in combination with bisoprolol, carvedilol IR/ER or metoprolol succinate ER.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# verzenio

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## Products Affected

- VERZENIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following: 1) HR mutation status and HER2 mutation status 2) Alternatives tried/failed 3) Concomitant therapy, if applicable to diagnosis 4) Ki-67 score greater than or equal to 20% per an FDA-approved test, if applicable to diagnosis.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# viberzi

## Products Affected

- **VIBERZI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Severe (Child-Pugh C) hepatic impairment
<b>Required Medical Information</b>	Documentation of diarrhea predominant, irritable bowel syndrome (IBS-D) -AND- trial/failure or intolerance to one of the following medications for IBS-D or documentation of contraindication to all: antidiarrheal (e.g., loperamide), antispasmodic (e.g., dicyclomine, hyoscyamine), tricyclic antidepressant (e.g., amitriptyline, nortriptyline).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# viibryd

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis major depressive disorder and trial and failure of one other antidepressant
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Vioice

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## Products Affected

- **VIJOICE ORAL TABLET 125 MG, 250 MG/DAY (200 MG X1-50 MG X1), 50 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of severe manifestations of PIK3CA Related Overgrowth Spectrum (PROS)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# vitrakvi

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation -AND- Tumors are metastatic or surgical resection is likely to result in severe morbidity - AND- There are no satisfactory alternative treatments or tumors have progressed following treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Vivjoa

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## Products Affected

- VIVJOA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of recurrent vulvovaginal candidiasis defined as at least 3 episodes of vulvovaginal candidiasis in less than one year -AND Documentation the member is NOT of reproductive potential defined as postmenopausal or another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# vizimpro

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## Products Affected

- VIZIMPRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic non-small cell lung cancer -AND- one of the following (1 or 2): 1. Epidermal growth factor (EGFR) exon 19 deletions - OR- 2. Epidermal growth factor receptor (EGFR) exon 21 L858R substitution mutations.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# Vonjo

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## Products Affected

- VONJO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of intermediate or high-risk myelofibrosis - AND- attestation of a platelet count of less than $50 \times 10^9/L$ .
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# voriconazole

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## Products Affected

- *voriconazole intravenous*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- attestation that the beneficiary cannot take oral voriconazole
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	For reauthorization, attestation of continued indicators of active disease (e.g. histopathology, positive cultures) is required
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## vosevi

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### Products Affected

- VOSEVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member has a contraindication to or is otherwise not a candidate for all regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# votrient

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## Products Affected

- VOTRIENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Documentation of adipocytic soft tissue sarcoma or gastrointestinal stromal tumor
<b>Required Medical Information</b>	Documentation of diagnosis -AND- if applicable to diagnosis, alternatives tried/failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# vraylar

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## Products Affected

- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE,DOSE PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- trial, intolerance, or contraindication to one other formulary generic atypical antipsychotic (e.g. quetiapine).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# vumerity

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## Products Affected

- VUMERITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
<b>Required Medical Information</b>	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- Therapeutic failure or intolerance to generic dimethyl fumarate
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# wakix

## Products Affected

- WAKIX

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

# Welireg

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## Products Affected

- **WELIREG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of von Hippel Lindau (VHL) syndrome -AND- one of the following diagnoses not requiring immediate surgery (1, 2, or 3): 1) Renal cell carcinoma. 2) CNS hemangioblastoma. 3) Pancreatic neuroendocrine tumor.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# xalkori

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## Products Affected

- **XALKORI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) documentation of ALK or ROS1 mutation status
<b>Age Restrictions</b>	Deny if less than 18 years of age for NSCLC. Deny if less than 1 year of age or greater than 21 years of age for ALCL.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# Xarelto Suspension

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## Products Affected

- **XARELTO ORAL SUSPENSION FOR RECONSTITUTION**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- Inability to swallow Xarelto (Rivaroxaban) tablets.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, member continues to have an inability to swallow Xarelto (Rivaroxaban) tablets.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# xcopri

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## Products Affected

- **XCOPRI 150MG X1)**
- **XCOPRI MAINTENANCE PACK ORAL • XCOPRI TITRATION PACK  
TABLET 250MG/DAY(150 MG X1-  
100MG X1), 350 MG/DAY (200 MG X1-**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of partial-onset seizures -AND- Therapeutic failure, intolerance or contraindication to 1 other anti-epileptic drug (e.g. carbamazepine, levetiracetam)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# xeljanz

## Products Affected

- XELJANZ ORAL TABLET
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis and an inadequate response or intolerance to methotrexate. Xeljanz immediate release for juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID).
Age Restrictions	Deny if less than 18 years of age for rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, ankylosing spondylitis, or less than 2 years of age for juvenile idiopathic arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	The member has experienced inadequate response or intolerance to at least 1 tumor necrosis factor (TNF) blocker. 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 and 22 mg per day for Xeljanz XR will not be approved for ulcerative colitis.
Indications	All FDA-approved Indications.
Off Label Uses	

# xeljanz solution

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## Products Affected

- XELJANZ ORAL SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of juvenile idiopathic arthritis -AND- Inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
<b>Age Restrictions</b>	Deny if less than 2 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	The member has experienced therapeutic failure or intolerance to at least 1 tumor necrosis factor (TNF) blocker.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## xenazine

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### Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- attestation that the beneficiary is not actively suicidal
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	In patients with comorbid depression, attestation of adequate treatment for depression is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# xermelo

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## Products Affected

- XERMELO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of carcinoid syndrome diarrhea AND used in combination with a somatostatin analog AND trial and failure of somatostatin analog monotherapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# xgeva

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## Products Affected

- XGEVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis. For hypercalcemia of malignancy, refractory to bisphosphonates. For giant cell tumor of bone, unresectable or surgical resection is likely to result in severe morbidity -AND- one of the following (1. or 2.)- 1.) the member is 18 years old or older -OR- 2.) the member is a skeletally mature adolescent (e.g. has at least one mature long bone)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# xifaxan

## Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of 1 or 2. 1) Diagnosis of hepatic encephalopathy AND trial/failure, intolerance, or contraindication to lactulose. 2) Diagnosis of Irritable Bowel Syndrome with Diarrhea (IBS-D) AND trial/failure, intolerance to one of the following medications for IBS-D or documentation of contraindication to all: antidiarrheal (e.g., loperamide), antispasmodic (e.g., dicyclomine, hyoscyamine), tricyclic antidepressant (e.g., amitriptyline, nortriptyline).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Hepatic encephalopathy: 1 year. IBS-D: 14 days.
Other Criteria	No more than three courses of rifaximin for the treatment of IBS-D will be approved per lifetime.
Indications	All FDA-approved Indications.
Off Label Uses	

# xolair

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 -OR- Documentation of add-on maintenance treatment for nasal polyps -AND- trial & failure, intolerance or contraindication to intra-nasal corticosteroids
<b>Age Restrictions</b>	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 -OR- deny if less than 18 years of age for nasal polyps
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For reauthorization, attestation of decreased rescue medication or oral corticosteroid use, decrease frequency of exacerbation, increased pulmonary function from baseline or reduction in asthma related symptoms in treatment of asthma -OR- improved symptoms in treatment of CIU -OR- reduction in nasal polyp score or nasal congestion/obstruction severity score in treatment of nasal polyps
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	

# xospata

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## Products Affected

- XOSPATA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- FLT3 mutations, if applicable to diagnosis
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# xpovio

## Products Affected

- **XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use in combination with dexamethasone for relapse or refractory multiple myeloma with failure, intolerance or contraindication to 5 therapies (e.g. bortezomib, carfilzomib, lenalidomide, pomalidomide and daratumumab) -OR- Documentation of use in combination with both bortezomib and dexamethasone for relapse or refractory multiple myeloma after receiving 1 prior multiple myeloma therapy -OR- Documentation of relapsing or refractory diffuse large B-cell lymphoma with failure, intolerance or contraindication to at least 2 lines of systemic therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# xtandi

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## Products Affected

- **XTANDI ORAL CAPSULE**
- **XTANDI ORAL TABLET 40 MG, 80 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- one of the following (1. or 2.): 1. Concomitant GnRH analog 2. The member has had a bilateral orchiectomy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# xuriden

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## Products Affected

- XURIDEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hereditary orotic aciduria
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# xyrem

## Products Affected

- XYREM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) - AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. If the member has a diagnosis of cataplexy provision of baseline number of cataplexy episodes is required.
<b>Age Restrictions</b>	Deny if less than 7 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	If no diagnosis of cataplexy- trial and failure, intolerance, or contraindication to generic modafinil AND a generic CNS stimulant indicated for use in narcolepsy (e.g. methylphenidate, amphetamine salts) is required. For reauthorization, attestation supporting improvement in symptoms of narcolepsy and cataplexy (if applicable) is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# yonsa

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## Products Affected

- YONSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following: 1) Alternatives tried/failed 2) Concomitant therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## zavesca

### Products Affected

- *miglustat*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of mild to moderate type 1 Gaucher disease confirmed by the following (A. or B.) A. (1, 2, 3, 4, or, 5): 1)Hepatomegaly. 2)Splenomegaly. 3)Bone disease (i.e. osteonecrosis, osteopenia, secondary pathologic fractures, bone infarct). 4)Bone marrow complications as defined by anemia with hemoglobin less than or equal to 11.5 g/dL for females or 12.5 g/dL for males or thrombocytopenia with platelet count less than or equal to 120,000/mm <sup>3</sup> -OR- 5)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). -OR- B. Attestation of deficiency in glucocerebrosidase activity in peripheral leukocytes or genetic testing confirms mutant alleles.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Documentation of trial/failure or intolerance to at least one enzyme replacement therapy product including Cerezyme, Elelyso, or VPRIV
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# zejula

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## Products Affected

- ZEJULA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- Alternatives tried/failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# zelboraf

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## Products Affected

- TAFINLAR
- ZELBORAF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Wild-type BRAF melanoma
<b>Required Medical Information</b>	Documentation of diagnosis -AND- both of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed and concomitant therapy, if applicable to diagnosis (e.g. diagnosis of V600K metastatic melanoma and drug regimen of Zelboraf and Cotellic)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# zepatier

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## Products Affected

- ZEPATIER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member has a contraindication to or is otherwise not a candidate for all regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
<b>Age Restrictions</b>	Deny if less than 12 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# zeposia

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## Products Affected

- **ZEPOSIA**
- **ZEPOSIA STARTER KIT**
- **ZEPOSIA STARTER PACK**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of Zeposia and other disease modifying agents such as interferons, Copaxone, Tysabri.
<b>Required Medical Information</b>	Documentation of diagnosis. For moderate to severe active ulcerative colitis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Ulcerative Colitis: 12 months, Multiple Sclerosis: 24 months
<b>Other Criteria</b>	For moderate to severe active ulcerative colitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Xeljanz/Xeljanz XR and Stelara SC.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# zolinza

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## Products Affected

- ZOLINZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following 2 systemic therapies. Systemic therapies include bexarotene, interferon alpha, extracorporeal photochemotherapy, PUVA, single agent or combination chemotherapies (e.g. cyclophosphamide, vinblastine, romidepsin)
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ZYDELIG

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## Products Affected

- ZYDELIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	First line treatment. Combination use with benadmustine and/or rituximab for the treatment of FL.
<b>Required Medical Information</b>	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) Alternatives tried/failed 2) Concomitant therapy 3) Candidacy for use of rituximab alone
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# zykadia

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## Products Affected

- ZYKADIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- ALK mutations, as detected by an FDA approved test.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# zytiga

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## Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- concomitant therapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



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# celecoxib

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## Products Affected

- *celecoxib 100 mg capsule*
- *celecoxib 200 mg capsule*
- *celecoxib 400 mg capsule*
- *celecoxib 50 mg capsule*

## Details

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<b>Criteria</b>	Require a 1 month trial of 2 formulary generic NSAIDs (Step 1 drug) in the last 180 days
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# **copaxone**

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## **Products Affected**

- **COPAXONE 20 MG/ML  
SUBCUTANEOUS SYRINGE**
- **COPAXONE 40 MG/ML  
SUBCUTANEOUS SYRINGE**

## **Details**

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<b>Criteria</b>	Require a 1 month trial of generic glatiramer and Glatopa in the last 180 days
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# herpetic keratitis

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## Products Affected

- ZIRGAN 0.15 % EYE GEL

## Details

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<b>Criteria</b>	Require a 1 month trial of generic trifluridine eye drops (Step 1 drug) in the last 90 days
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# **lupron**

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## **Products Affected**

- **LUPRON DEPOT 11.25 MG (3 MONTH) INTRAMUSCULAR SYRINGE KIT**
- **LUPRON DEPOT 22.5 MG (3 MONTH) INTRAMUSCULAR SYRINGE KIT**
- **LUPRON DEPOT 3.75 MG INTRAMUSCULAR SYRINGE KIT**
- **LUPRON DEPOT 30 MG (4 MONTH) INTRAMUSCULAR SYRINGE KIT**
- **LUPRON DEPOT 45 MG (6 MONTH) INTRAMUSCULAR SYRINGE KIT**
- **LUPRON DEPOT 7.5 MG INTRAMUSCULAR SYRINGE KIT**

## **Details**

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<b>Criteria</b>	Require a trial of Eligard (Step 1 drug) in the last 180 days when being utilized for the same medically accepted indication
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# rytary

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## Products Affected

- **RYTARY 23.75 MG-95 MG  
CAPSULE,EXTENDED RELEASE**
- **RYTARY 36.25 MG-145 MG  
CAPSULE,EXTENDED RELEASE**
- **RYTARY 48.75 MG-195 MG  
CAPSULE,EXTENDED RELEASE**
- **RYTARY 61.25 MG-245 MG  
CAPSULE,EXTENDED RELEASE**

## Details

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<b>Criteria</b>	Require a trial of generic carbidopa/levodopa product (Step 1 drug) in the last 90 days
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# Topical Psoriasis

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## Products Affected

- *calcitriol 3 mcg/gram topical ointment*

## Details

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<b>Criteria</b>	Require a 1 month trial of generic calcipotriene cream, ointment or solution (Step 1 drug) in the last 90 days
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**Index of Drugs**

*calcitriol 3 mcg/gram topical ointment*..... 6  
*celecoxib 100 mg capsule* ..... 1  
*celecoxib 200 mg capsule* ..... 1  
*celecoxib 400 mg capsule* ..... 1  
*celecoxib 50 mg capsule* ..... 1  
**COPAXONE 20 MG/ML  
SUBCUTANEOUS SYRINGE**..... 2  
**COPAXONE 40 MG/ML  
SUBCUTANEOUS SYRINGE**..... 2  
**LUPRON DEPOT 11.25 MG (3  
MONTH) INTRAMUSCULAR  
SYRINGE KIT** ..... 4  
**LUPRON DEPOT 22.5 MG (3 MONTH)  
INTRAMUSCULAR SYRINGE KIT** ..... 4  
**LUPRON DEPOT 3.75 MG  
INTRAMUSCULAR SYRINGE KIT** ..... 4  
**LUPRON DEPOT 30 MG (4 MONTH)  
INTRAMUSCULAR SYRINGE KIT** ..... 4  
**LUPRON DEPOT 45 MG (6 MONTH)  
INTRAMUSCULAR SYRINGE KIT** ..... 4  
**LUPRON DEPOT 7.5 MG  
INTRAMUSCULAR SYRINGE KIT** ..... 4  
**RYTARY 23.75 MG-95 MG  
CAPSULE,EXTENDED RELEASE** ..... 5  
**RYTARY 36.25 MG-145 MG  
CAPSULE,EXTENDED RELEASE** ..... 5  
**RYTARY 48.75 MG-195 MG  
CAPSULE,EXTENDED RELEASE** ..... 5  
**RYTARY 61.25 MG-245 MG  
CAPSULE,EXTENDED RELEASE** ..... 5  
**ZIRGAN 0.15 % EYE GEL**..... 3