2027 Retiree Pharmacy Prescription Drug Plan (PDP) Formulary

Medicare Part D: Compass Formulary 2027

Please click here.

For Medicare Part D: Prior Authorization Criteria

Please click here.

For Medicare Part D: Step Therapy Criteria

Please click here.

This formulary was updated on October 1, 2026.

For more recent information or other questions, please contact Retiree Pharmacy PDP Pharmacy Service at 1-877-461-9218, (TTY users should call 711), Oct. 1 – March 31, 8 a.m. – 8 p.m. ET, seven days a week, and April 1 – Aug. 30, 8 a.m. – 8 p.m. ET, Monday – Sunday or visit **medicare.highmark.com**.

Formulary ID: 27202 Version: 10

Updated: 10/2026

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

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

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

This document includes a Drug List (formulary) for our plan, which is current as of January 1, 2027. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2028, and from time to time during the year.

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

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

Can the formulary change?

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

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

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

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

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

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

  Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”
- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 31 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 31-day supply of the drug and notice of the change.

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

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2027 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2028 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

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

How do I use the formulary?

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

Medical Condition

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

Alphabetical Listing

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

What are generic drugs?

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

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

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

For discussion of drug types, please see the Evidence of Coverage, Chapter 3,

Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered.”

Are there any restrictions on my coverage?

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

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

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

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

What if my drug is not on the formulary?

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

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

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

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

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

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

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

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

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

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

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

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

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

For more information

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

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

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

Highmark Blue Cross Blue Shield Retiree Pharmacy PDP formulary

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

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

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

The following is a formulary Format Example Only:

Drug Name	Compass Drug Tier	Requirements/ Limits
Anti-Infectives		
XYZ DRUG	NF	QL-28

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Obstetrics / Gynecology 112
Ophthalmology 118
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Urologicals 128
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lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs

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

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

Drug Name	Drug Tier	Requirements/Limits
Anti - Infectives		
abacavir	T3	
abacavir-lamivudine	T4	
acyclovir oral capsule	T2	
acyclovir oral suspension 200 mg/5 ml	T2	
acyclovir oral tablet	T2	
acyclovir sodium intravenous solution	T2	PA-BvD
adefovir	T4	
albendazole	T4	
amantadine hcl oral capsule	T2	QL (124 EA per 31 days)
amantadine hcl oral solution	T2	
amantadine hcl oral tablet	T2	
AMBISOME	T5	PA-BvD
amikacin injection solution 500 mg/2 ml	T4	
amoxicillin oral capsule	T1	
amoxicillin oral suspension for reconstitution	T1	
amoxicillin oral tablet	T1	
amoxicillin oral tablet,chewable 125 mg, 250 mg	T1	
amoxicillin-pot clavulanate oral suspension for reconstitution	T2	

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

Drug Name	Drug Tier	Requirements/Limits
amoxicillin-pot clavulanate oral tablet 250-125 mg	T2	
amoxicillin-pot clavulanate oral tablet 500-125 mg, 875-125 mg	T1	
amoxicillin-pot clavulanate oral tablet extended release 12 hr	T2	
amoxicillin-pot clavulanate oral tablet,chewable	T2	
amphotericin b	T4	PA-BvD
amphotericin b liposome	T5	PA-BvD
ampicillin oral capsule 500 mg	T1	
ampicillin sodium injection recon soln 1 gram, 10 gram, 2 gram	T2	
ampicillin-sulbactam injection	T4	
ANCOBON	T5	PA
APTIVUS	T5	
ARIKAYCE	T5	PA
atazanavir	T4	
atovaquone	T4	
atovaquone-proguanil	T2	
AUGMENTIN ES-600	T4	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	T4	
AVYCAZ	T5	
AZACTAM INJECTION RECON SOLN 2 GRAM	T4	
azithromycin intravenous	T2	
azithromycin oral suspension for reconstitution	T2	
azithromycin oral tablet	T2	
aztreonam	T4	
BACTRIM	T4	
BACTRIM DS	T4	
BARACLUDE	T5	
BAXDELA	T5	
benznidazole oral tablet 100 mg	T4	QL (120 EA per 30 days)
benznidazole oral tablet 12.5 mg	T4	QL (180 EA per 30 days)
BETHKIS	T5	PA
BICILLIN C-R	T3	

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

Drug Name	Drug Tier	Requirements/Limits
BICILLIN L-A INTRAMUSCULAR SYRINGE 1,200,000 UNIT/2 ML, 2,400,000 UNIT/4 ML	T4	
BICILLIN L-A INTRAMUSCULAR SYRINGE 600,000 UNIT/ML	T3	
BIKTARVY	T5	QL (31 EA per 31 days)
BLUJEPA	T4	QL (20 EA per 5 days)
caspofungin	T4	
CAYSTON	T5	PA
cefaclor oral capsule	T2	
cefaclor oral suspension for reconstitution 250 mg/5 ml	T2	
cefaclor oral tablet extended release 12 hr	T2	
cefadroxil oral capsule	T2	
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	T2	
cefadroxil oral tablet	T3	
cefazolin injection recon soln 1 gram, 500 mg	T2	
cefazolin intravenous recon soln 10 gram	T2	
cefdinir	T2	
cefepime injection	T4	
cefixime oral capsule	T2	
cefixime oral suspension for reconstitution	T2	
cefixime oral tablet	T4	
cefotetan injection	T4	
cefoxitin	T3	
cefpodoxime	T2	
cefprozil	T2	
ceftaroline fosamil	T5	
ceftazidime	T4	
ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg	T2	
cefuroxime axetil oral tablet	T2	
cefuroxime sodium injection recon soln 750 mg	T4	
cefuroxime sodium intravenous recon soln 1.5 gram	T4	
cephalexin	T2	
chloroquine phosphate oral tablet 250 mg	T3	QL (50 EA per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
chloroquine phosphate oral tablet 500 mg	T3	QL (25 EA per 30 days)
CIMDUO	T5	QL (31 EA per 31 days)
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON	T4	
CIPRO ORAL TABLET 250 MG, 500 MG	T4	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	T1	
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	T2	
clarithromycin oral suspension for reconstitution	T3	
clarithromycin oral tablet	T2	
clarithromycin oral tablet extended release 24 hr	T3	
CLEOCIN PEDIATRIC	T4	
clindamycin hcl	T2	
clindamycin in 5 % dextrose	T2	
CLINDAMYCIN PEDIATRIC	T2	
clindamycin phosphate injection	T2	
clotrimazole mucous membrane	T2	
COARTEM	T4	
colistin (colistimethate na)	T4	
COMPLERA	T5	
CRESEMBA ORAL	T5	
cycloserine	T4	
dalbavancin	T5	
DALVANCE	T5	
dapsone oral	T3	
daptomycin	T4	
DARAPRIM	T5	PA
darunavir oral tablet 600 mg	T4	
darunavir oral tablet 800 mg	T5	
DELSTRIGO	T5	QL (31 EA per 31 days)
demeclocycline oral tablet 150 mg	T2	
demeclocycline oral tablet 300 mg	T4	
DESCOVY	T5	QL (31 EA per 31 days)
dicloxacillin	T2	
DIFICID ORAL SUSPENSION FOR RECONSTITUTION	T5	QL (136 ML per 12 days)
DIFICID ORAL TABLET	T5	PA; QL (20 EA per 10 days)

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

Drug Name	Drug Tier	Requirements/Limits
DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML	T4	
DORYX MPC ORAL TABLET,DELAYED RELEASE (DR/EC) 60 MG	T5	
DOVATO	T5	QL (31 EA per 31 days)
DOXY-100	T3	
doxycycline hyclate intravenous	T2	
doxycycline hyclate oral capsule 100 mg, 50 mg	T2	
doxycycline hyclate oral tablet 100 mg	T2	
doxycycline hyclate oral tablet 150 mg, 50 mg, 75 mg	T4	
doxycycline hyclate oral tablet 20 mg	T1	
doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg	T2	
doxycycline hyclate oral tablet,delayed release (dr/ec) 150 mg, 200 mg, 50 mg, 75 mg	T3	
doxycycline monohydrate oral capsule 100 mg, 50 mg	T2	
doxycycline monohydrate oral capsule 150 mg, 75 mg	T4	
doxycycline monohydrate oral capsule,ir - delay rel,biphase	T4	
doxycycline monohydrate oral suspension for reconstitution	T4	
doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg	T2	
doxycycline monohydrate oral tablet 150 mg	T4	
E.E.S. 400 ORAL TABLET	T4	
EDURANT	T5	
EDURANT PED	T5	
efavirenz oral tablet	T3	
efavirenz-emtricitabin-tenofov	T4	
efavirenz-lamivu-tenofov disop	T5	QL (31 EA per 31 days)
EMROSI	T5	PA; QL (31 EA per 31 days)
emtricitabine	T3	
emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 167-250 mg, 200-300 mg	T4	
emtricitabine-tenofovir (tdf) oral tablet 133-200 mg	T5	

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

Drug Name	Drug Tier	Requirements/Limits
emtricita-rilpivirine-tenof df	T5	
EMTRIVA	T4	
EMVERM	T5	
entecavir	T4	
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	T5	PA; QL (28 EA per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	T5	PA; QL (56 EA per 28 days)
EPCLUSA ORAL TABLET	T5	PA; QL (28 EA per 28 days)
EPIVIR	T4	
ERAXIS(WATER DILUENT)	T4	
ertapenem	T4	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	T4	
erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml	T4	
erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml	T5	
erythromycin oral tablet	T4	
erythromycin oral tablet,delayed release (dr/ec)	T4	
ethambutol	T2	
etravirine	T5	
EVOTAZ	T5	
famciclovir	T2	
fidaxomicin	T5	QL (20 EA per 10 days)
FIRVANQ	T4	
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml	T2	
fluconazole oral suspension for reconstitution	T3	
fluconazole oral tablet	T2	
flucytosine	T5	
fosamprenavir	T5	
fosfomycin tromethamine	T4	
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml	T2	
gentamicin injection	T2	
GENVOYA	T5	
griseofulvin microsize	T2	

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

Drug Name	Drug Tier	Requirements/Limits
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	T2	
griseofulvin ultramicrosize oral tablet 165 mg	T5	PA; QL (124 EA per 31 days)
HARVONI	T5	PA; QL (28 EA per 28 days)
HEPCLUDEX	T5	PA; QL (31 EA per 31 days)
HUMATIN	T5	
hydroxychloroquine oral tablet 100 mg	T4	QL (93 EA per 31 days)
hydroxychloroquine oral tablet 200 mg	T2	QL (93 EA per 31 days)
hydroxychloroquine oral tablet 300 mg	T4	QL (62 EA per 31 days)
hydroxychloroquine oral tablet 400 mg	T4	QL (31 EA per 31 days)
IDVYNSO	T5	QL (31 EA per 31 days)
imipenem-cilastatin	T4	
INTELENCE ORAL TABLET 200 MG	T5	
INTELENCE ORAL TABLET 25 MG	T4	
ISENTRESS HD	T5	
ISENTRESS ORAL POWDER IN PACKET	T5	
ISENTRESS ORAL TABLET	T5	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	T5	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	T3	
isoniazid oral	T2	
itraconazole oral capsule	T2	PA
itraconazole oral solution	T4	PA
ivermectin oral	T2	PA
JULUCA	T5	
ketoconazole oral	T2	
KITABIS PAK	T4	PA
KRINTAFEL	T4	
lamivudine oral solution	T2	
lamivudine oral tablet 100 mg	T3	
lamivudine oral tablet 150 mg, 300 mg	T2	
lamivudine-zidovudine	T2	
LAMPIT	T4	
ledipasvir-sofosbuvir	T5	PA; QL (28 EA per 28 days)
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	T2	
levofloxacin oral solution	T3	

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

Drug Name	Drug Tier	Requirements/Limits
levofloxacin oral tablet	T1	
linezolid in dextrose 5%	T4	
linezolid oral suspension for reconstitution	T5	
linezolid oral tablet	T4	
LIVTENCITY	T5	PA; QL (372 EA per 31 days)
lopinavir-ritonavir oral tablet	T4	
MACROBID	T4	
MALARONE	T4	
MALARONE PEDIATRIC	T4	
maraviroc oral tablet 150 mg	T5	
maraviroc oral tablet 300 mg	T3	
MAVYRET ORAL PELLETS IN PACKET	T5	PA; QL (140 EA per 28 days)
MAVYRET ORAL TABLET	T5	PA; QL (84 EA per 28 days)
mefloquine	T2	
MEPRON	T5	
meropenem intravenous recon soln 1 gram, 500 mg	T3	
methenamine hippurate	T2	
metronidazole in nacl (iso-os)	T2	
metronidazole oral capsule	T4	
metronidazole oral tablet 125 mg	T4	PA
metronidazole oral tablet 250 mg, 500 mg	T1	
micafungin	T4	
minocycline oral capsule	T2	
minocycline oral tablet	T2	
minocycline oral tablet extended release 24 hr	T4	
moxifloxacin oral	T3	
moxifloxacin-sod.chloride(iso)	T4	
nafcillin injection recon soln 1 gram, 2 gram	T4	
nafcillin injection recon soln 10 gram	T5	
NEBUPENT	T4	PA-BvD
neomycin	T2	
nevirapine oral suspension	T2	
nevirapine oral tablet	T2	
nevirapine oral tablet extended release 24 hr	T4	
nitazoxanide	T5	
nitrofurantoin	T5	

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

Drug Name	Drug Tier	Requirements/Limits
nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg	T2	
nitrofurantoin macrocrystal oral capsule 25 mg	T4	
nitrofurantoin monohyd/m-cryst	T2	
NORVIR ORAL TABLET	T4	
NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON	T5	PA; QL (32 EA per 31 days)
NUZYRA	T5	
nystatin oral suspension	T2	
nystatin oral tablet	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
ofloxacin oral tablet 400 mg	T2	
ORACEA	T4	PA; QL (31 EA per 31 days)
ORLYNVAH	T5	QL (10 EA per 5 days)
oseltamivir oral capsule 30 mg	T2	QL (170 EA per 365 days)
oseltamivir oral capsule 45 mg, 75 mg	T2	QL (90 EA per 365 days)
oseltamivir oral suspension for reconstitution	T3	QL (1080 ML per 365 days)
oxacillin	T4	
oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml	T4	
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (10)- 100 MG (10)	T2	QL (180 EA per 365 days)
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (6)- 100 MG (5)	T2	QL (99 EA per 365 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	T2	QL (270 EA per 365 days)
penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml	T4	
penicillin g potassium injection recon soln 20 million unit	T4	
penicillin g sodium	T5	
penicillin v potassium	T1	
PENTAM	T4	
pentamidine inhalation	T4	PA-BvD
pentamidine injection	T4	
PIFELTRO	T5	QL (62 EA per 31 days)
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram	T4	
PLAQUENIL	T4	QL (93 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
polymyxin b sulfate	T4	
posaconazole oral	T5	PA
praziquantel	T4	
pretomanid	T4	PA; QL (31 EA per 31 days)
PREVYMIS ORAL PELLETS IN PACKET	T5	PA; QL (124 EA per 31 days)
PREVYMIS ORAL TABLET	T5	QL (31 EA per 31 days)
PREZCOBIX	T5	
PREZISTA ORAL SUSPENSION	T5	
PREZISTA ORAL TABLET 150 MG, 600 MG, 800 MG	T5	
PREZISTA ORAL TABLET 75 MG	T4	
PRIFTIN	T4	
primaquine	T3	
pyrazinamide	T4	
pyrimethamine	T5	PA
quinine sulfate	T4	PA; QL (42 EA per 28 days)
RELENZA DISKHALER	T3	
RETROVIR ORAL CAPSULE	T4	
RETROVIR ORAL SYRUP	T4	
REYATAZ ORAL CAPSULE 200 MG, 300 MG	T5	
REYATAZ ORAL POWDER IN PACKET	T5	
ribavirin oral capsule	T2	
ribavirin oral tablet 200 mg	T2	
rifabutin	T4	
rifampin intravenous	T4	
rifampin oral	T2	
rifapentine	T3	
rilpivirine hcl	T5	
rimantadine	T2	
ritonavir	T3	
RUKOBIA	T5	QL (62 EA per 31 days)
SELZENTRY ORAL TABLET 150 MG, 300 MG	T5	
SEYSARA	T5	PA; QL (31 EA per 31 days)
SIRTURO	T5	PA
SIVEXTRO INTRAVENOUS	T5	

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

Drug Name	Drug Tier	Requirements/Limits
SIVEXTRO ORAL	T5	QL (6 EA per 31 days)
sofosbuvir-velpatasvir	T5	PA; QL (28 EA per 28 days)
SOLOSEC	T4	
SOVALDI	T5	PA; QL (28 EA per 28 days)
SOVUNA ORAL TABLET 200 MG	T4	QL (93 EA per 31 days)
SOVUNA ORAL TABLET 300 MG	T4	QL (62 EA per 31 days)
streptomycin	T5	
STRIBILD	T5	
STROMECTOL	T4	PA
sulfadiazine	T5	
sulfamethoxazole-trimethoprim oral suspension	T2	
sulfamethoxazole-trimethoprim oral tablet	T1	
SUNLENCA ORAL	T5	
SYMFI	T5	QL (31 EA per 31 days)
SYMTUZA	T5	QL (31 EA per 31 days)
TAMIFLU ORAL CAPSULE 75 MG	T4	QL (90 EA per 365 days)
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION	T4	QL (1080 ML per 365 days)
TARGADOX	T4	
TAZICEF INJECTION	T4	
TEFLARO	T5	
tenofovir disoproxil fumarate	T3	
terbinafine hcl oral	T1	QL (90 EA per 180 days)
tetracycline	T4	
tigecycline	T4	
tinidazole	T2	
TIVICAY ORAL TABLET 50 MG	T5	
TIVICAY PD	T5	
TOBI	T5	PA
TOBI PODHALER	T5	PA; QL (224 EA per 56 days)
tobramycin in 0.225 % nacl	T5	PA
tobramycin inhalation	T5	PA
tobramycin sulfate injection solution	T2	
TOLSURA	T5	PA; QL (130 EA per 31 days)
trimethoprim	T2	
TRIUMEQ	T5	
TRIUMEQ PD	T4	QL (186 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
TRUVADA	T5	
TYGACIL	T4	
TYZAVAN INTRAVENOUS PIGGYBACK 1 GRAM/200 ML	T4	
UNASYN INJECTION RECON SOLN 15 GRAM, 3 GRAM	T4	
VABOMERE	T5	
valacyclovir	T2	
VALCYTE ORAL RECON SOLN	T5	
valganciclovir oral recon soln	T5	
valganciclovir oral tablet	T3	
VALTREX	T4	
VANCOCIN ORAL CAPSULE 125 MG	T4	QL (124 EA per 31 days)
VANCOCIN ORAL CAPSULE 250 MG	T5	QL (248 EA per 31 days)
vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg	T2	
vancomycin oral capsule 125 mg	T4	QL (124 EA per 31 days)
vancomycin oral capsule 250 mg	T4	QL (248 EA per 31 days)
vancomycin oral recon soln	T4	
VEMLIDY	T5	QL (31 EA per 31 days)
VFEND IV	T4	PA
VFEND ORAL SUSPENSION FOR RECONSTITUTION	T5	
VIRACEPT ORAL TABLET	T5	
VIREAD	T5	
VIVJOA	T4	PA; QL (18 EA per 84 days)
voriconazole intravenous recon soln	T4	PA
voriconazole oral	T4	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	T3	QL (27 EA per 365 days)
XIFAXAN ORAL TABLET 550 MG	T3	PA; QL (62 EA per 31 days)
XOCOVA	T5	QL (63 EA per 365 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	T3	QL (9 EA per 365 days)
ZERBAXA	T5	
ZEVTERA	T5	
ZIAGEN ORAL SOLUTION	T4	
zidovudine	T2	

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

Drug Name	Drug Tier	Requirements/Limits
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION 200 MG/5 ML	T4	
ZITHROMAX TRI-PAK	T4	
ZITHROMAX Z-PAK	T4	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML	T4	
ZYVOX INTRAVENOUS PIGGYBACK 600 MG/300 ML	T4	
ZYVOX ORAL SUSPENSION FOR RECONSTITUTION	T4	
Antineoplastic / Immunosuppressant Drugs		
abiraterone oral tablet 250 mg	T5	PA-NS; QL (124 EA per 31 days)
abiraterone oral tablet 500 mg	T5	PA-NS; QL (62 EA per 31 days)
ABIRTEGA	T3	PA-NS; QL (124 EA per 31 days)
AFINITOR	T5	PA-NS; QL (31 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 5 MG	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG	T5	PA-NS; QL (93 EA per 31 days)
AKEEGA	T5	PA-NS; QL (62 EA per 31 days)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	T5	PA-NS; QL (31 EA per 31 days)
ALUNBRIG ORAL TABLET 30 MG	T5	PA-NS; QL (186 EA per 31 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	T5	PA-NS; QL (60 EA per 365 days)
anastrozole	T2	
ARIMIDEX	T5	
AROMASIN	T5	
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG	T4	PA-BvD
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 5 MG	T5	PA-BvD
AUGTYRO ORAL CAPSULE 160 MG	T5	PA-NS; QL (62 EA per 31 days)
AUGTYRO ORAL CAPSULE 40 MG	T5	PA-NS; QL (186 EA per 31 days)
AUKELSO	T5	PA-NS
AVMAPKI-FAKZYNJA	T5	PA-NS; QL (66 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
AYVAKIT	T5	PA-NS; QL (31 EA per 31 days)
AZASAN	T4	PA-BvD
azathioprine oral tablet 100 mg, 75 mg	T4	PA-BvD
azathioprine oral tablet 50 mg	T2	PA-BvD
BALVERSA	T5	PA-NS
bexarotene oral	T5	PA-NS
bexarotene topical	T5	PA-NS; QL (60 GM per 28 days)
bicalutamide	T2	
BILPREVDA	T3	PA-NS
BOMYNTRA	T5	PA-NS
BOSULIF ORAL CAPSULE 100 MG	T5	PA-NS; QL (186 EA per 31 days)
BOSULIF ORAL CAPSULE 50 MG	T5	PA-NS; QL (341 EA per 31 days)
BOSULIF ORAL TABLET 100 MG	T5	PA-NS; QL (93 EA per 31 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	T5	PA-NS; QL (31 EA per 31 days)
bosutinib oral tablet 400 mg	T5	PA-NS; QL (31 EA per 31 days)
BRAFTOVI	T5	PA-NS; QL (186 EA per 31 days)
BRUKINSA ORAL TABLET	T5	PA-NS; QL (62 EA per 31 days)
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CALQUENCE (ACALABRUTINIB MAL)	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 300 MG	T5	PA-NS; QL (31 EA per 31 days)
CASODEX	T4	
CELLCEPT	T5	PA-BvD
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	T5	PA-NS; QL (112 EA per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	T5	PA-NS; QL (84 EA per 28 days)
COPIKTRA	T5	PA-NS; QL (62 EA per 31 days)
COTELLIC	T5	PA-NS; LA; QL (63 EA per 28 days)
cyclophosphamide oral capsule	T3	PA-BvD
cyclophosphamide oral tablet 50 mg	T3	PA-BvD
cyclosporine modified oral capsule	T2	PA-BvD
cyclosporine modified oral solution	T5	PA-BvD
cyclosporine oral capsule	T3	PA-BvD
DANZITEN	T5	PA-NS; QL (124 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg	T5	PA-NS; QL (31 EA per 31 days)
dasatinib oral tablet 20 mg	T5	PA-NS; QL (93 EA per 31 days)
DAURISMO ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
DAURISMO ORAL TABLET 25 MG	T5	PA-NS; QL (62 EA per 31 days)
DROXIA	T4	
ELIGARD	T4	QL (1 EA per 30 days)
ELIGARD (3 MONTH)	T4	QL (1 EA per 90 days)
ELIGARD (4 MONTH)	T4	QL (1 EA per 120 days)
ELIGARD (6 MONTH)	T4	QL (1 EA per 180 days)
ENSACOVE	T5	PA-NS; QL (62 EA per 31 days)
ENSPRYNG	T5	PA; QL (1 ML per 28 days)
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG	T4	PA-BvD
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 4 MG	T5	PA-BvD
ERIVEDGE	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA ORAL TABLET 240 MG	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA ORAL TABLET 60 MG	T5	PA-NS; QL (93 EA per 31 days)
erlotinib	T5	PA-NS; QL (31 EA per 31 days)
EULEXIN	T4	
everolimus (antineoplastic) oral tablet	T5	PA-NS; QL (31 EA per 31 days)
everolimus (antineoplastic) oral tablet for suspension 2 mg, 5 mg	T5	PA-NS; QL (62 EA per 31 days)
everolimus (antineoplastic) oral tablet for suspension 3 mg	T5	PA-NS; QL (93 EA per 31 days)
everolimus (immunosuppressive) oral tablet 0.25 mg	T4	PA-BvD
everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg	T5	PA-BvD
exemestane	T2	
FEMARA	T4	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	T5	PA-NS
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	T4	PA-NS
FOTIVDA	T5	PA-NS; QL (21 EA per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	T5	PA-NS; QL (84 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
FRUZAQLA ORAL CAPSULE 5 MG	T5	PA-NS; QL (21 EA per 28 days)
GAVRETO	T5	PA-NS; QL (124 EA per 31 days)
gefitinib	T5	PA-NS; QL (31 EA per 31 days)
GENGRAF ORAL CAPSULE	T2	PA-BvD
GILOTRIF	T5	PA-NS; QL (31 EA per 31 days)
GLEEVEC ORAL TABLET 100 MG	T5	PA-NS; QL (93 EA per 31 days)
GLEEVEC ORAL TABLET 400 MG	T5	PA-NS; QL (62 EA per 31 days)
GLEOSTINE ORAL CAPSULE 10 MG, 40 MG	T4	PA-NS
GLEOSTINE ORAL CAPSULE 100 MG	T5	PA-NS
GOMEKLI ORAL CAPSULE 1 MG	T5	PA-NS; QL (126 EA per 28 days)
GOMEKLI ORAL CAPSULE 2 MG	T5	PA-NS; QL (84 EA per 28 days)
GOMEKLI ORAL TABLET FOR SUSPENSION	T5	PA-NS; QL (168 EA per 28 days)
HERNEXEOS	T5	PA-NS; QL (93 EA per 31 days)
HYDREA	T4	
hydroxyurea	T2	
HYRNUO	T5	PA-NS; QL (124 EA per 31 days)
IBRANCE ORAL CAPSULE 125 MG	T5	PA-NS; QL (21 EA per 28 days)
IBRANCE ORAL TABLET	T5	PA-NS; QL (21 EA per 28 days)
IBTROZI	T5	PA-NS; QL (93 EA per 31 days)
ICLUSIG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA	T5	PA-NS; QL (31 EA per 31 days)
imatinib oral tablet 100 mg	T5	PA-NS; QL (93 EA per 31 days)
imatinib oral tablet 400 mg	T5	PA-NS; QL (62 EA per 31 days)
IMBRUVICA ORAL CAPSULE 140 MG	T5	PA-NS; QL (124 EA per 31 days)
IMBRUVICA ORAL CAPSULE 70 MG	T5	PA-NS; QL (31 EA per 31 days)
IMBRUVICA ORAL SUSPENSION	T5	PA-NS; QL (216 ML per 25 days)
IMBRUVICA ORAL TABLET	T5	PA-NS; QL (31 EA per 31 days)
IMKELDI	T5	PA-NS; QL (280 ML per 28 days)
IMURAN	T4	PA-BvD
INLURIYO	T5	PA-NS; QL (62 EA per 31 days)
INLYTA	T5	PA-NS; QL (124 EA per 31 days)
INQOVI	T5	PA-NS; QL (5 EA per 28 days)
INREBIC	T5	PA-NS; QL (124 EA per 31 days)
IRESSA	T5	PA-NS; QL (31 EA per 31 days)
ITOVEBI ORAL TABLET 3 MG	T5	PA-NS; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
ITOVEBI ORAL TABLET 9 MG	T5	PA-NS; QL (31 EA per 31 days)
IWILFIN	T5	PA-NS; QL (248 EA per 31 days)
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
JAKAFI XR	T5	PA-NS; QL (31 EA per 31 days)
JAYPIRCA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
JAYPIRCA ORAL TABLET 50 MG	T5	PA-NS; QL (31 EA per 31 days)
JIDEYTRO ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
JIDEYTRO ORAL TABLET 25 MG	T5	PA-NS; QL (93 EA per 31 days)
JYLAMVO	T4	PA-BvD
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
KLISYRI (250 MG)	T5	PA
KOMZIFTI	T5	PA-NS; QL (90 EA per 30 days)
KOSELUGO ORAL CAPSULE 10 MG	T5	PA-NS; QL (279 EA per 31 days)
KOSELUGO ORAL CAPSULE 25 MG	T5	PA-NS; QL (124 EA per 31 days)
KOSELUGO ORAL CAPSULE, SPRINKLE 5 MG	T5	PA-NS; QL (600 EA per 30 days)
KOSELUGO ORAL CAPSULE, SPRINKLE 7.5 MG	T5	PA-NS; QL (360 EA per 30 days)
KRAZATI	T5	PA-NS; QL (186 EA per 31 days)
lapatinib	T5	PA-NS; QL (186 EA per 31 days)
LAZCLUZE ORAL TABLET 240 MG	T5	PA-NS; QL (30 EA per 30 days)
LAZCLUZE ORAL TABLET 80 MG	T5	PA-NS; QL (60 EA per 30 days)
lenalidomide	T5	PA-NS; QL (21 EA per 28 days)
LENVIMA	T5	PA-NS
letrozole	T2	
leucovorin calcium oral tablet 10 mg, 5 mg	T2	
leucovorin calcium oral tablet 15 mg, 25 mg	T3	
LEUKERAN	T5	
leuprolide subcutaneous kit	T4	QL (2 EA per 28 days)
LIFYORLI ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 125 MG/DAY(100 MG X1-25MG X3), 125 MG/DAY(100 MG X1-25MG X9)	T5	PA-NS; QL (18 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
LIFYORLI ORAL CAPSULE 150 MG/DAY(100 MG X1-25MG X2), 150 MG/DAY(100 MG X1-25MG X3), 150 MG/DAY(100 MG X1-25MG X9)	T5	PA-NS; QL (27 EA per 28 days)
lomustine oral capsule 10 mg, 40 mg	T4	PA-NS
lomustine oral capsule 100 mg	T5	PA-NS
LONSURF	T5	PA-NS
LORBRENA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
LORBRENA ORAL TABLET 25 MG	T5	PA-NS; QL (93 EA per 31 days)
LUMAKRAS ORAL TABLET 120 MG, 240 MG	T5	PA-NS; QL (62 EA per 31 days)
LUMAKRAS ORAL TABLET 320 MG	T5	PA-NS; QL (93 EA per 31 days)
LUPKYNIS	T5	PA; QL (186 EA per 31 days)
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	T5	QL (1 EA per 90 days)
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 22.5 MG	T5	QL (1 EA per 84 days)
LUPRON DEPOT (4 MONTH)	T5	QL (1 EA per 112 days)
LUPRON DEPOT (6 MONTH)	T5	QL (1 EA per 168 days)
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	T5	QL (1 EA per 30 days)
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG	T5	QL (1 EA per 28 days)
LUTRATE DEPOT (3 MONTH)	T4	QL (1 EA per 84 days)
LYNPARZA	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T5	
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)	T5	PA-NS; QL (93 EA per 31 days)
LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)	T5	PA-NS; QL (124 EA per 31 days)
LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)	T5	PA-NS; QL (155 EA per 31 days)
MATULANE	T5	
megestrol oral suspension 400 mg/10 ml (40 mg/ml)	T2	PA
megestrol oral suspension 625 mg/5 ml (125 mg/ml)	T4	PA
megestrol oral tablet	T2	PA-NS

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

Drug Name	Drug Tier	Requirements/Limits
MEKINIST ORAL RECON SOLN	T5	PA-NS; QL (1260 ML per 31 days)
MEKINIST ORAL TABLET 0.5 MG	T5	PA-NS; QL (93 EA per 31 days)
MEKINIST ORAL TABLET 2 MG	T5	PA-NS; QL (31 EA per 31 days)
MEKTOVI	T5	PA-NS; QL (186 EA per 31 days)
mercaptopurine oral suspension	T5	
mercaptopurine oral tablet	T2	
mesna oral	T4	
MESNEX ORAL	T4	
methotrexate sodium (pf) injection solution	T2	
methotrexate sodium injection	T2	
methotrexate sodium oral	T1	PA-BvD
MODEYSO	T5	PA-NS; QL (20 EA per 28 days)
MYCAPSSA	T5	PA; QL (124 EA per 31 days)
mycophenolate mofetil oral capsule	T2	PA-BvD
mycophenolate mofetil oral suspension for reconstitution	T5	PA-BvD
mycophenolate mofetil oral tablet	T2	PA-BvD
mycophenolate sodium	T2	PA-BvD
MYFORTIC ORAL TABLET,DELAYED RELEASE (DR/EC) 180 MG	T4	PA-BvD
MYFORTIC ORAL TABLET,DELAYED RELEASE (DR/EC) 360 MG	T5	PA-BvD
MYHIBBIN	T5	PA-BvD
NEMLUVIO	T5	PA; QL (2 EA per 28 days)
NEORAL	T4	PA-BvD
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
NEXAVAR	T5	PA-NS; QL (124 EA per 31 days)
nilotinib d-tartrate	T5	PA-NS; QL (124 EA per 31 days)
nilotinib hcl	T5	PA-NS; QL (124 EA per 31 days)
nilutamide	T5	
NINLARO	T5	PA-NS; QL (3 EA per 28 days)
NUBEQA	T5	PA-NS; QL (124 EA per 31 days)
octreotide acetate injection solution	T4	PA
ODOMZO	T5	PA-NS; LA; QL (31 EA per 31 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG	T5	PA-NS; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	T5	PA-NS; QL (96 ML per 28 days)
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)	T5	PA-NS; QL (16 EA per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	T5	PA-NS; QL (20 EA per 28 days)
OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)	T5	PA-NS; QL (24 EA per 28 days)
OJJAARA	T5	PA-NS; QL (31 EA per 31 days)
ONUREG	T5	PA-NS; QL (14 EA per 28 days)
ORGOVYX	T5	PA-NS; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 345 MG	T5	PA-NS; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 86 MG	T5	PA-NS; QL (93 EA per 31 days)
OSENVELT	T5	PA-NS
PALSONIFY	T5	PA; QL (62 EA per 31 days)
pazopanib oral tablet 200 mg	T5	PA-NS; QL (124 EA per 31 days)
PEMAZYRE	T5	PA-NS; QL (14 EA per 21 days)
PHYRAGO ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG	T5	PA-NS; QL (31 EA per 31 days)
PHYRAGO ORAL TABLET 20 MG	T5	PA-NS; QL (93 EA per 31 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (28 EA per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	T5	PA-NS; QL (56 EA per 28 days)
pomalidomide	T5	PA-NS; QL (21 EA per 28 days)
POMALYST	T5	PA-NS; QL (21 EA per 28 days)
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG	T4	PA-BvD
PROGRAF ORAL CAPSULE 5 MG	T5	PA-BvD
PROGRAF ORAL GRANULES IN PACKET	T4	PA-BvD
PURIXAN	T5	
QINLOCK	T5	PA-NS; QL (93 EA per 31 days)
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	T5	PA-NS; QL (62 EA per 31 days)
RETEVMO ORAL TABLET 40 MG	T5	PA-NS; QL (93 EA per 31 days)
REVLIMID	T5	PA-NS; QL (21 EA per 28 days)
REVUFORJ ORAL TABLET 110 MG	T5	PA-NS; QL (124 EA per 31 days)
REVUFORJ ORAL TABLET 160 MG	T5	PA-NS; QL (62 EA per 31 days)
REVUFORJ ORAL TABLET 25 MG	T5	PA-NS; QL (248 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
REZLIDHIA	T5	PA-NS; QL (62 EA per 31 days)
REZUROCK	T5	PA; QL (62 EA per 31 days)
ROMVIMZA	T5	PA-NS; QL (8 EA per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	T5	PA-NS; QL (155 EA per 31 days)
ROZLYTREK ORAL CAPSULE 200 MG	T5	PA-NS; QL (93 EA per 31 days)
ROZLYTREK ORAL PELLETS IN PACKET	T5	PA-NS; QL (372 EA per 31 days)
RUBRACA	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE ORAL CAPSULE	T4	PA-BvD
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML	T5	PA
SANDOSTATIN INJECTION SOLUTION 50 MCG/ML, 500 MCG/ML	T4	PA
SAPHNELO PEN	T5	PA; QL (3.2 ML per 28 days)
SAPHNELO SUBCUTANEOUS	T5	PA; QL (3.2 ML per 28 days)
SCEMBLIX ORAL TABLET 100 MG	T5	PA-NS; QL (124 EA per 31 days)
SCEMBLIX ORAL TABLET 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SCEMBLIX ORAL TABLET 40 MG	T5	PA-NS; QL (248 EA per 31 days)
SIGNIFOR	T5	PA
SIKLOS	T4	
sirolimus	T4	PA-BvD
SOLTAMOX	T4	
sorafenib	T5	PA-NS; QL (124 EA per 31 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG	T5	PA-NS; QL (31 EA per 31 days)
SPRYCEL ORAL TABLET 20 MG	T5	PA-NS; QL (93 EA per 31 days)
STIVARGA	T5	PA-NS; QL (84 EA per 28 days)
sunitinib malate	T5	PA-NS; QL (31 EA per 31 days)
SUTENT	T5	PA-NS; QL (31 EA per 31 days)
TABLOID	T4	
TABRECTA	T5	PA-NS; QL (124 EA per 31 days)
tacrolimus oral capsule 0.5 mg, 1 mg	T2	PA-BvD
tacrolimus oral capsule 5 mg	T4	PA-BvD
tacrolimus oral capsule,extended release 24hr 0.5 mg, 1 mg	T4	PA-BvD
tacrolimus oral capsule,extended release 24hr 5 mg	T5	PA-BvD
TAFINLAR ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
TAFINLAR ORAL TABLET FOR SUSPENSION	T5	PA-NS; QL (930 EA per 31 days)
TAGRISSO	T5	PA-NS; LA; QL (31 EA per 31 days)
TALZENNA	T5	PA-NS; QL (31 EA per 31 days)
tamoxifen	T1	
TARGRETIN ORAL	T5	PA-NS
TARGRETIN TOPICAL	T5	PA-NS; QL (60 GM per 28 days)
TASIGNA	T5	PA-NS; QL (124 EA per 31 days)
TEPMETKO	T5	PA-NS; QL (62 EA per 31 days)
THALOMID ORAL CAPSULE 100 MG	T5	PA-NS; QL (112 EA per 28 days)
THALOMID ORAL CAPSULE 50 MG	T5	PA-NS; QL (28 EA per 28 days)
TIBSOVO	T5	PA-NS; QL (62 EA per 31 days)
toremifene	T5	
TORPENZ	T5	PA-NS; QL (31 EA per 31 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG	T4	QL (1 EA per 84 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 22.5 MG	T4	QL (1 EA per 168 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG	T4	QL (1 EA per 28 days)
tretinoin (antineoplastic)	T5	
TREXALL	T3	PA-BvD
TRUQAP	T5	PA-NS; QL (64 EA per 28 days)
TRUTAKNA	T5	PA; QL (4 ML per 28 days)
TUKYSA ORAL TABLET 150 MG	T5	PA-NS; QL (124 EA per 31 days)
TUKYSA ORAL TABLET 50 MG	T5	PA-NS; QL (248 EA per 31 days)
TURALIO	T5	PA-NS; QL (124 EA per 31 days)
TYKERB	T5	PA-NS; QL (186 EA per 31 days)
VABRINTY (1 MONTH)	T5	ST-NS
VABRINTY (3 MONTH)	T5	ST-NS; QL (1 EA per 90 days)
VABRINTY (4 MONTH)	T5	ST-NS; QL (1 EA per 120 days)
VABRINTY (6 MONTH)	T5	ST-NS; QL (1 EA per 180 days)
VANFLYTA	T5	PA-NS; QL (62 EA per 31 days)
VENCLEXTA ORAL TABLET 10 MG	T3	PA-NS; QL (62 EA per 31 days)
VENCLEXTA ORAL TABLET 100 MG	T5	PA-NS; QL (186 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
VENCLEXTA ORAL TABLET 50 MG	T5	PA-NS; QL (31 EA per 31 days)
VENCLEXTA STARTING PACK	T5	PA-NS; QL (84 EA per 365 days)
VERZENIO	T5	PA-NS; QL (62 EA per 31 days)
VIJOICE ORAL GRANULES IN PACKET	T5	PA-NS; QL (31 EA per 31 days)
VIJOICE ORAL TABLET 125 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
VITRAKVI ORAL CAPSULE 100 MG	T5	PA-NS; QL (62 EA per 31 days)
VITRAKVI ORAL CAPSULE 25 MG	T5	PA-NS; QL (186 EA per 31 days)
VITRAKVI ORAL SOLUTION	T5	PA-NS; QL (310 ML per 31 days)
VONJO	T5	PA-NS; QL (124 EA per 31 days)
VORANIGO ORAL TABLET 10 MG	T5	PA-NS; QL (62 EA per 31 days)
VORANIGO ORAL TABLET 40 MG	T5	PA-NS; QL (31 EA per 31 days)
VOTRIENT	T5	PA-NS; QL (124 EA per 31 days)
VOYXACT	T5	PA; QL (2 ML per 28 days)
WAYRILZ	T5	PA; QL (62 EA per 31 days)
WELIREG	T5	PA-NS; QL (93 EA per 31 days)
WYOST	T3	PA-NS
XALKORI ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
XALKORI ORAL PELLET 150 MG	T5	PA-NS; QL (186 EA per 31 days)
XALKORI ORAL PELLET 20 MG, 50 MG	T5	PA-NS; QL (124 EA per 31 days)
XATMEP	T4	PA-BvD
XERMELO	T5	PA; QL (93 EA per 31 days)
XGEVA	T5	PA-NS
XOSPATA	T5	PA-NS; QL (124 EA per 31 days)
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2)	T5	PA-NS; QL (8 EA per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (10 MG X 4)	T5	PA-NS; QL (16 EA per 28 days)
XPOVIO ORAL TABLET 60 MG/WEEK (60 MG X 1), 80 MG/WEEK (80 MG X 1)	T5	PA-NS; QL (4 EA per 28 days)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)	T5	PA-NS; QL (24 EA per 28 days)
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	T5	PA-NS; QL (32 EA per 28 days)
XROMI	T5	
XTANDI ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
XTANDI ORAL TABLET 40 MG	T5	PA-NS; QL (124 EA per 31 days)
XTANDI ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
XTRENBO	T3	PA-NS
YONSA	T5	PA-NS; QL (124 EA per 31 days)
YULITHIRA	T3	PA-NS; QL (31 EA per 31 days)
ZEJULA	T5	PA-NS; QL (31 EA per 31 days)
ZELBORAF	T5	PA-NS; QL (248 EA per 31 days)
ZENBEXUS	T5	PA-NS; QL (21 EA per 28 days)
ZOLINZA	T5	PA-NS
ZORTRESS ORAL TABLET 0.25 MG	T4	PA-BvD
ZORTRESS ORAL TABLET 0.5 MG, 0.75 MG, 1 MG	T5	PA-BvD
ZYKADIA	T5	PA-NS; QL (93 EA per 31 days)
ZYTIGA ORAL TABLET 250 MG	T5	PA-NS; QL (124 EA per 31 days)
ZYTIGA ORAL TABLET 500 MG	T5	PA-NS; QL (62 EA per 31 days)
Autonomic / Cns Drugs, Neurology / Psych		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	T5	QL (2.4 ML per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	T5	QL (3.2 ML per 56 days)
ABILIFY MAINTENA	T5	QL (1 EA per 28 days)
ABILIFY ORAL TABLET	T4	PA-NS
acetaminophen-codeine oral solution 120-12 mg/5 ml	T2	PA; QL (5167 ML per 31 days)
acetaminophen-codeine oral tablet	T2	PA; QL (403 EA per 31 days)
ADDERALL ORAL TABLET 20 MG	T4	ST; QL (93 EA per 31 days)
ADDERALL ORAL TABLET 5 MG, 7.5 MG	T4	ST; QL (62 EA per 31 days)
ADDERALL XR	T4	ST; QL (31 EA per 31 days)
ADZENYS XR-ODT	T4	ST; QL (31 EA per 31 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	T3	PA; QL (1 ML per 28 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	T3	PA; QL (2 ML per 28 days)
AJOVY AUTOINJECTOR	T4	PA; QL (1.5 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
AJOVY SYRINGE	T4	PA; QL (1.5 ML per 28 days)
ALLZITAL	T4	QL (372 EA per 31 days)
almotriptan malate oral tablet 12.5 mg	T3	QL (8 EA per 28 days)
almotriptan malate oral tablet 6.25 mg	T3	QL (16 EA per 28 days)
ALPRAZOLAM INTENSOL	T4	PA
alprazolam oral tablet 0.25 mg, 0.5 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet 1 mg, 2 mg	T2	PA; QL (155 EA per 31 days)
alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg	T2	PA; QL (31 EA per 31 days)
alprazolam oral tablet extended release 24 hr 2 mg	T2	PA; QL (155 EA per 31 days)
alprazolam oral tablet extended release 24 hr 3 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg	T4	PA; QL (93 EA per 31 days)
alprazolam oral tablet,disintegrating 1 mg, 2 mg	T4	PA; QL (155 EA per 31 days)
AMBIEN	T4	PA; QL (31 EA per 31 days)
AMBIEN CR	T4	PA; QL (31 EA per 31 days)
amitriptyline	T2	PA-NS
amitriptyline-chlordiazepoxide	T4	PA-NS
amoxapine	T3	
amphetamine	T4	ST; QL (31 EA per 31 days)
amphetamine sulfate	T4	PA
AMPYRA	T5	PA; QL (62 EA per 31 days)
AMRIX	T5	QL (31 EA per 31 days)
ANAFRANIL	T4	PA-NS
APLENZIN	T5	QL (31 EA per 31 days)
APOKYN	T5	PA; QL (60 ML per 30 days)
apomorphine	T5	PA; QL (60 ML per 30 days)
APTIOM ORAL TABLET 200 MG	T4	QL (186 EA per 31 days)
APTIOM ORAL TABLET 400 MG	T5	QL (93 EA per 31 days)
APTIOM ORAL TABLET 600 MG, 800 MG	T5	QL (62 EA per 31 days)
ARICEPT	T4	
aripiprazole oral solution	T3	PA-NS
aripiprazole oral tablet	T2	
aripiprazole oral tablet,disintegrating	T4	PA-NS
ARISTADA INITIO	T5	QL (4.8 ML per 365 days)

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

Drug Name	Drug Tier	Requirements/Limits
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML	T5	QL (3.9 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML	T5	QL (1.6 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML	T5	QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML	T5	QL (3.2 ML per 28 days)
armodafinil	T3	PA; QL (31 EA per 31 days)
ARTHROTEC 50	T4	
ARTHROTEC 75	T4	
ARYNTA	T4	ST; QL (200 ML per 28 days)
ASCOMP WITH CODEINE	T4	PA; QL (372 EA per 31 days)
asenapine maleate	T4	PA-NS; QL (62 EA per 31 days)
ATIVAN ORAL TABLET 0.5 MG	T5	PA; QL (124 EA per 31 days)
ATIVAN ORAL TABLET 1 MG	T5	PA; QL (186 EA per 31 days)
ATIVAN ORAL TABLET 2 MG	T5	PA; QL (155 EA per 31 days)
atomoxetine oral capsule 10 mg, 25 mg, 40 mg	T3	QL (62 EA per 31 days)
atomoxetine oral capsule 100 mg, 60 mg, 80 mg	T3	QL (31 EA per 31 days)
atomoxetine oral capsule 18 mg	T3	QL (124 EA per 31 days)
atomoxetine oral solution	T4	PA; QL (800 ML per 31 days)
ATONCY	T4	PA; QL (800 ML per 31 days)
AUBAGIO	T5	PA; QL (31 EA per 31 days)
AUSTEDO ORAL TABLET 12 MG, 6 MG	T5	PA; QL (124 EA per 31 days)
AUSTEDO ORAL TABLET 9 MG	T5	PA; QL (155 EA per 31 days)
AUSTEDO XR	T5	PA; QL (31 EA per 31 days)
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG	T5	PA; QL (56 EA per 365 days)
AUVELITY ORAL TABLET, IR AND ER, BIPHASIC	T5	PA-NS; QL (62 EA per 31 days)
AZILECT ORAL TABLET 0.5 MG	T4	
AZILECT ORAL TABLET 1 MG	T5	
AZSTARYS	T4	ST; QL (31 EA per 31 days)
baclofen oral solution 10 mg/5 ml (2 mg/ml)	T4	PA; QL (1240 ML per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
baclofen oral solution 5 mg/5 ml	T4	PA; QL (2480 ML per 31 days)
baclofen oral suspension	T4	PA; QL (496 ML per 31 days)
baclofen oral tablet 10 mg	T1	
baclofen oral tablet 15 mg, 5 mg	T4	
baclofen oral tablet 20 mg	T2	
BAFIERTAM	T5	PA; QL (124 EA per 31 days)
BANZEL ORAL SUSPENSION	T5	PA-NS; QL (2480 ML per 31 days)
BANZEL ORAL TABLET 200 MG	T5	PA-NS; QL (124 EA per 31 days)
BANZEL ORAL TABLET 400 MG	T5	PA-NS; QL (248 EA per 31 days)
BELBUCA	T4	PA; QL (62 EA per 31 days)
BELSOMRA	T4	ST; QL (31 EA per 31 days)
benztropine oral	T2	PA
BREKIYA	T5	PA; QL (24 ML per 28 days)
brivaracetam oral solution	T5	QL (620 ML per 31 days)
brivaracetam oral tablet	T5	QL (62 EA per 31 days)
BRIVIACT ORAL SOLUTION	T5	QL (620 ML per 31 days)
BRIVIACT ORAL TABLET	T5	QL (62 EA per 31 days)
bromocriptine oral capsule	T4	
bromocriptine oral tablet	T2	
BUCAPSOL ORAL CAPSULE 10 MG	T5	PA; QL (155 EA per 31 days)
BUCAPSOL ORAL CAPSULE 15 MG	T5	PA; QL (124 EA per 31 days)
BUCAPSOL ORAL CAPSULE 7.5 MG	T5	PA; QL (62 EA per 31 days)
buprenorphine	T4	PA; QL (4 EA per 28 days)
buprenorphine hcl sublingual	T3	
buprenorphine-naloxone sublingual film	T2	
buprenorphine-naloxone sublingual tablet	T4	
bupropion hcl oral tablet	T2	
bupropion hcl oral tablet extended release 24 hr 150 mg	T2	QL (93 EA per 31 days)
bupropion hcl oral tablet extended release 24 hr 300 mg	T2	QL (31 EA per 31 days)
bupropion hcl oral tablet extended release 24 hr 450 mg	T4	QL (31 EA per 31 days)
bupropion hcl oral tablet sustained-release 12 hr	T2	QL (62 EA per 31 days)
buspirone oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	T2	
buspirone oral tablet 12.5 mg, 2.5 mg	T5	PA; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg	T4	PA; QL (403 EA per 31 days)
butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg	T4	PA; QL (372 EA per 31 days)
butalbital-acetaminophen oral capsule	T4	QL (403 EA per 31 days)
butalbital-acetaminophen oral tablet 50-300 mg	T4	QL (403 EA per 31 days)
butalbital-acetaminophen oral tablet 50-325 mg	T2	QL (372 EA per 31 days)
butalbital-acetaminophen-caff oral capsule 50-300-40 mg	T4	QL (403 EA per 31 days)
butalbital-acetaminophen-caff oral capsule 50-325-40 mg	T4	QL (372 EA per 31 days)
butalbital-acetaminophen-caff oral tablet	T2	QL (372 EA per 31 days)
butalbital-aspirin-caffeine oral capsule	T4	
butorphanol nasal	T2	QL (5 ML per 28 days)
BUTRANS	T4	PA; QL (4 EA per 28 days)
CAFERGOT	T4	PA
CAMBIA	T4	
CAPLYTA	T5	PA-NS; QL (31 EA per 31 days)
carbamazepine oral capsule, er multiphase 12 hr	T2	
carbamazepine oral suspension 100 mg/5 ml	T3	
carbamazepine oral tablet	T1	
carbamazepine oral tablet extended release 12 hr	T2	
carbamazepine oral tablet,chewable 100 mg	T1	
carbamazepine oral tablet,chewable 200 mg	T4	
CARBATROL	T4	
carbidopa	T4	
carbidopa-levodopa oral capsule, extended release	T4	ST
carbidopa-levodopa oral tablet	T2	
carbidopa-levodopa oral tablet extended release	T2	
carbidopa-levodopa oral tablet,disintegrating	T2	
carbidopa-levodopa-entacapone	T2	
carisoprodol oral tablet 250 mg	T4	
carisoprodol oral tablet 350 mg	T2	
CELEBREX	T4	ST; QL (62 EA per 31 days)
celecoxib	T2	QL (62 EA per 31 days)
CELEXA ORAL TABLET	T4	
CELONTIN ORAL CAPSULE 300 MG	T4	

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

Drug Name	Drug Tier	Requirements/Limits
chlordiazepoxide hcl	T2	PA
chlorpromazine oral	T4	
chlorzoxazone oral tablet 250 mg	T5	
chlorzoxazone oral tablet 375 mg, 750 mg	T4	
chlorzoxazone oral tablet 500 mg	T2	
citalopram oral capsule	T4	PA-NS; QL (31 EA per 31 days)
citalopram oral solution	T3	
citalopram oral tablet	T1	
cladribine(multiple sclerosis) oral tablet 10 mg (10 pack), 10 mg (4 pack), 10 mg (5 pack), 10 mg (6 pack), 10 mg (7 pack), 10 mg (8 pack), 10 mg (9 pack)	T5	PA; QL (40 EA per 365 days)
clobazam oral suspension	T4	PA-NS; QL (496 ML per 31 days)
clobazam oral tablet	T3	PA-NS; QL (62 EA per 31 days)
clomipramine	T4	PA-NS
clonazepam oral tablet 0.5 mg	T2	PA-NS; QL (93 EA per 31 days)
clonazepam oral tablet 1 mg	T2	PA-NS; QL (124 EA per 31 days)
clonazepam oral tablet 2 mg	T2	PA-NS; QL (310 EA per 31 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg	T2	PA-NS; QL (93 EA per 31 days)
clonazepam oral tablet,disintegrating 1 mg	T2	PA-NS; QL (124 EA per 31 days)
clonazepam oral tablet,disintegrating 2 mg	T2	PA-NS; QL (310 EA per 31 days)
clonidine hcl oral tablet extended release 12 hr	T4	PA
clorazepate dipotassium oral tablet 15 mg	T3	PA-NS; QL (186 EA per 31 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	T3	PA-NS; QL (93 EA per 31 days)
clozapine oral tablet 100 mg	T3	QL (279 EA per 31 days)
clozapine oral tablet 200 mg	T3	QL (124 EA per 31 days)
clozapine oral tablet 25 mg	T2	QL (279 EA per 31 days)
clozapine oral tablet 50 mg	T2	QL (93 EA per 31 days)
clozapine oral tablet,disintegrating 100 mg, 25 mg	T4	QL (279 EA per 31 days)
clozapine oral tablet,disintegrating 12.5 mg	T4	QL (93 EA per 31 days)
clozapine oral tablet,disintegrating 150 mg	T4	QL (186 EA per 31 days)
clozapine oral tablet,disintegrating 200 mg	T4	QL (124 EA per 31 days)
CLOZARIL ORAL TABLET 100 MG	T5	QL (279 EA per 31 days)
CLOZARIL ORAL TABLET 25 MG	T4	QL (279 EA per 31 days)
COBENFY	T5	PA-NS; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
COBENFY STARTER PACK	T5	PA-NS; QL (112 EA per 365 days)
codeine sulfate	T4	PA; QL (186 EA per 31 days)
codeine-butalbital-asa-caff	T4	PA; QL (372 EA per 31 days)
CONCERTA	T4	ST; QL (31 EA per 31 days)
CONZIP	T4	PA; QL (30 EA per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (31 ML per 31 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	T5	PA; QL (12 ML per 28 days)
COTEMPLA XR-ODT	T4	ST; QL (62 EA per 31 days)
CREXONT	T4	ST
cyclobenzaprine oral capsule,extended release 24hr	T4	QL (31 EA per 31 days)
cyclobenzaprine oral tablet 10 mg, 7.5 mg	T4	QL (93 EA per 31 days)
cyclobenzaprine oral tablet 5 mg	T4	QL (155 EA per 31 days)
dalfampridine	T3	PA; QL (62 EA per 31 days)
DANTRIUM ORAL CAPSULE 25 MG	T4	
dantrolene oral	T4	
DAYBUE	T5	PA; QL (3600 ML per 30 days)
DAYBUE STIX ORAL POWDER IN PACKET 5,000 MG, 6,000 MG	T5	PA; QL (124 EA per 31 days)
DAYBUE STIX ORAL POWDER IN PACKET 8,000 MG	T5	PA; QL (62 EA per 31 days)
DAYTRANA	T4	PA; QL (30 EA per 30 days)
DAYVIGO	T4	ST; QL (31 EA per 31 days)
DEMEROL (PF) INJECTION SYRINGE 25 MG/ML	T4	PA; QL (496 ML per 31 days)
DEMEROL INJECTION	T4	PA; QL (248 ML per 31 days)
DEPAKOTE	T4	
DEPAKOTE ER	T4	
DEPAKOTE SPRINKLES	T4	
desipramine	T2	
desvenlafaxine oral tablet extended release 24 hr 100 mg	T4	QL (124 EA per 31 days)
desvenlafaxine oral tablet extended release 24 hr 50 mg	T4	QL (31 EA per 31 days)
desvenlafaxine succinate	T3	QL (31 EA per 31 days)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG	T5	ST; QL (186 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
dexmethylphenidate oral capsule,er biphasic 50-50	T4	QL (31 EA per 31 days)
dexmethylphenidate oral tablet 10 mg	T2	QL (62 EA per 31 days)
dexmethylphenidate oral tablet 2.5 mg, 5 mg	T2	QL (93 EA per 31 days)
dextroamphetamine sulfate oral capsule, extended release 10 mg	T4	ST; QL (155 EA per 31 days)
dextroamphetamine sulfate oral capsule, extended release 15 mg	T4	ST; QL (124 EA per 31 days)
dextroamphetamine sulfate oral capsule, extended release 5 mg	T4	ST; QL (186 EA per 31 days)
dextroamphetamine sulfate oral solution	T4	
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	T3	QL (62 EA per 31 days)
dextroamphetamine sulfate oral tablet 15 mg, 20 mg, 30 mg	T4	QL (62 EA per 31 days)
dextroamphetamine-amphetamine oral capsule, er triphasic 24 hr	T4	ST; QL (31 EA per 31 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr	T3	QL (31 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	T1	QL (62 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 20 mg	T1	QL (93 EA per 31 days)
DHIVY	T4	ST
DIACOMIT ORAL CAPSULE 250 MG	T5	PA-NS; QL (341 EA per 31 days)
DIACOMIT ORAL CAPSULE 500 MG	T5	PA-NS; QL (186 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 250 MG	T5	PA-NS; QL (341 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 500 MG	T5	PA-NS; QL (186 EA per 31 days)
DIAZEPAM INTENSOL	T2	PA-NS; QL (248 ML per 31 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	T2	PA-NS; QL (1500 ML per 31 days)
diazepam oral tablet	T2	PA-NS; QL (124 EA per 31 days)
diazepam rectal	T4	
dichlorphenamide	T5	PA; QL (124 EA per 31 days)
diclofenac epolamine	T4	PA; QL (62 EA per 31 days)
diclofenac potassium oral capsule	T4	
diclofenac potassium oral powder in packet	T4	
diclofenac potassium oral tablet 25 mg	T5	

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

Drug Name	Drug Tier	Requirements/Limits
diclofenac potassium oral tablet 50 mg	T1	
diclofenac sodium oral	T1	
diclofenac sodium topical drops	T2	QL (450 ML per 28 days)
diclofenac sodium topical solution in metered-dose pump	T4	ST; QL (224 GM per 28 days)
diclofenac-misoprostol	T3	
diflunisal	T2	
dihydroergotamine nasal	T4	PA; QL (8 ML per 28 days)
DILANTIN	T3	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	
DILANTIN-125	T4	
DILAUDID ORAL LIQUID	T4	PA; QL (1240 ML per 31 days)
DILAUDID ORAL TABLET 2 MG, 4 MG	T4	PA; QL (186 EA per 31 days)
DILAUDID ORAL TABLET 8 MG	T4	PA; QL (155 EA per 31 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg	T4	PA; QL (62 EA per 31 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)	T4	PA; QL (120 EA per 365 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 240 mg	T5	PA; QL (62 EA per 31 days)
divalproex oral capsule, delayed rel sprinkle	T2	
divalproex oral tablet extended release 24 hr 250 mg	T2	
divalproex oral tablet extended release 24 hr 500 mg	T3	
divalproex oral tablet,delayed release (dr/ec)	T2	
DOLOBID	T5	
donepezil oral tablet 10 mg, 5 mg	T1	
donepezil oral tablet 23 mg	T3	QL (31 EA per 31 days)
donepezil oral tablet,disintegrating	T2	
doxepin oral capsule	T2	PA-NS
doxepin oral concentrate	T2	PA-NS
doxepin oral tablet	T3	PA
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG	T3	PA-NS; QL (93 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 30 MG, 60 MG	T3	PA-NS; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	T3	PA-NS; QL (31 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 120 mg, 80 mg, 90 mg	T4	QL (31 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 60 mg	T2	QL (62 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 30 mg	T2	QL (31 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 40 mg	T3	QL (31 EA per 31 days)
DUOPA	T5	PA-BvD
DYANAVEL XR ORAL SUSPEN, IR - ER, BIPHASIC 24HR	T4	ST; QL (248 ML per 31 days)
DYANAVEL XR ORAL TABLET, IR - ER, BIPHASIC 24HR	T4	ST; QL (31 EA per 31 days)
EDLUAR	T4	PA; QL (31 EA per 31 days)
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 37.5 MG	T4	QL (31 EA per 31 days)
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 75 MG	T4	QL (93 EA per 31 days)
eletriptan oral tablet 20 mg	T4	QL (12 EA per 28 days)
eletriptan oral tablet 40 mg	T4	QL (6 EA per 28 days)
ELYXYB	T4	PA
EMGALITY PEN	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	T5	PA; QL (3 ML per 28 days)
EMSAM	T5	QL (30 EA per 30 days)
entacapone	T2	
EPIDIOLEX	T5	PA-NS
EPRONTIA	T4	PA-NS; QL (496 ML per 31 days)
EQUETRO	T4	
ERGOMAR	T4	PA
ergotamine-caffeine	T3	PA
ERZOFRI INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	T5	QL (0.75 ML per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
ERZOFRI INTRAMUSCULAR SYRINGE 156 MG/ML	T5	QL (1 ML per 30 days)
ERZOFRI INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	T5	QL (1.5 ML per 30 days)
ERZOFRI INTRAMUSCULAR SYRINGE 351 MG/2.25 ML	T5	QL (4.5 ML per 365 days)
ERZOFRI INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T4	QL (0.25 ML per 30 days)
ERZOFRI INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	T5	QL (0.5 ML per 30 days)
escitalopram oxalate oral capsule	T4	PA-NS; QL (31 EA per 31 days)
escitalopram oxalate oral solution	T4	QL (620 ML per 31 days)
escitalopram oxalate oral tablet 10 mg	T1	QL (45 EA per 30 days)
escitalopram oxalate oral tablet 20 mg, 5 mg	T1	QL (30 EA per 30 days)
eslicarbazepine oral tablet 200 mg	T4	QL (186 EA per 31 days)
eslicarbazepine oral tablet 400 mg	T4	QL (93 EA per 31 days)
eslicarbazepine oral tablet 600 mg, 800 mg	T5	QL (62 EA per 31 days)
estazolam	T2	PA
eszopiclone	T2	PA; QL (31 EA per 31 days)
ethosuximide oral capsule	T3	
ethosuximide oral solution	T2	
etodolac oral capsule	T3	
etodolac oral tablet	T2	
etodolac oral tablet extended release 24 hr	T3	
EVEKEO	T4	PA
EVRYSDI ORAL RECON SOLN	T5	PA; QL (240 ML per 31 days)
EVRYSDI ORAL TABLET	T5	PA; QL (31 EA per 31 days)
EXELON PATCH	T4	QL (30 EA per 30 days)
EXXUA ORAL TABLET EXTENDED RELEASE 24 HR	T4	PA-NS; QL (31 EA per 31 days)
EXXUA ORAL TABLET, EXT REL 24HR DOSE PACK	T4	PA-NS; QL (64 EA per 365 days)
FANAPT	T5	PA-NS; QL (62 EA per 31 days)
FANAPT TITRATION PACK A	T4	PA-NS; QL (16 EA per 365 days)
FANAPT TITRATION PACK B	T4	PA-NS; QL (24 EA per 365 days)
FANAPT TITRATION PACK C	T4	PA-NS; QL (16 EA per 365 days)
felbamate	T4	
FELBATOL ORAL TABLET	T5	

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

Drug Name	Drug Tier	Requirements/Limits
fenoprofen oral capsule 200 mg, 300 mg	T5	
fenoprofen oral capsule 400 mg	T4	
FENOPRON	T5	
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	T3	PA; QL (10 EA per 30 days)
fentanyl transdermal patch 72 hour 37.5 mcg/hour, 62.5 mcg/hour, 87.5 mcg/hour	T4	PA; QL (10 EA per 30 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	T4	PA-NS; QL (56 EA per 365 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG	T4	PA-NS; QL (31 EA per 31 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	T4	PA-NS; QL (93 EA per 31 days)
FEXMID	T4	QL (93 EA per 31 days)
fingolimod	T5	PA; QL (31 EA per 31 days)
FINTEPLA	T5	PA-NS; QL (360 ML per 30 days)
FIORICET	T4	QL (403 EA per 31 days)
FIRDAPSE	T5	PA; QL (248 EA per 31 days)
FLECTOR	T4	PA; QL (62 EA per 31 days)
FLEQSUVY	T4	PA; QL (496 ML per 31 days)
fluoxetine (pmdd)	T1	
fluoxetine oral capsule	T1	
fluoxetine oral capsule,delayed release(dr/ec)	T3	
fluoxetine oral solution	T3	
fluoxetine oral tablet 10 mg, 20 mg	T1	
fluoxetine oral tablet 60 mg	T4	
fluphenazine decanoate	T2	
fluphenazine hcl injection	T2	
fluphenazine hcl oral concentrate	T2	
fluphenazine hcl oral elixir	T4	
fluphenazine hcl oral tablet	T2	
flurazepam	T2	PA
flurbiprofen oral tablet 100 mg	T3	
fluvoxamine oral capsule,extended release 24hr	T4	
fluvoxamine oral tablet	T2	
FOCALIN XR	T4	ST; QL (31 EA per 31 days)
frovatriptan	T3	QL (12 EA per 28 days)
FYCOMPA ORAL SUSPENSION	T5	QL (744 ML per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	T5	QL (31 EA per 31 days)
FYCOMPA ORAL TABLET 2 MG	T4	QL (31 EA per 31 days)
gabapentin oral capsule 100 mg, 400 mg	T2	QL (270 EA per 30 days)
gabapentin oral capsule 200 mg	T5	PA-NS; QL (540 EA per 30 days)
gabapentin oral capsule 300 mg	T2	QL (360 EA per 30 days)
gabapentin oral solution 250 mg/5 ml	T2	QL (2160 ML per 30 days)
gabapentin oral tablet 600 mg	T2	QL (180 EA per 30 days)
gabapentin oral tablet 800 mg	T2	QL (120 EA per 30 days)
gabapentin oral tablet extended release 24 hr 300 mg	T4	PA; QL (155 EA per 31 days)
gabapentin oral tablet extended release 24 hr 450 mg	T4	PA; QL (31 EA per 31 days)
gabapentin oral tablet extended release 24 hr 600 mg	T4	PA; QL (93 EA per 31 days)
gabapentin oral tablet extended release 24 hr 750 mg, 900 mg	T4	PA; QL (62 EA per 31 days)
GABARONE ORAL TABLET 100 MG	T5	PA-NS; QL (558 EA per 31 days)
GABARONE ORAL TABLET 400 MG	T5	PA-NS; QL (279 EA per 31 days)
galantamine oral capsule,ext rel. pellets 24 hr	T2	
galantamine oral solution	T4	
galantamine oral tablet	T2	
GEODON INTRAMUSCULAR	T4	
GEODON ORAL	T5	QL (62 EA per 31 days)
GILENYA	T5	PA; QL (31 EA per 31 days)
glatiramer subcutaneous syringe 20 mg/ml	T5	PA; QL (31 ML per 31 days)
glatiramer subcutaneous syringe 40 mg/ml	T5	PA; QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (31 ML per 31 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	T5	PA; QL (12 ML per 28 days)
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG	T5	PA; QL (62 EA per 31 days)
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 68.5 MG	T5	PA; QL (124 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T4	PA; QL (155 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG	T4	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T4	PA; QL (93 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 750 MG, 900 MG	T4	PA; QL (62 EA per 31 days)
guanfacine oral tablet extended release 24 hr	T2	PA
haloperidol	T1	
haloperidol decanoate	T2	
haloperidol lactate injection	T1	
haloperidol lactate oral	T2	
HETLIOZ	T5	PA; QL (31 EA per 31 days)
HETLIOZ LQ	T5	PA; QL (158 ML per 31 days)
HORIZANT	T4	PA; QL (60 EA per 30 days)
hydrocodone bitartrate oral capsule, oral only, er 12hr	T4	PA; QL (100 EA per 31 days)
hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr 100 mg, 120 mg	T5	PA; QL (31 EA per 31 days)
hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	T4	PA; QL (31 EA per 31 days)
hydrocodone-acetaminophen oral solution 10-300 mg/15 ml	T4	PA; QL (6200 ML per 31 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	T3	PA; QL (5723 ML per 31 days)
hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	T3	PA; QL (403 EA per 31 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	T3	PA; QL (372 EA per 31 days)
hydrocodone-ibuprofen	T4	PA; QL (155 EA per 31 days)
hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml	T4	PA
hydromorphone oral liquid	T4	PA; QL (1240 ML per 31 days)
hydromorphone oral tablet 2 mg, 4 mg	T2	PA; QL (186 EA per 31 days)
hydromorphone oral tablet 8 mg	T3	PA; QL (155 EA per 31 days)
hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 8 mg	T4	PA; QL (62 EA per 31 days)
hydromorphone oral tablet extended release 24 hr 32 mg	T4	PA; QL (31 EA per 31 days)
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 80 MG	T5	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 20 MG, 30 MG, 40 MG, 60 MG	T4	PA; QL (31 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	
ibuprofen oral suspension	T1	
ibuprofen oral tablet 300 mg	T4	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	T1	
ibuprofen-famotidine	T4	PA; QL (93 EA per 31 days)
imipramine hcl	T2	PA-NS
imipramine pamoate	T4	PA-NS
IMITREX ORAL TABLET 100 MG	T4	QL (9 EA per 28 days)
IMITREX ORAL TABLET 25 MG	T4	QL (36 EA per 28 days)
IMITREX ORAL TABLET 50 MG	T4	QL (18 EA per 28 days)
IMITREX STATDOSE PEN SUBCUTANEOUS PEN INJECTOR 4 MG/0.5 ML	T4	QL (6 ML per 28 days)
IMITREX STATDOSE REFILL SUBCUTANEOUS CARTRIDGE 6 MG/0.5 ML	T5	QL (4 ML per 28 days)
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	T5	PA; QL (300 EA per 30 days)
INDOCIN ORAL	T4	
INDOCIN RECTAL	T5	
indomethacin oral capsule	T1	
indomethacin oral capsule, extended release	T1	
indomethacin oral suspension	T4	
indomethacin rectal suppository 50 mg	T5	
INGREZZA INITIATION PK(TARDIV)	T5	PA; QL (56 EA per 365 days)
INGREZZA ORAL CAPSULE 40 MG	T5	PA; QL (62 EA per 31 days)
INGREZZA ORAL CAPSULE 60 MG, 80 MG	T5	PA; QL (31 EA per 31 days)
INGREZZA SPRINKLE	T5	PA; QL (31 EA per 31 days)
INTUNIV ER	T4	PA
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	T5	QL (3.5 ML per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	T5	QL (5 ML per 180 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 3 MG, 9 MG	T4	QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG	T4	QL (62 EA per 31 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	T5	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	T5	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	T5	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T4	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	T5	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	T5	QL (0.88 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	T5	QL (1.32 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	T5	QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	T5	QL (2.63 ML per 84 days)
JORNAY PM	T4	ST; QL (31 EA per 31 days)
JOURNAVX	T4	PA; QL (29 EA per 90 days)
KEPPRA ORAL SOLUTION	T5	
KEPPRA ORAL TABLET 1,000 MG	T5	
KEPPRA ORAL TABLET 250 MG, 500 MG, 750 MG	T4	
KEPPRA XR	T4	
KESIMPTA PEN	T5	PA; QL (0.4 ML per 28 days)
ketoprofen oral capsule 25 mg, 50 mg	T2	
ketoprofen oral capsule 75 mg	T5	QL (124 EA per 31 days)
ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg	T4	
ketorolac oral	T2	
KEVEYIS	T5	PA; QL (124 EA per 31 days)
KLONOPIN ORAL TABLET 0.5 MG	T4	PA-NS; QL (93 EA per 31 days)
KLONOPIN ORAL TABLET 1 MG	T4	PA-NS; QL (124 EA per 31 days)
KLONOPIN ORAL TABLET 2 MG	T4	PA-NS; QL (310 EA per 31 days)
KLOXXADO	T3	
lacosamide oral solution	T4	

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

Drug Name	Drug Tier	Requirements/Limits
lacosamide oral tablet 100 mg, 200 mg, 50 mg	T4	QL (62 EA per 31 days)
lacosamide oral tablet 150 mg	T4	
LAMICTAL ODT ORAL TABLET,DISINTEGRATING 100 MG	T5	
LAMICTAL ODT ORAL TABLET,DISINTEGRATING 200 MG, 25 MG, 50 MG	T4	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG	T4	
LAMICTAL ORAL TABLET 25 MG	T5	
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	T4	
LAMICTAL STARTER (BLUE) KIT	T4	
LAMICTAL STARTER (GREEN) KIT	T4	
LAMICTAL STARTER (ORANGE) KIT	T4	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR 100 MG, 200 MG, 25 MG, 50 MG	T5	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR 250 MG, 300 MG	T4	
LAMICTAL XR STARTER (BLUE)	T4	
LAMICTAL XR STARTER (GREEN)	T4	
LAMICTAL XR STARTER (ORANGE)	T4	
lamotrigine oral tablet	T2	
lamotrigine oral tablet disintegrating, dose pk	T4	
lamotrigine oral tablet extended release 24hr	T4	
lamotrigine oral tablet, chewable dispersible	T2	
lamotrigine oral tablet,disintegrating	T4	
lamotrigine oral tablets,dose pack	T4	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	T5	PA-NS; QL (31 EA per 31 days)
LATUDA ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 360 MG/1.8 ML	T5	PA; QL (7.2 ML per 28 days)
LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 500 MG/2.5 ML (250MG/1.25MLX2)	T5	PA; QL (10 ML per 28 days)
levetiracetam oral solution 100 mg/ml	T2	
levetiracetam oral tablet	T2	

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

Drug Name	Drug Tier	Requirements/Limits
levetiracetam oral tablet extended release 24 hr	T2	
levetiracetam oral tablet for suspension	T4	
levorphanol tartrate	T5	PA; QL (186 EA per 31 days)
LEXAPRO ORAL TABLET 10 MG	T4	QL (45 EA per 30 days)
LEXAPRO ORAL TABLET 20 MG, 5 MG	T4	QL (30 EA per 30 days)
LICART	T4	PA; QL (31 EA per 31 days)
lisdexamfetamine	T4	ST; QL (31 EA per 31 days)
lithium carbonate	T1	
lithium citrate oral solution	T1	
LITHOBID	T4	
LODINE ORAL TABLET	T4	
LODOSYN	T4	
LOFENA	T5	
lofexidine	T5	
LORAZEPAM INTENSOL	T2	PA; QL (155 ML per 31 days)
lorazepam oral tablet 0.5 mg	T2	PA; QL (124 EA per 31 days)
lorazepam oral tablet 1 mg	T2	PA; QL (186 EA per 31 days)
lorazepam oral tablet 2 mg	T2	PA; QL (155 EA per 31 days)
LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1 MG, 3 MG	T4	PA; QL (93 EA per 31 days)
LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1.5 MG, 2 MG	T4	PA; QL (155 EA per 31 days)
loxapine succinate	T2	
LUMRYZ	T5	PA; QL (31 EA per 31 days)
LUMRYZ STARTER PACK	T5	PA; QL (56 EA per 365 days)
LUNESTA ORAL TABLET 1 MG	T4	PA; QL (31 EA per 31 days)
LUNESTA ORAL TABLET 2 MG, 3 MG	T5	PA; QL (31 EA per 31 days)
lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg	T4	PA-NS; QL (31 EA per 31 days)
lurasidone oral tablet 80 mg	T4	PA-NS; QL (62 EA per 31 days)
LURBIRO	T5	
LYBALVI	T5	PA-NS; QL (31 EA per 31 days)
LYRICA CR	T4	PA; QL (31 EA per 31 days)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	T4	PA-NS; QL (93 EA per 31 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	T4	PA-NS; QL (62 EA per 31 days)
LYRICA ORAL SOLUTION	T4	PA-NS; QL (930 ML per 31 days)
MARPLAN	T3	

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

Drug Name	Drug Tier	Requirements/Limits
MAVENCLAD (10 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (4 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (5 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (6 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (7 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (8 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (9 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAXALT ORAL TABLET 10 MG	T4	QL (12 EA per 28 days)
MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG	T4	QL (12 EA per 28 days)
MAYZENT ORAL TABLET 0.25 MG	T5	PA; QL (155 EA per 31 days)
MAYZENT ORAL TABLET 1 MG, 2 MG	T5	PA; QL (31 EA per 31 days)
MAYZENT STARTER(FOR 1MG MAINT)	T4	PA; QL (14 EA per 365 days)
MAYZENT STARTER(FOR 2MG MAINT)	T4	PA; QL (24 EA per 365 days)
meclofenamate oral capsule 100 mg	T4	
meclofenamate oral capsule 50 mg	T2	
mefenamic acid	T4	
meloxicam oral suspension	T5	
meloxicam oral tablet	T1	
meloxicam submicronized	T4	PA; QL (31 EA per 31 days)
memantine oral capsule,sprinkle,er 24hr	T3	
memantine oral solution	T3	
memantine oral tablet	T2	
memantine-donepezil	T4	PA
meperidine (pf) injection solution 100 mg/ml, 50 mg/ml	T4	PA; QL (248 ML per 31 days)
meperidine (pf) injection solution 25 mg/ml	T4	PA; QL (496 ML per 31 days)
meperidine oral solution	T4	PA; QL (1860 ML per 31 days)
meperidine oral tablet 50 mg	T4	PA; QL (372 EA per 31 days)
meprobamate oral tablet 200 mg	T3	QL (341 EA per 31 days)
meprobamate oral tablet 400 mg	T3	QL (186 EA per 31 days)
MESTINON ORAL	T5	
MESTINON TIMESPAN	T5	
METADATE CD	T4	ST; QL (31 EA per 31 days)
metaxalone oral tablet 400 mg, 800 mg	T4	
metaxalone oral tablet 640 mg	T5	
methadone oral solution 10 mg/5 ml	T2	PA; QL (620 ML per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
methadone oral solution 5 mg/5 ml	T2	PA; QL (1240 ML per 31 days)
methadone oral tablet 10 mg	T2	PA; QL (124 EA per 31 days)
methadone oral tablet 5 mg	T2	PA; QL (248 EA per 31 days)
methamphetamine	T5	PA
methocarbamol oral tablet 1,000 mg	T5	
methocarbamol oral tablet 500 mg, 750 mg	T2	
methsuximide	T4	
METHYLIN ORAL SOLUTION 10 MG/5 ML	T4	ST; QL (930 ML per 31 days)
METHYLIN ORAL SOLUTION 5 MG/5 ML	T4	ST; QL (465 ML per 31 days)
methylphenidate hcl oral cap,er sprinkle,biphasic 40-60	T4	ST; QL (31 EA per 31 days)
methylphenidate hcl oral capsule, er biphasic 30-70	T3	QL (31 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 10 mg	T4	QL (186 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 20 mg	T4	QL (93 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 40 mg	T4	QL (62 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 60 mg	T4	QL (31 EA per 31 days)
methylphenidate hcl oral solution 10 mg/5 ml	T2	QL (930 ML per 31 days)
methylphenidate hcl oral solution 5 mg/5 ml	T2	QL (465 ML per 31 days)
methylphenidate hcl oral tablet	T2	QL (93 EA per 31 days)
methylphenidate hcl oral tablet extended release	T2	QL (93 EA per 31 days)
methylphenidate hcl oral tablet extended release 24hr	T4	QL (31 EA per 31 days)
methylphenidate hcl oral tablet,chewable 10 mg	T4	QL (186 EA per 31 days)
methylphenidate hcl oral tablet,chewable 2.5 mg, 5 mg	T4	QL (93 EA per 31 days)
methylphenidate oral	T4	ST; QL (60 EA per 30 days)
methylphenidate transdermal	T4	PA; QL (30 EA per 30 days)
MIGERGOT	T5	
MIPLYFFA	T5	PA; QL (93 EA per 31 days)
mirtazapine	T2	
modafinil	T2	PA; QL (31 EA per 31 days)
molindone	T4	
morphine concentrate oral solution	T2	PA; QL (310 ML per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
morphine oral capsule, er multiphase 24 hr 120 mg	T4	PA; QL (51 EA per 31 days)
morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	T4	PA; QL (62 EA per 31 days)
morphine oral capsule,extend.release pellets 10 mg, 100 mg, 20 mg, 50 mg, 60 mg, 80 mg	T4	PA; QL (62 EA per 31 days)
morphine oral solution 10 mg/5 ml (2 mg/ml)	T2	PA; QL (2800 ML per 31 days)
morphine oral solution 20 mg/5 ml (4 mg/ml)	T2	PA; QL (1400 ML per 31 days)
morphine oral tablet	T2	PA; QL (186 EA per 31 days)
morphine oral tablet extended release 100 mg	T2	PA; QL (62 EA per 31 days)
morphine oral tablet extended release 15 mg, 30 mg, 60 mg	T2	PA; QL (100 EA per 31 days)
morphine oral tablet extended release 200 mg	T3	PA; QL (31 EA per 31 days)
MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG	T4	PA-NS; QL (31 EA per 31 days)
MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 200 MG	T5	PA-NS; QL (62 EA per 31 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG, 60 MG	T4	PA; QL (100 EA per 31 days)
MYDAYIS	T4	ST; QL (31 EA per 31 days)
MYSOLINE	T5	
nabumetone	T1	
NALOCET	T4	PA; QL (403 EA per 31 days)
naloxone injection solution	T2	
naloxone injection syringe	T2	
naltrexone	T2	
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR	T4	PA
naproxen oral suspension	T4	
naproxen oral tablet	T1	
naproxen oral tablet,delayed release (dr/ec) 375 mg	T2	
naproxen oral tablet,delayed release (dr/ec) 500 mg	T3	
naproxen sodium oral tablet 275 mg	T1	
naproxen sodium oral tablet 550 mg	T2	
naproxen sodium oral tablet, er multiphase 24 hr	T4	

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

Drug Name	Drug Tier	Requirements/Limits
naproxen-esomeprazole	T4	PA; QL (62 EA per 31 days)
naratriptan oral tablet 1 mg	T2	QL (20 EA per 28 days)
naratriptan oral tablet 2.5 mg	T2	QL (9 EA per 28 days)
NARDIL	T4	
NAYZILAM	T4	PA-NS; QL (10 EA per 30 days)
nefazodone	T2	
NEUPRO	T4	
NEURONTIN ORAL CAPSULE 100 MG	T4	PA-NS; QL (270 EA per 30 days)
NEURONTIN ORAL CAPSULE 300 MG	T5	PA-NS; QL (360 EA per 30 days)
NEURONTIN ORAL CAPSULE 400 MG	T5	PA-NS; QL (270 EA per 30 days)
NEURONTIN ORAL SOLUTION	T4	PA-NS; QL (2160 ML per 30 days)
NEURONTIN ORAL TABLET 600 MG	T5	PA-NS; QL (180 EA per 30 days)
NEURONTIN ORAL TABLET 800 MG	T4	PA-NS; QL (120 EA per 30 days)
NORGESIC	T4	PA; QL (248 EA per 31 days)
NORGESIC FORTE	T4	PA; QL (124 EA per 31 days)
nortriptyline	T2	PA-NS
NOURIANZ	T5	PA; QL (31 EA per 31 days)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 150 MG, 200 MG, 250 MG	T5	PA; QL (62 EA per 31 days)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 50 MG	T4	PA; QL (62 EA per 31 days)
NUCYNTA ORAL TABLET 100 MG, 75 MG	T5	PA; QL (186 EA per 31 days)
NUCYNTA ORAL TABLET 50 MG	T4	PA; QL (186 EA per 31 days)
NUEDEXTA	T5	PA; QL (62 EA per 31 days)
NUPLAZID	T5	PA-NS; QL (31 EA per 31 days)
NURTEC ODT	T3	PA; QL (18 EA per 28 days)
NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG	T5	PA; QL (31 EA per 31 days)
NUVIGIL ORAL TABLET 50 MG	T4	PA; QL (31 EA per 31 days)
olanzapine intramuscular	T2	
olanzapine oral	T2	QL (31 EA per 31 days)
olanzapine-fluoxetine	T4	
ONAPGO	T5	PA; QL (620 ML per 31 days)
ONFI ORAL SUSPENSION	T5	PA-NS; QL (496 ML per 31 days)
ONFI ORAL TABLET	T5	PA-NS; QL (62 EA per 31 days)
ONGENTYS	T4	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
ONTRALFY	T4	PA; QL (2790 ML per 31 days)
ONYDA XR	T4	PA; QL (120 ML per 30 days)
ONZETRA XSAIL	T4	QL (16 EA per 28 days)
OPIPZA	T5	PA-NS
OPVEE	T4	
ORMALVI	T5	PA; QL (124 EA per 31 days)
orphenadrine citrate oral	T4	PA
orphenadrine-asa-caffeine oral tablet 25-385-30 mg	T4	PA; QL (248 EA per 31 days)
ORUDIS	T5	QL (124 EA per 31 days)
oxaprozin oral tablet	T2	
oxazepam	T2	PA
oxcarbazepine oral suspension	T4	
oxcarbazepine oral tablet	T2	
oxcarbazepine oral tablet extended release 24 hr 150 mg, 300 mg	T4	
oxcarbazepine oral tablet extended release 24 hr 600 mg	T5	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG	T4	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T5	
oxycodone oral capsule	T2	PA; QL (186 EA per 31 days)
oxycodone oral concentrate	T4	PA; QL (180 ML per 31 days)
oxycodone oral solution	T3	PA; QL (4133 ML per 31 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg	T2	PA; QL (186 EA per 31 days)
oxycodone oral tablet 30 mg	T3	PA; QL (138 EA per 31 days)
oxycodone oral tablet, oral only	T5	PA; QL (186 EA per 31 days)
oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	T5	PA; QL (403 EA per 31 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg	T3	PA; QL (372 EA per 31 days)
oxycodone-acetaminophen oral tablet 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG	T4	PA; QL (100 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 40 MG	T5	PA; QL (100 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG	T5	PA; QL (69 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	T5	PA; QL (62 EA per 31 days)
oxymorphone oral tablet	T4	PA; QL (186 EA per 31 days)
oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg	T4	PA; QL (100 EA per 31 days)
oxymorphone oral tablet extended release 12 hr 30 mg	T5	PA; QL (69 EA per 31 days)
oxymorphone oral tablet extended release 12 hr 40 mg	T5	PA; QL (51 EA per 31 days)
OZOBAX DS	T4	PA; QL (1240 ML per 31 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	T4	QL (31 EA per 31 days)
paliperidone oral tablet extended release 24hr 6 mg	T4	QL (62 EA per 31 days)
PARLODEL	T4	
PARNATE	T5	
paroxetine hcl oral suspension	T4	PA-NS
paroxetine hcl oral tablet	T1	PA-NS
paroxetine hcl oral tablet extended release 24 hr	T3	PA-NS
paroxetine mesylate(menop.sym)	T4	PA
PAXIL CR	T4	PA-NS
PAXIL ORAL TABLET	T4	PA-NS
pentazocine-naloxone	T2	QL (335 EA per 31 days)
perampanel oral suspension	T5	QL (744 ML per 31 days)
perampanel oral tablet	T4	QL (31 EA per 31 days)
PERCOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	T5	PA; QL (372 EA per 31 days)
perphenazine	T4	
perphenazine-amitriptyline	T2	PA-NS
phenelzine	T2	
phenobarbital	T2	
PHENYTEK	T3	
phenytoin oral suspension 125 mg/5 ml	T2	
phenytoin oral tablet,chewable	T2	
phenytoin sodium extended oral capsule 100 mg	T2	

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

Drug Name	Drug Tier	Requirements/Limits
pimozide	T2	
piroxicam	T2	
PONVORY	T5	PA; QL (31 EA per 31 days)
PONVORY 14-DAY STARTER PACK	T5	PA; QL (28 EA per 365 days)
pramipexole oral tablet	T2	
pramipexole oral tablet extended release 24 hr	T3	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	T2	PA-NS; QL (93 EA per 31 days)
pregabalin oral capsule 225 mg, 300 mg	T2	PA-NS; QL (62 EA per 31 days)
pregabalin oral solution	T2	PA-NS; QL (930 ML per 31 days)
pregabalin oral tablet extended release 24 hr	T4	PA; QL (31 EA per 31 days)
primidone oral tablet 125 mg	T3	
primidone oral tablet 250 mg, 50 mg	T2	
PRISTIQ	T4	QL (31 EA per 31 days)
PROCENTRA	T4	
PROLATE ORAL SOLUTION	T4	PA; QL (2066 ML per 31 days)
PROLATE ORAL TABLET 10-300 MG	T5	PA; QL (403 EA per 31 days)
PROLATE ORAL TABLET 5-300 MG, 7.5-300 MG	T4	PA; QL (403 EA per 31 days)
protriptyline	T4	
PROVIGIL	T5	PA; QL (31 EA per 31 days)
pyridostigmine bromide oral syrup	T4	
pyridostigmine bromide oral tablet 30 mg	T3	
pyridostigmine bromide oral tablet 60 mg	T2	
pyridostigmine bromide oral tablet extended release 180 mg	T4	
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG	T4	PA; QL (93 EA per 31 days)
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG	T4	PA; QL (62 EA per 31 days)
quetiapine oral tablet 100 mg, 200 mg, 300 mg, 400 mg, 50 mg	T2	QL (62 EA per 31 days)
quetiapine oral tablet 150 mg	T3	QL (62 EA per 31 days)
quetiapine oral tablet 25 mg	T1	QL (62 EA per 31 days)
quetiapine oral tablet extended release 24 hr	T3	QL (62 EA per 31 days)
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 20 MG, 40 MG	T4	ST; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 30 MG	T4	ST; QL (62 EA per 31 days)
QUILLIVANT XR	T4	ST; QL (360 ML per 30 days)
QULIPTA	T3	PA; QL (31 EA per 31 days)
QUVIVIQ	T4	ST; QL (31 EA per 31 days)
RADICAVA ORS STARTER KIT SUSP	T5	PA; QL (70 ML per 28 days)
RALDESY	T5	
ramelteon	T4	QL (31 EA per 31 days)
rasagiline	T3	
RELAFEN DS	T5	
RELEXXII	T4	ST; QL (31 EA per 31 days)
RELGAABI ORAL CAPSULE 200 MG	T5	PA-NS; QL (540 EA per 30 days)
RELGAABI ORAL CAPSULE 300 MG	T2	QL (360 EA per 30 days)
RELGAABI ORAL CAPSULE 400 MG	T2	QL (270 EA per 30 days)
RELPAX ORAL TABLET 20 MG	T4	QL (12 EA per 28 days)
RELPAX ORAL TABLET 40 MG	T4	QL (6 EA per 28 days)
REMERON ORAL TABLET 15 MG, 30 MG	T4	
REMERON SOLTAB	T4	
RESTORIL	T4	PA; QL (31 EA per 31 days)
REXULTI ORAL TABLET	T5	PA-NS; QL (31 EA per 31 days)
REZENOPY	T3	
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML	T4	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 25 MG/2 ML, 37.5 MG/2 ML, 50 MG/2 ML	T5	QL (2 EA per 28 days)
RISPERDAL ORAL SOLUTION	T4	QL (496 ML per 31 days)
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG	T4	QL (31 EA per 31 days)
RISPERDAL ORAL TABLET 3 MG	T4	QL (93 EA per 31 days)
RISPERDAL ORAL TABLET 4 MG	T4	QL (124 EA per 31 days)
risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml	T4	QL (2 EA per 28 days)
risperidone microspheres intramuscular suspension,extended rel recon 25 mg/2 ml, 37.5 mg/2 ml, 50 mg/2 ml	T5	QL (2 EA per 28 days)
risperidone oral solution	T2	QL (496 ML per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	T1	QL (31 EA per 31 days)
risperidone oral tablet 3 mg	T1	QL (93 EA per 31 days)
risperidone oral tablet 4 mg	T1	QL (124 EA per 31 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg	T4	QL (31 EA per 31 days)
risperidone oral tablet,disintegrating 3 mg	T4	QL (93 EA per 31 days)
risperidone oral tablet,disintegrating 4 mg	T4	QL (124 EA per 31 days)
RITALIN	T4	ST; QL (93 EA per 31 days)
rivastigmine	T2	QL (30 EA per 30 days)
rivastigmine tartrate	T2	
rizatriptan oral tablet 10 mg	T2	QL (12 EA per 28 days)
rizatriptan oral tablet 5 mg	T2	QL (24 EA per 28 days)
rizatriptan oral tablet,disintegrating 10 mg	T2	QL (12 EA per 28 days)
rizatriptan oral tablet,disintegrating 5 mg	T2	QL (24 EA per 28 days)
ropinirole	T2	
ROWEEPRA	T2	
ROXICODONE ORAL TABLET 15 MG	T4	PA; QL (186 EA per 31 days)
ROXICODONE ORAL TABLET 30 MG	T5	PA; QL (138 EA per 31 days)
ROXYBOND	T5	PA; QL (186 EA per 31 days)
ROZEREM	T4	QL (31 EA per 31 days)
rufinamide oral suspension	T5	PA-NS; QL (2480 ML per 31 days)
rufinamide oral tablet 200 mg	T4	PA-NS; QL (124 EA per 31 days)
rufinamide oral tablet 400 mg	T5	PA-NS; QL (248 EA per 31 days)
RYTARY	T3	ST
SABRIL	T5	PA-NS
SAPHRIS SUBLINGUAL TABLET 10 MG, 2.5 MG	T4	PA-NS; QL (62 EA per 31 days)
SAPHRIS SUBLINGUAL TABLET 5 MG	T5	PA-NS; QL (62 EA per 31 days)
SECUADO	T5	PA-NS; QL (31 EA per 31 days)
selegiline hcl	T2	
SEROQUEL ORAL TABLET 100 MG, 25 MG, 300 MG, 50 MG	T4	QL (62 EA per 31 days)
SEROQUEL ORAL TABLET 200 MG	T4	QL (124 EA per 31 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG, 300 MG, 50 MG	T4	QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 400 MG	T5	QL (62 EA per 31 days)
sertraline oral capsule	T4	PA-NS; QL (31 EA per 31 days)
sertraline oral concentrate	T2	
sertraline oral tablet	T1	
SILENOR	T4	PA
SINEMET ORAL TABLET 10-100 MG, 25-100 MG	T4	
SKYCLARYS	T5	PA; QL (93 EA per 31 days)
sodium oxybate	T5	PA; QL (540 ML per 30 days)
SOMA	T4	
SPRITAM ORAL TABLET FOR SUSPENSION 250 MG, 500 MG	T4	
SPRIX	T5	QL (5 EA per 31 days)
SUBOXONE	T4	ST
SUBVENITE ORAL SUSPENSION	T5	
SUBVENITE ORAL TABLET	T2	
SUBVENITE STARTER (BLUE) KIT	T4	
SUBVENITE STARTER (GREEN) KIT	T5	
SUBVENITE STARTER (ORANGE) KIT	T4	
sulindac	T2	
sumatriptan nasal spray,non-aerosol 20 mg/actuation	T4	QL (8 EA per 28 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	T4	QL (32 EA per 28 days)
sumatriptan succinate oral tablet 100 mg	T2	QL (9 EA per 28 days)
sumatriptan succinate oral tablet 25 mg	T2	QL (36 EA per 28 days)
sumatriptan succinate oral tablet 50 mg	T2	QL (18 EA per 28 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	T4	QL (4 ML per 28 days)
sumatriptan succinate subcutaneous solution	T4	QL (4 ML per 28 days)
sumatriptan-naproxen	T4	QL (9 EA per 28 days)
SUNOSI	T4	PA; QL (31 EA per 31 days)
SYMBRAVO	T4	QL (9 EA per 30 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SYMPAZAN ORAL FILM 5 MG	T4	PA-NS; QL (62 EA per 31 days)
TANLOR	T4	
tapentadol oral tablet 100 mg	T5	PA; QL (186 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
tapentadol oral tablet 50 mg, 75 mg	T4	PA; QL (186 EA per 31 days)
tapentadol oral tablet extended release 12 hr 100 mg, 150 mg, 200 mg, 250 mg	T5	PA; QL (62 EA per 31 days)
tapentadol oral tablet extended release 12 hr 50 mg	T4	PA; QL (62 EA per 31 days)
TASCENSO ODT	T5	PA; QL (31 EA per 31 days)
tasimelteon	T5	PA; QL (31 EA per 31 days)
TASMAR ORAL TABLET 100 MG	T5	
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG (14)- 240 MG (46)	T5	PA; QL (120 EA per 365 days)
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 240 MG	T5	PA; QL (62 EA per 31 days)
TEGRETOL ORAL SUSPENSION	T4	
TEGRETOL ORAL TABLET	T4	
TEGRETOL XR	T4	
temazepam	T4	PA; QL (31 EA per 31 days)
TENCON	T4	QL (372 EA per 31 days)
teriflunomide	T5	PA; QL (31 EA per 31 days)
tetrabenazine oral tablet 12.5 mg	T4	PA; QL (93 EA per 31 days)
tetrabenazine oral tablet 25 mg	T5	PA; QL (124 EA per 31 days)
thioridazine	T2	
thiothixene oral capsule 1 mg	T1	
thiothixene oral capsule 10 mg, 2 mg, 5 mg	T2	
tiagabine	T4	
tizanidine oral capsule 2 mg, 4 mg, 6 mg	T2	
tizanidine oral capsule 8 mg	T5	PA; QL (124 EA per 31 days)
tizanidine oral tablet	T2	
tolcapone	T5	
TOLECTIN 600	T5	
TOLECTIN DS	T5	
tolmetin oral capsule	T4	
tolmetin oral tablet 600 mg	T5	
TONMYA	T4	PA; QL (60 EA per 30 days)
TOPAMAX ORAL CAPSULE, SPRINKLE	T4	
TOPAMAX ORAL TABLET 100 MG, 200 MG	T5	
TOPAMAX ORAL TABLET 25 MG, 50 MG	T4	
topiramate oral capsule, sprinkle 15 mg, 25 mg	T2	

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

Drug Name	Drug Tier	Requirements/Limits
topiramate oral capsule, sprinkle 50 mg	T4	
topiramate oral capsule,extended release 24hr 100 mg, 25 mg, 50 mg	T4	
topiramate oral capsule,extended release 24hr 200 mg	T5	
topiramate oral capsule,sprinkle,er 24hr 100 mg, 150 mg, 25 mg, 50 mg	T4	
topiramate oral capsule,sprinkle,er 24hr 200 mg	T5	
topiramate oral solution	T4	PA-NS; QL (496 ML per 31 days)
topiramate oral tablet	T2	
TOSYMRA	T4	QL (12 EA per 28 days)
tramadol oral capsule,er biphase 24 hr 17-83	T4	PA; QL (30 EA per 30 days)
tramadol oral capsule,er biphase 24 hr 25-75 100 mg, 200 mg	T4	PA; QL (30 EA per 30 days)
tramadol oral tablet 100 mg	T4	PA; QL (124 EA per 31 days)
tramadol oral tablet 25 mg	T4	PA; QL (496 EA per 31 days)
tramadol oral tablet 50 mg	T1	PA; QL (240 EA per 30 days)
tramadol oral tablet 75 mg	T4	PA; QL (155 EA per 31 days)
tramadol oral tablet extended release 24 hr	T2	PA; QL (30 EA per 30 days)
tramadol-acetaminophen	T2	PA; QL (372 EA per 31 days)
tranylcypromine	T4	
trazodone oral tablet 100 mg, 150 mg, 50 mg	T1	
trazodone oral tablet 300 mg	T2	
TREXIMET	T5	QL (9 EA per 28 days)
triazolam	T2	PA
trifluoperazine	T2	
trihexyphenidyl	T2	
TRILEPTAL ORAL SUSPENSION	T4	
TRILEPTAL ORAL TABLET 150 MG	T4	
TRILEPTAL ORAL TABLET 300 MG, 600 MG	T5	
trimipramine	T4	
TRINTELLIX	T4	PA-NS; QL (31 EA per 31 days)
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG	T5	
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 25 MG, 50 MG	T4	

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

Drug Name	Drug Tier	Requirements/Limits
TRUDHESA	T5	PA; QL (12 ML per 28 days)
UBRELVY ORAL TABLET 100 MG	T3	PA; QL (17 EA per 28 days)
UBRELVY ORAL TABLET 50 MG	T3	PA; QL (34 EA per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 100 MG/0.28 ML	T5	QL (0.28 ML per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 125 MG/0.35 ML	T5	QL (0.35 ML per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 150 MG/0.42 ML	T5	QL (0.42 ML per 60 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 200 MG/0.56 ML	T5	QL (0.56 ML per 60 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 250 MG/0.7 ML	T5	QL (0.7 ML per 60 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 50 MG/0.14 ML	T5	QL (0.14 ML per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 75 MG/0.21 ML	T5	QL (0.21 ML per 30 days)
VALIUM	T4	PA-NS; QL (124 EA per 31 days)
valproic acid	T2	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	T2	
VALTOCO	T5	PA-NS; QL (10 EA per 30 days)
venlafaxine besylate	T4	PA-NS; QL (62 EA per 31 days)
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	T2	QL (31 EA per 31 days)
venlafaxine oral capsule,extended release 24hr 75 mg	T2	QL (93 EA per 31 days)
venlafaxine oral tablet	T2	
venlafaxine oral tablet extended release 24hr	T3	QL (31 EA per 31 days)
VERSACLOZ	T5	QL (558 ML per 31 days)
vigabatrin	T5	PA-NS
VIGADRONE	T5	PA-NS
VIGAFYDE	T5	PA-NS
VIIBRYD ORAL TABLET	T4	PA-NS; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
vilazodone	T3	PA-NS; QL (31 EA per 31 days)
VIMPAT ORAL SOLUTION	T5	
VIMPAT ORAL TABLET 100 MG, 200 MG	T5	QL (62 EA per 31 days)
VIMPAT ORAL TABLET 150 MG	T5	
VIMPAT ORAL TABLET 50 MG	T4	QL (62 EA per 31 days)
VIVITROL	T5	
VRAYLAR	T3	QL (31 EA per 31 days)
VUMERITY	T5	PA; QL (124 EA per 31 days)
VYSCOXA	T4	ST; QL (1240 ML per 31 days)
VYVANSE	T4	ST; QL (31 EA per 31 days)
VYVGART HYTRULO SUBCUTANEOUS SYRINGE	T5	PA; QL (20 ML per 28 days)
WAINUA SUBCUTANEOUS AUTO-INJECTOR	T5	PA; QL (0.8 ML per 30 days)
WAKIX	T5	PA; QL (62 EA per 31 days)
WELLBUTRIN SR	T4	QL (62 EA per 31 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG	T5	QL (93 EA per 31 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T5	QL (31 EA per 31 days)
XANAX ORAL TABLET 0.25 MG, 0.5 MG	T4	PA; QL (93 EA per 31 days)
XANAX ORAL TABLET 1 MG, 2 MG	T4	PA; QL (155 EA per 31 days)
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 2 MG	T4	PA; QL (155 EA per 31 days)
XCOPRI MAINTENANCE PACK	T5	PA-NS; QL (56 EA per 28 days)
XCOPRI ORAL TABLET 100 MG, 25 MG, 50 MG	T5	PA-NS; QL (31 EA per 31 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	T5	PA-NS; QL (62 EA per 31 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	T4	PA-NS; QL (56 EA per 365 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	T5	PA-NS; QL (56 EA per 365 days)
XELSTRYM	T4	ST; QL (30 EA per 30 days)
XENAZINE ORAL TABLET 12.5 MG	T5	PA; QL (93 EA per 31 days)
XENAZINE ORAL TABLET 25 MG	T5	PA; QL (124 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 13.5 MG, 18 MG, 9 MG	T4	PA; QL (62 EA per 31 days)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 27 MG, 36 MG	T5	PA; QL (62 EA per 31 days)
XYREM	T5	PA; QL (540 ML per 30 days)
XYWAV	T5	PA; QL (540 ML per 30 days)
zaleplon oral capsule 10 mg	T2	PA; QL (62 EA per 31 days)
zaleplon oral capsule 5 mg	T2	PA; QL (93 EA per 31 days)
ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG	T4	
ZANAFLEX ORAL CAPSULE 8 MG	T5	PA; QL (124 EA per 31 days)
ZANAFLEX ORAL TABLET	T4	
ZARONTIN	T4	
ZAVZPRET	T5	PA; QL (8 EA per 30 days)
ZELAPAR	T5	
ZEMBRACE SYMTOUCH	T5	QL (8 ML per 28 days)
ZENZEDI	T4	QL (62 EA per 31 days)
ZEPOSIA	T5	PA; QL (31 EA per 31 days)
ZEPOSIA STARTER KIT (28-DAY)	T5	PA; QL (56 EA per 365 days)
ZEPOSIA STARTER PACK (7-DAY)	T5	PA; QL (14 EA per 365 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML	T5	PA; QL (11.648 ML per 28 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 23 MG/0.574 ML	T5	PA; QL (16.072 ML per 28 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 32.4 MG/0.81 ML	T5	PA; QL (22.68 ML per 28 days)
ziprasidone hcl	T2	QL (62 EA per 31 days)
ziprasidone mesylate	T3	
ZIPSOR	T5	
zolmitriptan nasal spray,non-aerosol 5 mg	T4	QL (8 EA per 28 days)
zolmitriptan oral tablet 2.5 mg	T2	QL (16 EA per 28 days)
zolmitriptan oral tablet 5 mg	T2	QL (8 EA per 28 days)
zolmitriptan oral tablet,disintegrating 2.5 mg	T2	QL (16 EA per 28 days)
zolmitriptan oral tablet,disintegrating 5 mg	T2	QL (8 EA per 28 days)
ZOLOFT	T4	
zolpidem oral capsule	T4	PA; QL (31 EA per 31 days)
zolpidem oral tablet	T2	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
zolpidem oral tablet,ext release multiphase	T2	PA; QL (31 EA per 31 days)
zolpidem sublingual	T4	PA; QL (31 EA per 31 days)
ZOMIG NASAL SPRAY,NON-AEROSOL 2.5 MG	T4	QL (16 EA per 28 days)
ZOMIG NASAL SPRAY,NON-AEROSOL 5 MG	T4	QL (8 EA per 28 days)
ZOMIG ORAL TABLET 2.5 MG	T4	QL (16 EA per 28 days)
ZOMIG ORAL TABLET 5 MG	T4	QL (8 EA per 28 days)
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG	T5	
ZONISADE	T5	PA-NS; QL (930 ML per 31 days)
zonisamide	T2	
ZTALMY	T5	PA-NS; QL (1100 ML per 30 days)
ZUBSOLV	T3	
ZUNVEYL	T4	PA; QL (62 EA per 31 days)
ZURNAI	T4	
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	T5	PA-NS; QL (28 EA per 180 days)
ZURZUVAE ORAL CAPSULE 30 MG	T5	PA-NS; QL (14 EA per 180 days)
ZYBIC	T5	
ZYPREXA INTRAMUSCULAR	T4	
ZYPREXA ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	T4	QL (31 EA per 31 days)
ZYPREXA ORAL TABLET 15 MG, 20 MG	T5	QL (31 EA per 31 days)
ZYPREXA ZYDIS ORAL TABLET,DISINTEGRATING 10 MG, 5 MG	T4	QL (31 EA per 31 days)
ZYPREXA ZYDIS ORAL TABLET,DISINTEGRATING 15 MG, 20 MG	T5	QL (31 EA per 31 days)
Cardiovascular, Hypertension / Lipids		
acebutolol	T2	
ALDACTONE ORAL TABLET 50 MG	T4	
aliskiren	T4	
ALVAIZ ORAL TABLET 18 MG, 9 MG	T5	PA; QL (31 EA per 31 days)
ALVAIZ ORAL TABLET 36 MG, 54 MG	T5	PA; QL (62 EA per 31 days)
amiloride	T1	
amiloride-hydrochlorothiazide	T1	
amiodarone oral	T2	

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

Drug Name	Drug Tier	Requirements/Limits
amlodipine	T1	
amlodipine-atorvastatin	T2	
amlodipine-benazepril	T1	
amlodipine-olmesartan	T2	QL (31 EA per 31 days)
amlodipine-valsartan	T2	
amlodipine-valsartan-hcthiazid	T4	
ARBLI	T4	QL (330 ML per 31 days)
ARIXTRA SUBCUTANEOUS SYRINGE 10 MG/0.8 ML, 5 MG/0.4 ML, 7.5 MG/0.6 ML	T5	
ARIXTRA SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	T4	
aspirin-dipyridamole	T2	
ATACAND	T4	
ATACAND HCT	T4	
atenolol	T1	
atenolol-chlorthalidone	T1	
ATORVALIQ	T4	PA; QL (600 ML per 30 days)
atorvastatin	T1	
ATTRUBY	T5	PA; QL (124 EA per 31 days)
AVALIDE	T4	QL (31 EA per 31 days)
AVAPRO ORAL TABLET 150 MG, 300 MG	T4	QL (31 EA per 31 days)
azilsartan medoxomil	T2	
AZOR	T4	QL (31 EA per 31 days)
BAXFENDY	T4	PA; QL (31 EA per 31 days)
benazepril	T1	
benazepril-hydrochlorothiazide	T1	
BENICAR HCT	T4	QL (31 EA per 31 days)
BENICAR ORAL TABLET 20 MG, 40 MG	T4	QL (31 EA per 31 days)
BENICAR ORAL TABLET 5 MG	T4	QL (93 EA per 31 days)
BETAPACE AF	T4	
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	T4	
betaxolol oral	T1	
BIDIL	T4	
bisoprolol fumarate oral tablet 10 mg, 5 mg	T1	
bisoprolol fumarate oral tablet 2.5 mg	T4	
bisoprolol-hydrochlorothiazide	T1	

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

Drug Name	Drug Tier	Requirements/Limits
BRILINTA	T4	
bumetanide	T2	
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG	T4	QL (93 EA per 31 days)
BYSTOLIC ORAL TABLET 20 MG	T4	QL (62 EA per 31 days)
BYSTOLIC ORAL TABLET 5 MG	T4	QL (217 EA per 31 days)
CABLIVI INJECTION KIT	T5	PA; QL (31 EA per 31 days)
CADUET	T4	
CAMZYOS	T5	PA; QL (31 EA per 31 days)
candesartan	T2	
candesartan-hydrochlorothiazid	T2	
captopril	T1	
CARDAMYST	T5	PA; QL (12 EA per 90 days)
CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 180 MG	T4	
CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 240 MG, 300 MG, 360 MG	T5	
CARDIZEM LA	T4	
CARDIZEM ORAL TABLET 120 MG, 30 MG	T4	
CARDIZEM ORAL TABLET 60 MG	T5	
CARDURA	T4	
CARDURA XL	T4	
CAROSPIR	T4	
CARTIA XT	T1	
carvedilol	T1	
carvedilol phosphate	T4	
chlorthalidone oral tablet 25 mg, 50 mg	T1	
cholestyramine (with sugar) oral powder in packet	T2	
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET	T2	
cilostazol	T2	
clonidine	T4	
clonidine hcl oral tablet 0.05 mg	T4	QL (62 EA per 31 days)
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	T1	
clonidine hcl oral tablet extended release 24 hr	T4	ST

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

Drug Name	Drug Tier	Requirements/Limits
clopidogrel	T1	
colesevelam	T4	
COLESTID ORAL TABLET	T4	
colestipol oral packet	T2	
colestipol oral tablet	T2	
COREG CR	T5	
COREG ORAL TABLET 12.5 MG, 3.125 MG, 6.25 MG	T4	
COREG ORAL TABLET 25 MG	T5	
COZAAR ORAL TABLET 100 MG	T4	QL (31 EA per 31 days)
COZAAR ORAL TABLET 25 MG	T4	QL (93 EA per 31 days)
COZAAR ORAL TABLET 50 MG	T4	QL (62 EA per 31 days)
CRESTOR	T4	
dabigatran etexilate oral capsule 110 mg	T4	QL (124 EA per 31 days)
dabigatran etexilate oral capsule 150 mg, 75 mg	T4	QL (62 EA per 31 days)
digoxin oral solution	T3	QL (155 ML per 31 days)
digoxin oral tablet 125 mcg (0.125 mg)	T1	QL (62 EA per 31 days)
digoxin oral tablet 250 mcg (0.25 mg)	T2	QL (31 EA per 31 days)
digoxin oral tablet 62.5 mcg (0.0625 mg)	T4	QL (124 EA per 31 days)
diltiazem hcl oral capsule,extended release 12 hr	T2	
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	T1	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	T1	
diltiazem hcl oral tablet	T1	
diltiazem hcl oral tablet extended release 24 hr	T2	
DILT-XR	T1	
DIOVAN HCT	T4	QL (31 EA per 31 days)
DIOVAN ORAL TABLET 160 MG, 40 MG, 80 MG	T4	QL (62 EA per 31 days)
DIOVAN ORAL TABLET 320 MG	T4	QL (31 EA per 31 days)
dipyridamole oral	T2	
disopyramide phosphate oral capsule	T3	
dofetilide	T3	
DOPTELET (10 TAB PACK)	T5	PA
DOPTELET (15 TAB PACK)	T5	PA
DOPTELET (30 TAB PACK)	T5	PA
DOPTELET SPRINKLE	T5	PA; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
doxazosin	T1	
DYRENIUM	T4	
EDARBI	T4	ST
EDARBYCLOR	T4	
EDECRIN	T5	
EFFIENT	T4	
ELIQUIS DVT-PE TREAT 30D START	T3	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET FOR SUSPENSION 0.5 MG	T3	QL (112 EA per 28 days)
ELIQUIS ORAL TABLET FOR SUSPENSION 1.5 MG (0.5 MG X 3)	T3	QL (336 EA per 28 days)
ELIQUIS ORAL TABLET FOR SUSPENSION 2 MG (0.5 MG X 4)	T3	QL (560 EA per 28 days)
ELIQUIS SPRINKLE	T3	QL (70 EA per 28 days)
eltrombopag olamine oral powder in packet 12.5 mg	T5	PA; QL (372 EA per 31 days)
eltrombopag olamine oral powder in packet 25 mg	T5	PA; QL (31 EA per 31 days)
eltrombopag olamine oral tablet 12.5 mg, 25 mg	T5	PA; QL (31 EA per 31 days)
eltrombopag olamine oral tablet 50 mg, 75 mg	T5	PA; QL (62 EA per 31 days)
enalapril maleate oral solution	T4	
enalapril maleate oral tablet	T1	
enalapril-hydrochlorothiazide	T1	
ENBUMYST	T5	PA; QL (48 EA per 30 days)
enoxaparin subcutaneous syringe 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml	T4	
enoxaparin subcutaneous syringe 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml	T2	
ENTRESTO ORAL TABLET 24-26 MG	T4	ST; QL (186 EA per 31 days)
ENTRESTO ORAL TABLET 49-51 MG	T4	ST; QL (93 EA per 31 days)
ENTRESTO ORAL TABLET 97-103 MG	T4	ST; QL (62 EA per 31 days)
ENTRESTO SPRINKLE	T4	PA; QL (248 EA per 31 days)
eplerenone	T2	
ethacrynic acid	T4	
EXFORGE	T4	
EXFORGE HCT	T4	

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

Drug Name	Drug Tier	Requirements/Limits
ezetimibe	T2	
ezetimibe-simvastatin	T3	QL (31 EA per 31 days)
felodipine	T2	
fenofibrate micronized	T2	
fenofibrate nanocrystallized	T2	
fenofibrate oral capsule	T4	
fenofibrate oral tablet 120 mg, 40 mg	T4	
fenofibrate oral tablet 160 mg, 54 mg	T2	
fenofibric acid (choline)	T2	
FILSPARI ORAL TABLET 200 MG	T5	PA; QL (31 EA per 31 days)
FILSPARI ORAL TABLET 400 MG	T5	PA; QL (62 EA per 31 days)
flecainide	T2	
FLOLIPID	T4	PA
fluvastatin oral capsule	T1	
fluvastatin oral tablet extended release 24 hr	T2	
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	T5	
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	T4	
fosinopril	T1	
fosinopril-hydrochlorothiazide	T1	
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 18,000 ANTI-XA UNIT/0.72 ML, 5,000 ANTI-XA UNIT/0.2 ML, 7,500 ANTI-XA UNIT/0.3 ML	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 2,500 ANTI-XA UNIT/0.2 ML	T4	
FUROSCIX	T5	PA; QL (8 EA per 30 days)
furosemide injection	T2	
furosemide oral solution	T2	
furosemide oral tablet	T1	
gemfibrozil	T1	
guanfacine oral tablet	T2	
HEMANGEOL	T5	PA; QL (360 ML per 31 days)
HEMICLOR	T4	QL (248 EA per 31 days)
heparin (porcine) injection solution	T2	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
hydralazine oral	T1	
hydrochlorothiazide	T1	
HYZAAR	T4	
icosapent ethyl oral capsule 0.5 gram	T4	QL (248 EA per 31 days)
icosapent ethyl oral capsule 1 gram	T4	QL (124 EA per 31 days)
indapamide	T1	
INDERAL LA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 60 MG	T4	
INDERAL LA ORAL CAPSULE,EXTENDED RELEASE 24 HR 160 MG, 80 MG	T5	
INNOPRAN XL	T5	
INZIRQO	T4	QL (310 ML per 31 days)
irbesartan	T1	QL (31 EA per 31 days)
irbesartan-hydrochlorothiazide	T1	QL (31 EA per 31 days)
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	T2	
isosorbide dinitrate oral tablet 40 mg	T4	
isosorbide mononitrate	T1	
isosorbide-hydralazine	T4	
isradipine	T2	
ivabradine oral tablet 5 mg	T4	PA; QL (93 EA per 31 days)
ivabradine oral tablet 7.5 mg	T4	PA; QL (62 EA per 31 days)
JANTOVEN	T1	
JAVADIN	T5	PA; QL (3600 ML per 30 days)
JUXTAPID ORAL CAPSULE 10 MG, 2 MG, 5 MG	T5	PA; QL (28 EA per 28 days)
JUXTAPID ORAL CAPSULE 20 MG, 30 MG	T5	PA; QL (56 EA per 28 days)
KATERZIA	T4	PA
KERENDIA	T4	PA; QL (31 EA per 31 days)
labetalol oral tablet 100 mg, 200 mg, 300 mg	T1	
labetalol oral tablet 400 mg	T4	
LANOXIN ORAL TABLET 125 MCG (0.125 MG)	T4	QL (62 EA per 31 days)
LANOXIN ORAL TABLET 250 MCG (0.25 MG)	T4	QL (31 EA per 31 days)
LANOXIN ORAL TABLET 62.5 MCG (0.0625 MG)	T4	QL (124 EA per 31 days)
LASIX ONYU	T5	PA; QL (24 EA per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
LEROCHOL	T4	PA; QL (1.2 ML per 30 days)
LESCOL XL	T4	
LIPFENDRA	T4	PA; QL (31 EA per 31 days)
LIPITOR	T4	
LIPOFEN	T4	
lisinopril	T1	
lisinopril-hydrochlorothiazide	T1	
LIVALO	T4	
LODOCO	T4	PA; QL (31 EA per 31 days)
LOPRESSOR ORAL SOLUTION	T4	QL (1395 ML per 31 days)
LOPRESSOR ORAL TABLET	T4	
losartan oral tablet 100 mg	T1	QL (31 EA per 31 days)
losartan oral tablet 25 mg	T1	QL (93 EA per 31 days)
losartan oral tablet 50 mg	T1	QL (62 EA per 31 days)
losartan-hydrochlorothiazide	T1	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	T4	
lovastatin	T1	
LOVAZA	T4	PA; QL (124 EA per 31 days)
LOVENOX SUBCUTANEOUS SYRINGE	T4	
MATZIM LA	T2	
methyldopa	T4	
metolazone	T2	
metoprolol succinate	T1	
metoprolol ta-hydrochlorothiaz	T2	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	T1	
metoprolol tartrate oral tablet 12.5 mg	T4	
metyrosine	T5	PA
mexiletine	T3	
MICARDIS HCT	T4	
minoxidil oral	T2	
moexipril	T1	
MULPLETA	T5	PA
MULTAQ	T4	
MYQORZO	T5	PA; QL (31 EA per 31 days)
nadolol	T1	

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

Drug Name	Drug Tier	Requirements/Limits
nebivolol oral tablet 10 mg, 2.5 mg	T2	QL (93 EA per 31 days)
nebivolol oral tablet 20 mg	T2	QL (62 EA per 31 days)
nebivolol oral tablet 5 mg	T2	QL (217 EA per 31 days)
NEXICLON XR	T4	ST
NEXLETOL	T4	PA; QL (31 EA per 31 days)
NEXLIZET	T4	PA; QL (31 EA per 31 days)
niacin oral tablet 500 mg	T4	
niacin oral tablet extended release 24 hr 1,000 mg, 750 mg	T3	
niacin oral tablet extended release 24 hr 500 mg	T3	QL (31 EA per 31 days)
NIACOR	T4	
nicardipine oral	T4	
nifedipine	T2	
nimodipine oral capsule	T4	
nimodipine oral solution	T5	
NITRO-BID	T2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.4 MG/HR, 0.6 MG/HR	T4	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	T5	
nitroglycerin sublingual	T2	
nitroglycerin transdermal patch 24 hour	T2	
nitroglycerin translingual	T3	
NITROLINGUAL	T4	
NITROSTAT	T4	
NORLIQVA	T4	PA; QL (300 ML per 30 days)
NORPACE	T4	
NORVASC	T4	
NYMALIZE ORAL SYRINGE 60 MG/10 ML	T5	
olmesartan oral tablet 20 mg, 40 mg	T1	QL (31 EA per 31 days)
olmesartan oral tablet 5 mg	T1	QL (93 EA per 31 days)
olmesartan-amlodipin-hcthiazid	T3	
olmesartan-hydrochlorothiazide	T1	QL (31 EA per 31 days)
omega-3 acid ethyl esters	T3	QL (124 EA per 31 days)
ORENITRAM MONTH 1 TITRATION KT	T5	PA; QL (336 EA per 365 days)
ORENITRAM MONTH 2 TITRATION KT	T5	PA; QL (672 EA per 365 days)
ORENITRAM MONTH 3 TITRATION KT	T5	PA; QL (504 EA per 365 days)

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

Drug Name	Drug Tier	Requirements/Limits
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	T4	PA; QL (93 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG	T5	PA; QL (186 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG	T5	PA; QL (521 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG	T5	PA; QL (261 EA per 31 days)
PACERONE ORAL TABLET 100 MG, 200 MG	T2	
pentoxifylline	T2	
perindopril erbumine	T1	
phenoxybenzamine	T5	PA
pindolol	T1	
pitavastatin calcium	T3	
PLAVIX ORAL TABLET 75 MG	T4	
PRADAXA ORAL CAPSULE 110 MG	T4	QL (124 EA per 31 days)
PRADAXA ORAL CAPSULE 150 MG, 75 MG	T4	QL (62 EA per 31 days)
PRADAXA ORAL PELLETS IN PACKET 110 MG, 30 MG, 40 MG, 50 MG	T5	QL (120 EA per 30 days)
PRADAXA ORAL PELLETS IN PACKET 150 MG, 20 MG	T5	QL (60 EA per 30 days)
PRALUENT PEN	T4	PA; QL (2 ML per 28 days)
prasugrel hcl	T2	
pravastatin	T1	
prazosin	T1	
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24HR 30 MG, 60 MG	T4	
PROMACTA ORAL POWDER IN PACKET 12.5 MG	T5	PA; QL (372 EA per 31 days)
PROMACTA ORAL POWDER IN PACKET 25 MG	T5	PA; QL (31 EA per 31 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG	T5	PA; QL (31 EA per 31 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	T5	PA; QL (62 EA per 31 days)
propafenone	T2	
propranolol oral capsule,extended release 24 hr	T2	
propranolol oral solution	T1	

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

Drug Name	Drug Tier	Requirements/Limits
propranolol oral tablet	T1	
QBRELIS	T5	
QUESTRAN LIGHT	T4	
QUESTRAN ORAL POWDER	T4	
quinapril	T1	
quinapril-hydrochlorothiazide	T1	
quinidine gluconate oral	T4	
quinidine sulfate oral tablet 200 mg	T2	
quinidine sulfate oral tablet 300 mg	T4	
ramipril	T1	
ranolazine	T3	QL (62 EA per 31 days)
REDEMPLO	T5	PA; QL (0.5 ML per 90 days)
REPATHA SURECLICK	T3	PA; QL (3 ML per 28 days)
REPATHA SYRINGE	T3	PA; QL (3 ML per 28 days)
rivaroxaban oral suspension for reconstitution	T3	QL (930 ML per 31 days)
rivaroxaban oral tablet	T3	QL (62 EA per 31 days)
rosuvastatin	T1	
sacubitril-valsartan oral tablet 24-26 mg	T2	QL (186 EA per 31 days)
sacubitril-valsartan oral tablet 49-51 mg	T2	QL (93 EA per 31 days)
sacubitril-valsartan oral tablet 97-103 mg	T2	QL (62 EA per 31 days)
SAVAYSA	T4	QL (31 EA per 31 days)
SDAMLO ORAL POWDER IN CONTAINER 10 MG, 2.5 MG	T4	PA; QL (30 EA per 30 days)
SDAMLO ORAL POWDER IN CONTAINER 5 MG	T4	PA; QL (60 EA per 30 days)
simvastatin	T1	
SOAANZ ORAL TABLET 40 MG	T4	ST
SOTALOL AF	T1	
sotalol oral	T1	
SOTYLIZE	T4	
spironolactone oral suspension	T4	
spironolactone oral tablet	T1	
spironolacton-hydrochlorothiaz	T1	
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	T4	
TAVALISSE	T5	PA; QL (62 EA per 31 days)
TEKTURNA	T4	

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

Drug Name	Drug Tier	Requirements/Limits
telmisartan	T1	
telmisartan-amlodipine	T2	
telmisartan-hydrochlorothiazid	T1	
TENORMIN	T4	
terazosin	T1	
THALITONE	T4	
TIADYLT ER	T1	
TIAZAC	T4	
ticagrelor	T2	
TIKOSYN	T4	
timolol maleate oral	T1	
TOPROL XL	T4	
torsemide oral	T1	
trandolapril	T1	
trandolapril-verapamil	T4	
triamterene	T4	
triamterene-hydrochlorothiazid	T1	
TRIBENZOR	T4	
TRYNGOLZA	T5	PA; QL (0.8 ML per 28 days)
TRYVIO	T4	PA; QL (31 EA per 31 days)
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	T5	PA; QL (62 EA per 31 days)
UPTRAVI ORAL TABLET 200 MCG	T5	PA; QL (224 EA per 28 days)
UPTRAVI ORAL TABLETS,DOSE PACK	T5	PA; QL (400 EA per 365 days)
valsartan oral solution	T5	QL (2480 ML per 31 days)
valsartan oral tablet 160 mg, 40 mg, 80 mg	T1	QL (62 EA per 31 days)
valsartan oral tablet 320 mg	T1	QL (31 EA per 31 days)
valsartan-hydrochlorothiazide	T1	QL (31 EA per 31 days)
VANRAFIA	T5	PA; QL (31 EA per 31 days)
VASCEPA ORAL CAPSULE 0.5 GRAM	T4	QL (248 EA per 31 days)
VASCEPA ORAL CAPSULE 1 GRAM	T4	QL (124 EA per 31 days)
VASERETIC	T4	
VASOTEC ORAL TABLET 10 MG	T5	
VASOTEC ORAL TABLET 2.5 MG, 20 MG, 5 MG	T4	
VECAMYL	T5	

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

Drug Name	Drug Tier	Requirements/Limits
verapamil oral capsule, 24 hr er pellet ct	T3	
verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg	T3	
verapamil oral capsule,ext rel. pellets 24 hr 360 mg	T2	
verapamil oral tablet	T2	
verapamil oral tablet extended release	T2	
VERQUVO	T4	PA; QL (31 EA per 31 days)
VYNDAMAX	T5	PA; QL (31 EA per 31 days)
VYTORIN 10-10	T4	QL (31 EA per 31 days)
VYTORIN 10-20	T4	QL (31 EA per 31 days)
VYTORIN 10-40	T4	QL (31 EA per 31 days)
VYTORIN 10-80	T4	QL (31 EA per 31 days)
warfarin	T1	
WELCHOL	T4	
XARELTO DVT-PE TREAT 30D START	T4	ST; QL (51 EA per 30 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	T4	ST; QL (930 ML per 31 days)
XARELTO ORAL TABLET 10 MG, 20 MG	T4	ST; QL (31 EA per 31 days)
XARELTO ORAL TABLET 15 MG	T4	ST; QL (52 EA per 31 days)
XARELTO ORAL TABLET 2.5 MG	T4	ST; QL (62 EA per 31 days)
ZESTORETIC	T4	
ZESTRIL	T4	
ZETIA	T4	
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG	T4	
ZYPITAMAG	T4	
Dermatologicals/Topical Therapy		
ABSORICA	T5	
ABSORICA LD	T5	
ACANYA TOPICAL GEL WITH PUMP	T4	
ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG	T4	
acitretin	T4	PA
acyclovir topical cream	T3	QL (5 GM per 28 days)
acyclovir topical ointment	T1	QL (30 GM per 30 days)
ACZONE TOPICAL GEL WITH PUMP	T4	QL (90 GM per 28 days)
adapalene topical cream	T4	PA

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

Drug Name	Drug Tier	Requirements/Limits
adapalene topical gel 0.3 %	T3	PA
adapalene topical swab	T4	PA
adapalene-benzoyl peroxide topical gel with pump 0.3-2.5 %	T2	PA
ADBRY	T5	PA; QL (4 ML per 28 days)
AKLIEF	T4	PA
ALA-CORT TOPICAL CREAM	T1	
ALA-SCALP	T4	
alclometasone	T1	
ALTRENO	T4	PA; QL (45 GM per 28 days)
amcinonide topical cream	T2	
amcinonide topical ointment	T2	
ammonium lactate	T2	
AMNESTEEM	T4	
AMZEEQ	T4	QL (30 GM per 28 days)
ANALPRAM-HC TOPICAL	T4	
ANZUPGO	T5	PA; QL (60 GM per 30 days)
ARAZLO	T4	PA; QL (45 GM per 28 days)
ATRALIN	T4	PA; QL (45 GM per 28 days)
azelaic acid	T4	ST; QL (50 GM per 28 days)
AZELEX	T4	QL (50 GM per 28 days)
BENZAMYCIN	T4	
betamethasone dipropionate topical cream	T2	
betamethasone dipropionate topical lotion	T1	
betamethasone dipropionate topical ointment	T1	
betamethasone valerate topical cream	T2	
betamethasone valerate topical foam	T4	
betamethasone valerate topical lotion	T2	
betamethasone valerate topical ointment	T2	
betamethasone, augmented	T2	
BIMZELX AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 160 MG/ML	T5	PA; QL (1 ML per 28 days)
BIMZELX AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 320 MG/2 ML	T5	PA; QL (2 ML per 28 days)
BIMZELX SUBCUTANEOUS SYRINGE 160 MG/ML	T5	PA; QL (1 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
BIMZELX SUBCUTANEOUS SYRINGE 320 MG/2 ML	T5	PA; QL (2 ML per 28 days)
brimonidine topical	T4	ST
BRYHALI	T4	QL (100 GM per 28 days)
CABTREO	T4	PA; QL (50 GM per 28 days)
calcipotriene scalp	T2	QL (60 ML per 28 days)
calcipotriene topical cream	T2	QL (60 GM per 28 days)
calcipotriene topical foam	T4	ST; QL (120 GM per 28 days)
calcipotriene topical ointment	T2	QL (60 GM per 28 days)
calcipotriene-betamethasone	T4	ST; QL (400 GM per 28 days)
calcitriol topical	T4	ST
CIBINQO	T5	PA; QL (31 EA per 31 days)
ciclopirox topical cream	T2	QL (90 GM per 28 days)
ciclopirox topical gel	T2	QL (45 GM per 28 days)
ciclopirox topical shampoo	T2	QL (120 ML per 28 days)
ciclopirox topical solution	T2	
ciclopirox topical suspension	T3	QL (60 ML per 28 days)
CLARAVIS	T2	
CLEOCIN T TOPICAL LOTION	T4	QL (60 ML per 28 days)
CLINDACIN	T2	QL (100 GM per 28 days)
CLINDACIN ETZ TOPICAL SWAB	T4	
CLINDAGEL	T5	QL (75 ML per 28 days)
clindamycin phosphate topical foam	T4	QL (100 GM per 28 days)
clindamycin phosphate topical gel	T2	QL (60 GM per 28 days)
clindamycin phosphate topical gel, once daily	T4	QL (75 ML per 28 days)
clindamycin phosphate topical lotion	T2	QL (60 ML per 28 days)
clindamycin phosphate topical solution	T2	QL (60 ML per 28 days)
clindamycin phosphate topical swab	T2	
clindamycin-benzoyl peroxide topical gel	T2	
clindamycin-benzoyl peroxide topical gel with pump 1.2 %(1 % base) -3.75 %, 1.2-2.5 %	T4	
clindamycin-tretinoin	T4	PA; QL (60 GM per 28 days)
clobetasol scalp	T2	QL (50 ML per 28 days)
clobetasol topical cream 0.025 %	T4	QL (100 GM per 28 days)
clobetasol topical cream 0.05 %	T2	QL (60 GM per 28 days)
clobetasol topical foam	T2	QL (100 GM per 28 days)
clobetasol topical gel	T2	QL (60 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
clobetasol topical lotion	T3	QL (118 ML per 28 days)
clobetasol topical ointment	T3	QL (60 GM per 28 days)
clobetasol topical shampoo	T2	QL (118 ML per 28 days)
clobetasol topical spray,non-aerosol	T2	QL (125 ML per 28 days)
clobetasol-emollient topical cream	T3	QL (60 GM per 28 days)
clobetasol-emollient topical foam	T3	QL (100 GM per 28 days)
clocortolone pivalate	T4	
CLODAN	T4	QL (118 ML per 28 days)
clotrimazole topical cream	T2	QL (45 GM per 28 days)
clotrimazole topical solution	T2	QL (30 ML per 28 days)
clotrimazole-betamethasone topical cream	T2	QL (45 GM per 28 days)
clotrimazole-betamethasone topical lotion	T2	QL (60 ML per 28 days)
CORDRAN TAPE LARGE ROLL	T4	
COSENTYX (2 SYRINGES)	T5	PA; QL (2 ML per 28 days)
COSENTYX PEN (2 PENS)	T5	PA; QL (2 ML per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
COSENTYX UNOREADY PEN	T5	PA; QL (2 ML per 28 days)
CROTAN	T4	
dapsone topical gel 5 %	T4	QL (90 GM per 28 days)
dapsone topical gel with pump	T4	QL (90 GM per 28 days)
DENAVIR	T4	QL (5 GM per 28 days)
DERMA-SMOOTHE/FS SCALP OIL	T4	QL (118.28 ML per 28 days)
desonide topical cream	T3	QL (60 GM per 28 days)
desonide topical gel	T3	QL (60 GM per 28 days)
desonide topical lotion	T3	QL (118 ML per 28 days)
desonide topical ointment	T3	QL (60 GM per 28 days)
desoximetasone topical cream	T2	QL (100 GM per 28 days)
desoximetasone topical gel	T4	QL (60 GM per 28 days)
desoximetasone topical ointment 0.05 %	T4	QL (100 GM per 28 days)
desoximetasone topical ointment 0.25 %	T2	QL (100 GM per 28 days)
desoximetasone topical spray,non-aerosol	T2	QL (100 ML per 28 days)
diclofenac sodium topical gel 3 %	T4	PA; QL (100 GM per 28 days)
diflorasone	T4	QL (60 GM per 28 days)
DIPROLENE (AUGMENTED) TOPICAL OINTMENT	T4	
doxepin topical	T4	PA; QL (45 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
DUOBRII	T4	PA; QL (200 GM per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
EBGLYSS PEN	T5	PA; QL (2 ML per 28 days)
EBGLYSS SYRINGE	T5	PA; QL (2 ML per 28 days)
econazole nitrate topical cream	T2	QL (85 GM per 28 days)
econazole nitrate topical foam	T5	ST; QL (70 GM per 28 days)
ENSTILAR	T5	ST; QL (60 GM per 28 days)
EPIDUO FORTE	T4	PA
EPSOLAY	T4	ST; QL (30 GM per 28 days)
ERTACZO	T4	ST; QL (60 GM per 28 days)
ERY PADS	T2	
erythromycin with ethanol topical gel	T2	QL (60 GM per 28 days)
erythromycin with ethanol topical solution	T2	QL (60 ML per 28 days)
erythromycin-benzoyl peroxide	T2	
EUCRISA	T4	PA; QL (60 GM per 30 days)
EURAX TOPICAL CREAM	T4	
EVESSE	T4	QL (118 ML per 28 days)
EXELDERM TOPICAL CREAM	T4	ST; QL (60 GM per 28 days)
FILSUVEZ	T5	PA
FINACEA TOPICAL FOAM	T4	ST; QL (50 GM per 28 days)
fluocinolone and shower cap	T2	QL (118.28 ML per 28 days)
fluocinolone topical cream 0.01 %	T2	QL (60 GM per 28 days)
fluocinolone topical cream 0.025 %	T2	QL (120 GM per 28 days)
fluocinolone topical ointment	T2	QL (120 GM per 28 days)
fluocinolone topical solution	T2	QL (90 ML per 28 days)
fluocinonide topical cream 0.05 %	T2	QL (60 GM per 28 days)
fluocinonide topical cream 0.1 %	T4	QL (120 GM per 28 days)
fluocinonide topical gel	T2	QL (60 GM per 28 days)
fluocinonide topical ointment	T2	QL (60 GM per 28 days)
fluocinonide topical solution	T2	QL (60 ML per 28 days)
fluocinonide-emollient	T2	QL (60 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
fluorouracil topical cream 0.5 %	T5	PA-NS
fluorouracil topical cream 5 %	T2	
fluorouracil topical solution	T2	
flurandrenolide topical lotion	T4	QL (120 ML per 28 days)
fluticasone propionate topical cream	T2	
fluticasone propionate topical lotion	T4	QL (120 ML per 28 days)
fluticasone propionate topical ointment	T2	
gentamicin topical	T2	QL (60 GM per 28 days)
halcinonide topical cream	T4	QL (60 GM per 28 days)
halcinonide topical solution	T4	QL (120 ML per 28 days)
halobetasol propionate topical cream	T2	QL (50 GM per 28 days)
halobetasol propionate topical foam	T4	QL (100 GM per 28 days)
halobetasol propionate topical lotion	T5	QL (60 ML per 28 days)
halobetasol propionate topical ointment	T2	QL (50 GM per 28 days)
HALOG TOPICAL CREAM	T4	QL (60 GM per 28 days)
HALOG TOPICAL SOLUTION	T4	QL (120 ML per 28 days)
hydrocortisone butyrate topical cream	T2	QL (45 GM per 28 days)
hydrocortisone butyrate topical lotion	T4	QL (118 ML per 28 days)
hydrocortisone butyrate topical ointment	T2	QL (45 GM per 28 days)
hydrocortisone butyrate topical solution	T2	QL (60 ML per 28 days)
hydrocortisone topical cream 1 %	T1	
hydrocortisone topical lotion 2 %	T5	QL (118.4 ML per 28 days)
hydrocortisone topical lotion 2.5 %	T1	QL (118 ML per 28 days)
hydrocortisone topical ointment 1 %, 2.5 %	T1	
hydrocortisone topical solution	T4	
hydrocortisone valerate	T2	QL (60 GM per 28 days)
HYFTOR	T5	PA; QL (30 GM per 30 days)
ICOTYDE	T5	PA; QL (31 EA per 31 days)
ILUMYA	T5	PA; QL (1 ML per 84 days)
imiquimod topical cream in metered-dose pump	T4	
imiquimod topical cream in packet 5 %	T2	
IMULDOSA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
IMULDOSA SUBCUTANEOUS SYRINGE 90 MG/ML	T4	PA; QL (1 ML per 56 days)
isotretinoin	T4	
ivermectin topical cream	T4	ST; QL (45 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
JUBLIA	T5	QL (8 ML per 28 days)
ketoconazole topical cream	T2	QL (60 GM per 28 days)
ketoconazole topical foam	T4	QL (100 GM per 28 days)
ketoconazole topical shampoo	T2	QL (120 ML per 28 days)
KETODAN	T2	ST; QL (100 GM per 28 days)
KLARON	T4	
LEXETTE	T4	QL (100 GM per 28 days)
lidocaine hcl mucous membrane solution 2 %	T2	
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	T2	PA; QL (50 ML per 28 days)
lidocaine topical adhesive patch,medicated 5 %	T2	PA; QL (93 EA per 31 days)
lidocaine topical ointment	T2	PA; QL (50 GM per 28 days)
lidocaine-prilocaine topical cream	T2	PA; QL (30 GM per 28 days)
LIDOCAN III	T4	PA; QL (93 EA per 31 days)
luliconazole	T4	QL (60 GM per 28 days)
LUZU	T4	QL (60 GM per 28 days)
malathion	T3	
methoxsalen	T5	
metronidazole topical cream	T2	
metronidazole topical gel	T2	
metronidazole topical lotion	T2	
MIRVASO	T4	ST
mometasone topical	T2	
mupirocin	T2	
mupirocin calcium	T4	ST
naftifine topical cream 1 %	T4	ST; QL (90 GM per 28 days)
naftifine topical cream 2 %	T4	ST; QL (60 GM per 28 days)
naftifine topical gel	T4	ST; QL (60 GM per 28 days)
NAFTIN TOPICAL GEL 2 %	T4	ST; QL (60 GM per 28 days)
NATROBA	T4	
NEO-SYNALAR	T4	
NEUAC	T4	
NORITATE	T5	ST
NYAMYC	T2	QL (60 GM per 28 days)
nystatin topical cream	T2	QL (30 GM per 28 days)
nystatin topical ointment	T2	QL (30 GM per 28 days)
nystatin topical powder	T2	QL (60 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
nystatin-triamcinolone	T2	QL (60 GM per 28 days)
NYSTOP	T2	QL (60 GM per 28 days)
ONEXTON TOPICAL GEL WITH PUMP	T4	
OPZELURA	T5	PA; QL (240 GM per 28 days)
OTULFI SUBCUTANEOUS SOLUTION	T4	PA; QL (0.5 ML per 84 days)
OTULFI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
OTULFI SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
OVIDE	T4	
oxiconazole	T4	ST; QL (90 GM per 28 days)
oxymetazoline topical	T4	ST
PANRETIN	T5	PA-NS
penciclovir	T3	QL (5 GM per 28 days)
permethrin	T2	
pimecrolimus	T3	QL (100 GM per 28 days)
podofilox topical gel	T4	
podofilox topical solution	T2	
PRAMOSONE TOPICAL CREAM 1-1 %	T4	
PRAMOSONE TOPICAL LOTION	T4	
PRUDOXIN	T4	PA; QL (45 GM per 28 days)
PRURADIK	T4	
PYZCHIVA AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
PYZCHIVA AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 90 MG/ML	T5	PA; QL (1 ML per 56 days)
PYZCHIVA SUBCUTANEOUS SOLUTION	T4	PA; QL (0.5 ML per 84 days)
PYZCHIVA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
PYZCHIVA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
QBREXZA	T4	QL (30 EA per 30 days)
RETIN-A	T4	PA; QL (45 GM per 28 days)
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %	T4	PA; QL (50 GM per 28 days)
RHOFADE	T4	ST
SANTYL	T4	QL (180 GM per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
SELARSDI SUBCUTANEOUS SOLUTION	T4	PA; QL (0.5 ML per 84 days)
SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
SELARSDI SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
selenium sulfide topical lotion	T1	
SILIQ	T5	PA; QL (6 ML per 28 days)
SILVADENE	T4	
silver sulfadiazine	T1	
SKYRIZI SUBCUTANEOUS PEN INJECTOR	T5	PA; QL (1 ML per 84 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (1 ML per 84 days)
SKYRIZI SUBCUTANEOUS SYRINGE 55 MG/0.37 ML	T5	PA; QL (0.37 ML per 84 days)
SOFDRA	T5	QL (40.2 ML per 30 days)
SOOLANTRA	T4	ST; QL (45 GM per 28 days)
SORILUX	T5	ST; QL (120 GM per 28 days)
SOTYKTU	T5	PA; QL (31 EA per 31 days)
SPEVIGO SUBCUTANEOUS	T5	PA; QL (2 ML per 28 days)
spinosad	T4	
SSD	T4	
STARJEMZA SUBCUTANEOUS SOLUTION	T4	PA; QL (0.5 ML per 84 days)
STARJEMZA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
STARJEMZA SUBCUTANEOUS SYRINGE 90 MG/ML	T4	PA; QL (1 ML per 56 days)
STELARA SUBCUTANEOUS SOLUTION	T5	PA; QL (0.5 ML per 84 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 84 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
STEQEYMA SUBCUTANEOUS SOLUTION	T3	PA; QL (0.5 ML per 84 days)
STEQEYMA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T3	PA; QL (0.5 ML per 84 days)
STEQEYMA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
sulfacetamide sodium (acne)	T2	

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

Drug Name	Drug Tier	Requirements/Limits
SULFAMYLON TOPICAL CREAM	T4	
SYNALAR TOPICAL CREAM	T4	QL (120 GM per 28 days)
SYNALAR TOPICAL OINTMENT	T4	QL (120 GM per 28 days)
TACLONEX TOPICAL SUSPENSION	T5	ST; QL (400 GM per 28 days)
tacrolimus topical	T2	QL (100 GM per 28 days)
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML	T5	PA; QL (0.25 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 40 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML	T5	PA; QL (1 ML per 28 days)
tavaborole	T4	QL (10 ML per 28 days)
tazarotene topical cream	T4	PA; QL (60 GM per 28 days)
tazarotene topical foam	T4	PA; QL (100 GM per 28 days)
tazarotene topical gel	T4	PA; QL (100 GM per 28 days)
TAZORAC TOPICAL CREAM	T4	PA; QL (60 GM per 28 days)
TAZORAC TOPICAL GEL	T4	PA; QL (100 GM per 28 days)
TEXACORT	T4	
TOPICORT TOPICAL SPRAY,NON-AEROSOL	T4	QL (100 ML per 28 days)
TOVET EMOLLIENT	T3	QL (100 GM per 28 days)
TREMFYA ONE-PRESS	T5	PA; QL (1 ML per 56 days)
TREMFYA PEN INDUCTION PK(2PEN)	T5	PA; QL (24 ML per 365 days)
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML	T5	PA; QL (2 ML per 28 days)
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (1 ML per 56 days)
TREMFYA SUBCUTANEOUS SYRINGE 200 MG/2 ML	T5	PA; QL (2 ML per 28 days)
tretinoin microspheres topical gel	T4	PA; QL (50 GM per 28 days)
tretinoin microspheres topical gel with pump 0.08 %	T4	PA; QL (50 GM per 28 days)
tretinoin topical cream	T2	PA; QL (45 GM per 28 days)
tretinoin topical gel 0.01 %, 0.025 %	T2	PA; QL (45 GM per 28 days)
tretinoin topical gel 0.05 %	T3	PA; QL (45 GM per 28 days)
triamcinolone acetonide topical cream	T1	
triamcinolone acetonide topical lotion	T1	

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

Drug Name	Drug Tier	Requirements/Limits
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	T1	
triamcinolone acetonide topical ointment 0.05 %	T4	
TRIDERM TOPICAL CREAM 0.5 %	T1	
TRILITAS	T4	PA; QL (100 GM per 28 days)
TWYNEO	T4	PA; QL (30 GM per 28 days)
ULTRAVATE TOPICAL LOTION	T4	QL (120 ML per 28 days)
ustekinumab subcutaneous solution	T5	PA; QL (0.5 ML per 84 days)
ustekinumab subcutaneous syringe 45 mg/0.5 ml	T5	PA; QL (0.5 ML per 84 days)
ustekinumab subcutaneous syringe 90 mg/ml	T5	PA; QL (1 ML per 56 days)
ustekinumab-aauz subcutaneous syringe 45 mg/0.5 ml	T4	PA; QL (0.5 ML per 84 days)
ustekinumab-aauz subcutaneous syringe 90 mg/ml	T4	PA; QL (1 ML per 56 days)
ustekinumab-aekn subcutaneous syringe 45 mg/0.5 ml	T4	PA; QL (0.5 ML per 84 days)
ustekinumab-aekn subcutaneous syringe 90 mg/ml	T5	PA; QL (1 ML per 56 days)
ustekinumab-ttwe subcutaneous solution	T5	PA; QL (0.5 ML per 84 days)
ustekinumab-ttwe subcutaneous syringe 45 mg/0.5 ml	T4	PA; QL (0.5 ML per 84 days)
ustekinumab-ttwe subcutaneous syringe 90 mg/ml	T5	PA; QL (1 ML per 56 days)
VALCHLOR	T5	PA-NS
VECTICAL	T4	ST
VEREGEN	T5	QL (30 GM per 28 days)
VTAMA	T5	PA; QL (60 GM per 28 days)
WEZLANA SUBCUTANEOUS SOLUTION	T5	PA; QL (0.5 ML per 84 days)
WEZLANA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 84 days)
WEZLANA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
WINLEVI	T4	PA; QL (60 GM per 28 days)
XERESE	T5	
YESINTEK SUBCUTANEOUS SOLUTION	T3	PA; QL (0.5 ML per 84 days)
YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T3	PA; QL (0.5 ML per 84 days)
YESINTEK SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
ZELSUVMI	T5	PA; QL (31 GM per 28 days)
ZENATANE	T4	
ZIANA	T4	PA; QL (60 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
ZILXI	T4	ST; QL (30 GM per 28 days)
ZONALON	T4	PA; QL (30 GM per 28 days)
ZORYVE	T4	PA; QL (60 GM per 28 days)
ZOVIRAX TOPICAL CREAM	T4	QL (5 GM per 28 days)
ZOVIRAX TOPICAL OINTMENT	T4	QL (30 GM per 30 days)
ZTLIDO	T4	PA; QL (93 EA per 31 days)
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP 3.75 %	T5	
Diagnostics / Miscellaneous Agents		
acamprosate	T2	
AGRYLIN	T5	
anagrelide	T3	
AQVESME	T5	PA; QL (62 EA per 31 days)
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
bupropion hcl (smoking deter)	T2	QL (62 EA per 31 days)
CARBAGLU	T5	PA
carglumic acid	T5	PA
CARNITOR ORAL	T4	PA-BvD
cevimeline	T4	
CHANTIX	T4	QL (60 EA per 30 days)
CHANTIX CONTINUING MONTH BOX	T4	QL (60 EA per 30 days)
CHANTIX STARTING MONTH BOX	T4	QL (106 EA per 365 days)
CHEMET	T4	
CLINIMIX 4.25%/D5W SULFIT FREE	T4	PA-BvD
CLINIMIX E 2.75%/D5W SULF FREE	T4	PA-BvD
CUVRIOR	T5	PA; QL (310 EA per 31 days)
d10 %-0.45 % sodium chloride	T2	
d2.5 %-0.45 % sodium chloride	T2	
d5 % and 0.9 % sodium chloride	T2	
d5 %-0.45 % sodium chloride	T2	
deferasirox oral granules in packet	T5	PA
deferasirox oral tablet 180 mg	T4	PA
deferasirox oral tablet 360 mg	T5	PA
deferasirox oral tablet 90 mg	T3	PA
deferasirox oral tablet, dispersible 125 mg	T4	PA

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Drug Name	Drug Tier	Requirements/Limits
deferasirox oral tablet, dispersible 250 mg, 500 mg	T5	PA
deferiprone	T5	PA
dextrose 10 % and 0.2 % nacl	T4	
dextrose 10 % in water (d10w)	T2	
dextrose 5 % in water (d5w) intravenous parenteral solution	T2	
dextrose 5%-0.2 % sod chloride	T2	
disulfiram	T2	
droxidopa oral capsule 100 mg	T4	PA; QL (465 EA per 31 days)
droxidopa oral capsule 200 mg, 300 mg	T5	PA; QL (186 EA per 31 days)
DUVYZAT	T5	PA; QL (420 ML per 35 days)
EMPAVELI	T5	PA; QL (160 ML per 28 days)
ENDARI	T5	PA; QL (180 EA per 30 days)
EVOXAC	T4	
EXJADE	T5	PA
FABHALTA	T5	PA; QL (62 EA per 31 days)
FERRIPROX (2 TIMES A DAY)	T5	PA
FERRIPROX ORAL SOLUTION	T5	PA
FERRIPROX ORAL TABLET 1,000 MG	T5	PA
FORZINITY	T5	PA; QL (14 ML per 28 days)
FOSRENOL	T4	PA-BvD
GLASSIA	T5	PA
glutamine (sickle cell)	T5	PA; QL (180 EA per 30 days)
glycerol phenylbutyrate	T5	PA
HARLIKU	T5	PA; QL (31 EA per 31 days)
INCRELEX	T5	PA
JADENU	T5	PA
JADENU SPRINKLE	T5	PA
JOENJA ORAL TABLET 70 MG	T5	PA; QL (60 EA per 30 days)
KIONEX ORAL SUSPENSION	T2	
KYGEVVI	T5	PA; QL (496 EA per 30 days)
lanthanum	T4	PA-BvD
levocarnitine (with sugar)	T3	PA-BvD
levocarnitine oral tablet	T2	PA-BvD
LITFULO	T5	PA; QL (28 EA per 28 days)
LITHOSTAT	T4	

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

Drug Name	Drug Tier	Requirements/Limits
LOARGYS	T5	PA
LOKELMA	T3	QL (93 EA per 31 days)
midodrine	T2	
NICOTROL NS	T4	
nitisinone	T5	PA
NITYR	T5	PA
NORTHERA ORAL CAPSULE 100 MG	T5	PA; QL (465 EA per 31 days)
NORTHERA ORAL CAPSULE 200 MG, 300 MG	T5	PA; QL (186 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 2 GRAM, 3 GRAM	T5	PA; QL (186 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 4 GRAM	T5	PA; QL (155 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 5 GRAM	T5	PA; QL (124 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 6 GRAM	T5	PA; QL (93 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 6.67 GRAM	T5	PA; QL (62 EA per 31 days)
ORFADIN	T5	PA
PHEBURANE	T5	PA; QL (620 GM per 31 days)
pilocarpine hcl oral	T2	
PROLASTIN-C INTRAVENOUS SOLUTION	T5	PA
PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG	T5	PA; QL (56 EA per 28 days)
PYRUKYND ORAL TABLET 5 MG	T5	PA; QL (14 EA per 365 days)
PYRUKYND ORAL TABLETS,DOSE PACK	T5	PA; QL (28 EA per 365 days)
REVCOVI	T5	
REZDIFFRA	T5	PA; QL (31 EA per 31 days)
RHAPSIDO	T5	PA; QL (62 EA per 31 days)
riluzole	T4	
risedronate oral tablet 30 mg	T5	
SALAGEN (PILOCARPINE)	T4	
sevelamer carbonate	T3	PA-BvD
sevelamer hcl	T3	PA-BvD
sodium chloride 0.9 % intravenous parenteral solution	T2	
sodium chloride irrigation	T2	
sodium phenylbutyrate	T5	PA

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

Drug Name	Drug Tier	Requirements/Limits
sodium polystyrene sulfonate	T2	
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 5 MG	T5	PA; QL (31 EA per 31 days)
SOHONOS ORAL CAPSULE 10 MG	T5	PA; QL (62 EA per 31 days)
SPS (WITH SORBITOL) ORAL	T2	
SYPRINE	T5	QL (248 EA per 31 days)
TAVNEOS	T5	PA; QL (186 EA per 31 days)
THIOLA	T5	PA
THIOLA EC	T5	PA
TIGLUTIK	T5	PA
tiopronin	T5	PA
trientine oral capsule 250 mg	T5	QL (248 EA per 31 days)
trientine oral capsule 500 mg	T5	PA; QL (124 EA per 31 days)
varenicline tartrate oral tablet	T4	QL (60 EA per 30 days)
varenicline tartrate oral tablets,dose pack	T4	QL (106 EA per 365 days)
VELPHORO	T5	PA-BvD
VELTASSA ORAL POWDER IN PACKET 1 GRAM	T4	QL (120 EA per 30 days)
VELTASSA ORAL POWDER IN PACKET 16.8 GRAM, 25.2 GRAM, 8.4 GRAM	T4	QL (30 EA per 30 days)
VENXXIVA	T5	PA
VOYDEYA	T5	PA; QL (180 EA per 30 days)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG	T5	PA; QL (93 EA per 31 days)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 25 MG	T5	PA; QL (124 EA per 31 days)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 75 MG	T5	PA; QL (217 EA per 31 days)
WEGOVY ORAL	T3	PA; QL (31 EA per 31 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML	T3	PA; QL (2 ML per 28 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 1.7 MG/0.75 ML, 2.4 MG/0.75 ML	T3	PA; QL (3 ML per 28 days)
ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
ZEPBOUND KWIKPEN	T4	PA; QL (2.4 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
ZEPBOUND SUBCUTANEOUS PEN INJECTOR 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 5 MG/0.5 ML	T4	PA; QL (2 ML per 28 days)
ZEPBOUND SUBCUTANEOUS PEN INJECTOR 2.5 MG/0.5 ML, 7.5 MG/0.5 ML	T5	PA; QL (2 ML per 28 days)
ZOKINVY	T5	PA
Ear, Nose / Throat Medications		
acetic acid otic (ear)	T2	
azelastine nasal spray,non-aerosol 137 mcg (0.1 %)	T2	QL (30 ML per 25 days)
chlorhexidine gluconate mucous membrane	T1	
CIPRO HC	T4	
ciprofloxacin hcl otic (ear)	T4	
ciprofloxacin-dexamethasone	T3	
ciprofloxacin-hydrocortisone	T4	
CLOTIC	T5	PA; QL (112 EA per 365 days)
DERMOTIC OIL	T4	
fluocinolone acetonide oil	T2	
hydrocortisone-acetic acid	T2	
ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)	T1	QL (30 ML per 28 days)
ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)	T1	QL (15 ML per 28 days)
KOURZEQ	T2	
neomycin-polymyxin-hc otic (ear)	T2	
ofloxacin otic (ear)	T2	
olopatadine nasal	T2	QL (30.5 GM per 30 days)
PERIOGARD	T1	
triamcinolone acetonide dental	T2	
XTORO	T4	
Endocrine/Diabetes		
acarbose	T1	QL (93 EA per 31 days)
ACTHAR	T5	PA
ACTHAR SELFJECT	T5	PA
ACTOPLUS MET	T4	QL (93 EA per 31 days)
ACTOS	T4	QL (31 EA per 31 days)
ADMELOG SOLOSTAR U-100 INSULIN	T4	
ADMELOG U-100 INSULIN LISPRO	T4	

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

Drug Name	Drug Tier	Requirements/Limits
AFREZZA INHALATION CARTRIDGE WITH INHALER 12 UNIT, 4 UNIT (90)/ 8 UNIT (90), 4 UNIT/8 UNIT/ 12 UNIT (60), 8 UNIT (90)/ 12 UNIT (90)	T5	ST
AFREZZA INHALATION CARTRIDGE WITH INHALER 4 UNIT, 8 UNIT	T4	ST
AGAMREE	T5	PA; QL (300 ML per 40 days)
ALCOHOL PADS	T2	PA
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG	T4	PA
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 1 MG, 2 MG, 5 MG	T5	PA
alogliptin	T4	ST; QL (31 EA per 31 days)
alogliptin-metformin	T4	ST; QL (62 EA per 31 days)
alogliptin-pioglitazone	T4	ST; QL (31 EA per 31 days)
APIDRA SOLOSTAR U-100 INSULIN	T4	
APIDRA U-100 INSULIN	T4	
AVEED	T4	PA
AWIQLI FLEXTOUCH	T4	
BAQSIMI	T4	
BASAGLAR KWIKPEN U-100 INSULIN	T4	
BRYNOVIN	T4	ST; QL (124 ML per 31 days)
cabergoline	T2	
calcitonin (salmon) nasal	T2	PA-BvD
calcitriol oral capsule	T2	PA-BvD
calcitriol oral solution	T3	PA-BvD
CERDELGA	T5	PA; QL (62 EA per 31 days)
cinacalcet oral tablet 30 mg, 60 mg	T3	PA-BvD; QL (62 EA per 31 days)
cinacalcet oral tablet 90 mg	T3	PA-BvD; QL (124 EA per 31 days)
CORTEF	T4	
CORTROPHIN GEL	T5	PA
CRENESSITY ORAL CAPSULE 100 MG	T5	PA; QL (124 EA per 31 days)
CRENESSITY ORAL CAPSULE 50 MG	T5	PA; QL (62 EA per 31 days)
CRENESSITY ORAL SOLUTION	T5	PA; QL (124 ML per 31 days)
CYCLOSET	T4	
CYTOMEL	T4	
danazol	T2	

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

Drug Name	Drug Tier	Requirements/Limits
dapagliflozin	T3	QL (31 EA per 31 days)
dapagliflozin-metformin oral tablet, ir - er, biphasic 24hr 10-1,000 mg, 10-500 mg, 5-500 mg	T4	ST; QL (31 EA per 31 days)
dapagliflozin-metformin oral tablet, ir - er, biphasic 24hr 5-1,000 mg	T4	ST; QL (62 EA per 31 days)
dapagliflozin-saxagliptin	T4	ST; QL (31 EA per 31 days)
DDAVP ORAL	T4	
deflazacort	T5	PA
DEPO-TESTOSTERONE	T4	PA
DESMODA	T5	PA; QL (725 ML per 30 days)
desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)	T4	
desmopressin oral	T2	
dexamethasone oral solution	T1	
dexamethasone oral tablet	T1	
dexamethasone oral tablets,dose pack	T2	
DEXLYT	T4	
diazoxide	T5	
doxercalciferol oral	T4	PA-BvD
DUETACT	T4	QL (31 EA per 31 days)
EMFLAZA	T5	PA
FARXIGA	T3	ST; QL (31 EA per 31 days)
FIASP FLEXTOUCH U-100 INSULIN	T3	
FIASP PENFILL U-100 INSULIN	T3	
FIASP U-100 INSULIN	T3	
fludrocortisone	T1	
GALAFOLD	T5	PA; QL (14 EA per 28 days)
glimepiride oral tablet 1 mg, 2 mg, 4 mg	T1	
glimepiride oral tablet 3 mg	T4	
glipizide oral tablet 10 mg, 5 mg	T1	
glipizide oral tablet 15 mg, 2.5 mg	T3	
glipizide oral tablet extended release 24hr	T1	
glipizide-metformin	T1	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
glyburide	T2	
glyburide-metformin	T2	
GLYXAMBI	T3	QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
GVOKE	T3	
GVOKE HYPOPEN 2-PACK	T3	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	T3	
HEMADY	T4	PA-NS
HUMALOG JUNIOR KWIKPEN U-100	T3	
HUMALOG KWIKPEN INSULIN	T3	
HUMALOG MIX 50-50 KWIKPEN	T3	
HUMALOG MIX 75-25 KWIKPEN	T3	
HUMALOG MIX 75-25(U-100)INSULN	T3	
HUMALOG U-100 INSULIN	T3	
HUMULIN 70/30 U-100 INSULIN	T3	
HUMULIN 70/30 U-100 KWIKPEN	T3	
HUMULIN N NPH INSULIN KWIKPEN	T3	
HUMULIN N NPH U-100 INSULIN	T3	
HUMULIN R REGULAR U-100 INSULN	T3	
HUMULIN R U-500 (CONC) KWIKPEN	T3	
hydrocortisone oral	T1	
INPEFA	T4	ST; QL (31 EA per 31 days)
insulin glargine u-300 conc	T4	
insulin glargine-yfgn	T3	
insulin lispro	T3	
insulin lispro protamin-lispro	T3	
INVOKAMET	T4	ST; QL (62 EA per 31 days)
INVOKAMET XR	T4	ST; QL (62 EA per 31 days)
INVOKANA ORAL TABLET 100 MG	T4	ST; QL (62 EA per 31 days)
INVOKANA ORAL TABLET 300 MG	T4	ST; QL (31 EA per 31 days)
ISTURISA ORAL TABLET 1 MG	T5	PA; QL (558 EA per 31 days)
ISTURISA ORAL TABLET 5 MG	T5	PA; QL (372 EA per 31 days)
JANUMET	T3	ST; QL (62 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	T3	ST; QL (31 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	T3	ST; QL (62 EA per 31 days)
JANUVIA ORAL TABLET 100 MG, 50 MG	T3	ST; QL (31 EA per 31 days)
JANUVIA ORAL TABLET 25 MG	T3	ST; QL (93 EA per 31 days)
JARDIANCE ORAL TABLET 10 MG	T3	ST; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
JARDIANCE ORAL TABLET 25 MG	T3	ST; QL (31 EA per 31 days)
JATENZO ORAL CAPSULE 158 MG, 198 MG	T4	PA; QL (124 EA per 31 days)
JATENZO ORAL CAPSULE 237 MG	T4	PA; QL (62 EA per 31 days)
JAVYGTOR	T5	PA
JAYTHARI	T5	PA
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG	T3	ST; QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	T3	ST; QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	T3	ST; QL (31 EA per 31 days)
JYNARQUE ORAL TABLET	T5	PA; QL (112 EA per 28 days)
JYNARQUE ORAL TABLETS, SEQUENTIAL	T5	PA; QL (56 EA per 28 days)
KHINDIVI	T5	PA
KIRSTY	T3	
KIRSTY PEN	T3	
KORLYM	T5	PA; QL (124 EA per 31 days)
KUVAN	T5	PA
KYMBEE	T5	PA
KYZATREX ORAL CAPSULE 150 MG, 200 MG	T4	PA; QL (124 EA per 31 days)
LANTUS SOLOSTAR U-100 INSULIN	T3	
LANTUS U-100 INSULIN	T3	
levothyroxine oral capsule	T4	
levothyroxine oral tablet	T1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	T3	
LIOMNY	T2	
liothyronine oral	T2	
liraglutide	T4	PA; QL (9 ML per 30 days)
LYUMJEV KWIKPEN U-100 INSULIN	T4	
LYUMJEV KWIKPEN U-200 INSULIN	T4	
LYUMJEV U-100 INSULIN	T4	
MEDROL (PAK)	T4	

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

Drug Name	Drug Tier	Requirements/Limits
MEDROL ORAL TABLET 16 MG, 2 MG, 4 MG, 8 MG	T4	
MERILOG	T4	ST
MERILOG SOLOSTAR	T4	ST
metformin oral solution	T4	ST; QL (791 ML per 31 days)
metformin oral tablet 1,000 mg, 500 mg, 850 mg	T1	
metformin oral tablet 625 mg	T4	ST; QL (124 EA per 31 days)
metformin oral tablet 750 mg	T5	ST; QL (93 EA per 31 days)
metformin oral tablet extended release 24 hr	T1	
metformin oral tablet extended release 24hr 1,000 mg	T4	ST; QL (62 EA per 31 days)
metformin oral tablet extended release 24hr 500 mg	T4	ST; QL (31 EA per 31 days)
metformin oral tablet,er gast.retention 24 hr 1,000 mg	T4	ST; QL (62 EA per 31 days)
metformin oral tablet,er gast.retention 24 hr 500 mg	T4	ST; QL (31 EA per 31 days)
methimazole oral tablet 10 mg, 5 mg	T1	
METHITEST	T5	PA
methylprednisolone	T2	
methyltestosterone oral capsule	T5	PA
mifepristone oral tablet 300 mg	T5	PA; QL (124 EA per 31 days)
miglitol	T2	
miglustat	T5	PA; QL (93 EA per 31 days)
MOUNJARO	T3	PA; QL (2 ML per 28 days)
MYALEPT	T5	PA
nateglinide	T1	QL (93 EA per 31 days)
NOVOLIN 70/30 U-100 INSULIN	T3	
NOVOLIN 70-30 FLEXPEN U-100	T3	
NOVOLIN N FLEXPEN	T3	
NOVOLIN N NPH U-100 INSULIN	T3	
NOVOLIN R FLEXPEN	T3	
NOVOLIN R REGULAR U100 INSULIN	T3	
NOVOLOG FLEXPEN U-100 INSULIN	T4	ST
NOVOLOG MIX 70-30 U-100 INSULN	T3	
NOVOLOG MIX 70-30FLEXPEN U-100	T3	
NOVOLOG PENFILL U-100 INSULIN	T4	ST
NOVOLOG U-100 INSULIN ASPART	T4	ST

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

Drug Name	Drug Tier	Requirements/Limits
ORAPRED ODT	T4	
ORILISSA ORAL TABLET 150 MG	T5	PA; QL (31 EA per 31 days)
ORILISSA ORAL TABLET 200 MG	T5	PA; QL (62 EA per 31 days)
OZEMPIC ORAL	T3	PA; QL (31 EA per 31 days)
OZEMPIC SUBCUTANEOUS	T3	PA; QL (3 ML per 28 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	T5	PA; QL (15 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	T5	PA; QL (4 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (90 ML per 30 days)
paricalcitol oral	T2	PA-BvD
pioglitazone	T1	QL (31 EA per 31 days)
pioglitazone-glimepiride	T4	QL (31 EA per 31 days)
pioglitazone-metformin	T2	QL (93 EA per 31 days)
prednisolone oral solution	T2	
prednisolone oral tablet	T4	
prednisolone sodium phosphate oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)	T4	
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	T2	
prednisolone sodium phosphate oral tablet,disintegrating	T4	
PREDNISONE INTENSOL	T4	
prednisone oral solution	T2	
prednisone oral tablet	T1	
prednisone oral tablet,delayed release (dr/ec)	T5	
prednisone oral tablets,dose pack	T2	
PROGLYCEM	T4	
propylthiouracil	T2	
PYQUVI	T5	PA
RAYALDEE	T5	QL (62 EA per 31 days)
RECORLEV	T5	PA; QL (248 EA per 31 days)
repaglinide oral tablet 0.5 mg, 1 mg	T1	QL (124 EA per 31 days)
repaglinide oral tablet 2 mg	T1	QL (248 EA per 31 days)
REZVOGLAR KWIKPEN	T3	
ROCALTROL	T4	PA-BvD
SAMSCA ORAL TABLET 15 MG	T5	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
SAMSCA ORAL TABLET 30 MG	T5	PA; QL (62 EA per 31 days)
sapropterin	T5	PA
saxagliptin	T3	QL (31 EA per 31 days)
saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg	T3	QL (62 EA per 31 days)
saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg	T3	QL (31 EA per 31 days)
SEGLUROMET	T4	ST; QL (62 EA per 31 days)
SEMGLEE(INSULIN GLARGINE-YFGN)	T4	
SEMGLEE(INSULIN GLARG-YFGN)PEN	T4	
SEPHIENCE ORAL POWDER IN PACKET 1,000 MG	T5	PA
SEPHIENCE ORAL POWDER IN PACKET 250 MG	T5	PA; QL (90 EA per 30 days)
sitagliptin oral tablet 100 mg, 50 mg	T3	QL (31 EA per 31 days)
sitagliptin oral tablet 25 mg	T3	QL (93 EA per 31 days)
sitagliptin phos-metformin oral tablet	T3	QL (62 EA per 31 days)
sitagliptin phos-metformin oral tablet, er multiphase 24 hr 100-1,000 mg, 50-500 mg	T3	QL (31 EA per 31 days)
sitagliptin phos-metformin oral tablet, er multiphase 24 hr 50-1,000 mg	T3	QL (62 EA per 31 days)
sitagliptin phosphate oral tablet 100 mg, 50 mg	T3	QL (31 EA per 31 days)
sitagliptin phosphate oral tablet 25 mg	T3	QL (93 EA per 31 days)
sitagliptin-metformin oral tablet	T3	QL (62 EA per 31 days)
sitagliptin-metformin oral tablet, er multiphase 24 hr 100-1,000 mg, 50-500 mg	T3	QL (31 EA per 31 days)
sitagliptin-metformin oral tablet, er multiphase 24 hr 50-1,000 mg	T3	QL (62 EA per 31 days)
SOLIQUA 100/33	T3	QL (18 ML per 30 days)
SOMAVERT	T5	PA
STEGLATRO	T4	ST; QL (31 EA per 31 days)
STEGLUJAN	T4	ST; QL (31 EA per 31 days)
SYNAREL	T5	PA
SYNJARDY	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	T3	QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
SYNTHROID	T3	
TARPEYO	T5	PA; QL (124 EA per 31 days)
TESTIM	T4	PA
testosterone cypionate	T2	PA
testosterone enanthate	T2	PA
testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)	T4	PA
testosterone transdermal gel in packet	T4	PA
testosterone transdermal solution in metered pump w/app	T4	PA
THYQUIDITY	T4	
TIROSINT	T4	
TIROSINT-SOL	T4	
TLANDO	T4	PA; QL (124 EA per 31 days)
tolvaptan (polycys kidney dis) oral tablet	T5	PA; QL (112 EA per 28 days)
tolvaptan (polycys kidney dis) oral tablets, sequential	T5	PA; QL (56 EA per 28 days)
tolvaptan oral tablet 15 mg	T5	PA; QL (31 EA per 31 days)
tolvaptan oral tablet 30 mg	T5	PA; QL (62 EA per 31 days)
TOUJEO MAX U-300 SOLOSTAR	T3	
TOUJEO SOLOSTAR U-300 INSULIN	T3	
TRADJENTA	T3	ST; QL (31 EA per 31 days)
TRESIBA FLEXTOUCH U-100	T4	
TRESIBA FLEXTOUCH U-200	T4	
TRESIBA U-100 INSULIN	T4	
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	T3	QL (31 EA per 31 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	T3	QL (62 EA per 31 days)
TRULICITY	T3	PA; QL (2 ML per 28 days)
UNITHROID	T3	
VICTOZA 3-PAK	T4	PA; QL (9 ML per 30 days)
VOGELXO TRANSDERMAL GEL	T4	PA
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	T4	PA
VOXZOGO	T5	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 5-500 MG	T3	QL (31 EA per 31 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
XULTOPHY 100/3.6	T3	QL (15 ML per 30 days)
XYOSTED	T4	PA
YARGESA	T5	PA; QL (93 EA per 31 days)
YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML	T5	PA; QL (1.12 ML per 28 days)
YORVIPATH SUBCUTANEOUS PEN INJECTOR 294 MCG/0.98 ML	T5	PA; QL (1.96 ML per 28 days)
YORVIPATH SUBCUTANEOUS PEN INJECTOR 420 MCG/1.4 ML	T5	PA; QL (2.8 ML per 28 days)
YUVIWEL SUBCUTANEOUS RECON SOLN 1.3 MG, 2.8 MG	T5	PA; QL (4 EA per 28 days)
YUVIWEL SUBCUTANEOUS RECON SOLN 5.5 MG	T5	PA; QL (8 EA per 28 days)
ZAVESCA	T5	PA; QL (93 EA per 31 days)
ZELVYSIA	T5	PA
ZITUVIMET	T4	ST; QL (62 EA per 31 days)
ZITUVIMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	T4	ST; QL (31 EA per 31 days)
ZITUVIMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	T4	ST; QL (62 EA per 31 days)
ZITUVIO ORAL TABLET 100 MG, 50 MG	T4	ST; QL (31 EA per 31 days)
ZITUVIO ORAL TABLET 25 MG	T4	ST; QL (93 EA per 31 days)
Gastroenterology		
ACIPHEX	T5	QL (62 EA per 31 days)
alosetron oral tablet 0.5 mg	T4	PA; QL (93 EA per 31 days)
alosetron oral tablet 1 mg	T5	PA; QL (62 EA per 31 days)
AMITIZA	T4	PA; QL (62 EA per 31 days)
amoxicil-clarithromy-lansopraz	T4	
ANALPRAM-HC RECTAL CREAM 1-1 %	T4	
ANALPRAM-HC SINGLES	T4	
ANUSOL-HC TOPICAL	T4	
aprepitant oral capsule 125 mg	T5	PA-BvD
aprepitant oral capsule 40 mg, 80 mg	T4	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
aprepitant oral capsule,dose pack	T4	PA-BvD
APRISO	T4	PA; QL (124 EA per 31 days)
AZULFIDINE	T4	
AZULFIDINE EN-TABS	T4	
balsalazide	T2	
betaine	T5	
bismuth subcit k-metronidz-tcn	T4	
BONJESTA	T4	PA; QL (62 EA per 31 days)
budesonide oral capsule,delayed,extend.release	T4	
budesonide oral tablet,delayed and ext.release	T5	
budesonide rectal	T4	
BYLVAY ORAL CAPSULE 1,200 MCG	T5	PA; QL (186 EA per 31 days)
BYLVAY ORAL CAPSULE 400 MCG	T5	PA; QL (558 EA per 31 days)
BYLVAY ORAL PELLET 200 MCG	T5	PA; QL (1116 EA per 31 days)
BYLVAY ORAL PELLET 600 MCG	T5	PA; QL (372 EA per 31 days)
CANASA	T5	PA; QL (31 EA per 31 days)
CARAFATE ORAL TABLET	T4	
chlordiazepoxide-clidinium	T4	
CHOLBAM	T5	PA
cimetidine	T2	
cimetidine hcl oral	T2	
CIMZIA POWDER FOR RECONST	T5	PA; QL (2 EA per 28 days)
CIMZIA STARTER KIT	T5	PA; QL (6 EA per 365 days)
CIMZIA SUBCUTANEOUS SYRINGE KIT 200 MG/ML	T5	PA; QL (4 EA per 28 days)
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	T5	PA; QL (2 EA per 28 days)
CLENPIQ ORAL SOLUTION 10 MG-3.5 GRAM- 12 GRAM/175 ML	T4	
COMPRO	T2	
CONSTULOSE	T2	
CREON	T3	
cromolyn oral	T4	
CTEXLI	T5	PA; QL (93 EA per 31 days)
CUVPOSA	T4	
CYSTADANE	T5	
CYTOTEC	T4	

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

Drug Name	Drug Tier	Requirements/Limits
DEXILANT	T4	QL (31 EA per 31 days)
dexlansoprazole	T4	QL (31 EA per 31 days)
DICLEGIS	T4	PA; QL (124 EA per 31 days)
dicyclomine oral capsule	T2	
dicyclomine oral solution	T2	
dicyclomine oral tablet 20 mg	T2	
dicyclomine oral tablet 40 mg	T4	PA; QL (124 EA per 31 days)
DIPENTUM	T5	
diphenoxylate-atropine oral liquid	T4	
diphenoxylate-atropine oral tablet	T2	
doxylamine-pyridoxine (vit b6)	T4	PA; QL (124 EA per 31 days)
dronabinol oral capsule 10 mg, 5 mg	T4	PA-BvD
dronabinol oral capsule 2.5 mg	T2	PA-BvD
EMEND ORAL CAPSULE 80 MG	T4	PA-BvD
EMEND ORAL CAPSULE,DOSE PACK	T4	PA-BvD
EMEND ORAL SUSPENSION FOR RECONSTITUTION	T4	PA-BvD
ENTYVIO PEN	T5	PA; QL (1.36 ML per 28 days)
ENULOSE	T2	
EOHILIA	T5	PA; QL (1800 ML per 365 days)
esomeprazole magnesium oral capsule,delayed release(dr/ec)	T2	QL (31 EA per 31 days)
esomeprazole magnesium oral granules dr for susp in packet	T4	QL (31 EA per 31 days)
famotidine oral suspension for reconstitution	T1	
famotidine oral tablet 20 mg, 40 mg	T1	
GASTROCROM	T4	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T1	
GAVILYTE-G	T1	
GAVILYTE-N	T1	
GENERLAC	T2	
GIMOTI	T5	PA; QL (9.8 ML per 28 days)
GLYCATE	T4	PA; QL (155 EA per 31 days)
glycopyrrolate oral solution	T4	
glycopyrrolate oral tablet 1 mg, 2 mg	T2	
glycopyrrolate oral tablet 1.5 mg	T4	PA; QL (155 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
GOLYTELY	T4	
granisetron hcl oral	T2	PA-BvD
GRANISOL	T5	PA-BvD
hydrocortisone acetate topical cream with perineal applicator	T5	
hydrocortisone rectal	T4	
hydrocortisone topical cream with perineal applicator 2.5 %	T1	
hydrocortisone-pramoxine rectal cream 1-1 %	T4	
IBSRELA	T5	PA; QL (62 EA per 31 days)
IQIRVO	T5	PA; QL (31 EA per 31 days)
KONVOMEP	T4	
KRISTALOSE	T4	ST
lactulose oral packet 10 gram	T5	ST
lactulose oral packet 20 gram	T4	ST
lactulose oral solution	T1	
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	T2	QL (31 EA per 31 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	T2	QL (62 EA per 31 days)
lansoprazole oral tablet,disintegrat, delay rel 15 mg	T4	QL (31 EA per 31 days)
lansoprazole oral tablet,disintegrat, delay rel 30 mg	T4	QL (62 EA per 31 days)
LIALDA	T5	PA; QL (124 EA per 31 days)
LIBRAX (WITH CLIDINIUM)	T5	
LINZESS	T3	QL (31 EA per 31 days)
LIVDELZI	T5	PA; QL (31 EA per 31 days)
LIVMARLI ORAL SOLUTION 19 MG/ML	T5	PA; QL (60 ML per 30 days)
LIVMARLI ORAL SOLUTION 9.5 MG/ML	T5	PA; QL (90 ML per 30 days)
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG	T5	PA; QL (62 EA per 31 days)
LIVMARLI ORAL TABLET 30 MG	T5	PA; QL (31 EA per 31 days)
LOMOTIL	T4	
loperamide oral capsule	T2	
lubiprostone	T4	QL (62 EA per 31 days)
MARINOL ORAL CAPSULE 2.5 MG	T4	PA-BvD
meclizine	T4	

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

Drug Name	Drug Tier	Requirements/Limits
mesalamine oral capsule (with del rel tablets)	T3	QL (186 EA per 31 days)
mesalamine oral capsule, extended release 250 mg	T4	QL (496 EA per 31 days)
mesalamine oral capsule, extended release 500 mg	T4	PA; QL (248 EA per 31 days)
mesalamine oral capsule,extended release 24hr	T3	QL (124 EA per 31 days)
mesalamine oral tablet,delayed release (dr/ec) 1.2 gram	T3	QL (124 EA per 31 days)
mesalamine oral tablet,delayed release (dr/ec) 800 mg	T4	PA; QL (186 EA per 31 days)
mesalamine rectal enema	T3	QL (1860 ML per 31 days)
mesalamine rectal suppository	T4	PA; QL (31 EA per 31 days)
methscopolamine	T2	
metoclopramide hcl oral solution	T2	
metoclopramide hcl oral tablet	T2	
misoprostol	T2	
MOTEGRITY	T4	PA; QL (31 EA per 31 days)
MOTOFEN	T4	
MOVANTIK	T3	QL (31 EA per 31 days)
MOVIPREP	T4	
MYTESI	T5	QL (62 EA per 31 days)
NEREUS	T4	PA; QL (60 EA per 365 days)
NEXIUM	T4	QL (31 EA per 31 days)
NEXIUM PACKET	T4	QL (31 EA per 31 days)
nitroglycerin rectal	T4	
nizatidine oral capsule	T2	
omeprazole oral capsule,delayed release(dr/ec)	T1	
omeprazole-sodium bicarbonate oral capsule	T2	
omeprazole-sodium bicarbonate oral packet	T5	
OMVOH PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML	T5	PA; QL (2 ML per 28 days)
OMVOH PEN SUBCUTANEOUS PEN INJECTOR 300MG/3ML(100MG /ML-200 MG/2ML)	T5	PA; QL (3 ML per 28 days)
OMVOH SUBCUTANEOUS SYRINGE 200 MG/2 ML	T5	PA; QL (2 ML per 28 days)
OMVOH SUBCUTANEOUS SYRINGE 300MG/3ML(100MG /ML-200 MG/2ML)	T5	PA; QL (3 ML per 28 days)
ondansetron hcl oral solution	T2	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
ondansetron hcl oral tablet 4 mg, 8 mg	T2	PA-BvD
ondansetron oral tablet,disintegrating 4 mg, 8 mg	T2	PA-BvD
PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,500-35,500- 61,500 UNIT, 16,800-56,800- 98,400 UNIT, 2,600-8,800- 15,200 UNIT, 4,200-14,200- 24,600 UNIT	T4	ST
PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 21,000-54,700- 83,900 UNIT, 37,000-97,300- 149,900 UNIT	T5	ST
pantoprazole oral granules dr for susp in packet	T4	
pantoprazole oral tablet,delayed release (dr/ec)	T1	
peg 3350-electrolytes	T1	
peg3350-sod sul-nacl-kcl-asb-c	T4	
peg-electrolyte soln	T1	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	T3	QL (496 EA per 31 days)
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	T5	PA; QL (248 EA per 31 days)
PEPCID ORAL TABLET	T4	
PERTZYE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 16,000-57,500- 60,500 UNIT, 4,000-14,375- 15,125 UNIT, 8,000-28,750- 30,250 UNIT	T4	ST
PERTZYE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 24,000-86,250- 90,750 UNIT	T5	ST
PREVACID	T4	QL (62 EA per 31 days)
PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 15 MG	T4	QL (31 EA per 31 days)
PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 30 MG	T4	QL (62 EA per 31 days)
PRILOSEC ORAL SUSP,DELAYED RELEASE FOR RECON 10 MG	T5	
PRILOSEC ORAL SUSP,DELAYED RELEASE FOR RECON 2.5 MG	T4	
prochlorperazine	T2	
prochlorperazine maleate	T2	
PROCTOFOAM HC	T4	

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

Drug Name	Drug Tier	Requirements/Limits
PROCTO-MED HC	T2	
PROCTOSOL HC TOPICAL	T2	
PROCTOZONE-HC	T2	
PROTONIX ORAL	T4	
prucalopride	T4	PA; QL (31 EA per 31 days)
PYLERA	T4	
rabeprazole oral tablet,delayed release (dr/ec)	T2	QL (62 EA per 31 days)
ranitidine hcl oral tablet	T4	
REGLAN ORAL	T4	
RELISTOR ORAL	T5	PA; QL (93 EA per 31 days)
RELISTOR SUBCUTANEOUS SOLUTION	T5	PA; QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	T5	PA; QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	T5	PA; QL (12.4 ML per 31 days)
RELTONE	T5	ST
ROWASA RECTAL ENEMA KIT	T4	PA; QL (4 EA per 28 days)
SANCUSO	T5	
scopolamine base	T3	QL (10 EA per 30 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	T5	PA; QL (1.2 ML per 56 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	T5	PA; QL (2.4 ML per 56 days)
sodium,potassium,mag sulfates	T4	
SUCRAID	T5	PA
sucralfate oral suspension	T4	
sucralfate oral tablet	T2	
SUFLAVE	T4	
sulfasalazine	T2	
SUPREP BOWEL PREP KIT	T4	
SUTAB	T4	
SYMPROIC	T4	PA; QL (31 EA per 31 days)
TALICIA	T4	PA
TRANSDERM-SCOP	T4	QL (10 EA per 30 days)
trimethobenzamide oral	T4	PA
TRULANCE	T4	PA; QL (31 EA per 31 days)
UCERIS ORAL	T5	
UCERIS RECTAL	T4	

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

Drug Name	Drug Tier	Requirements/Limits
ursodiol oral capsule 200 mg, 400 mg	T4	ST
ursodiol oral capsule 300 mg	T3	
ursodiol oral tablet	T3	
URSOLIGN	T5	ST
VARUBI	T4	PA-BvD
VELSIPITY	T5	PA; QL (31 EA per 31 days)
VIBERZI	T5	PA; QL (62 EA per 31 days)
VIOKACE ORAL TABLET 10,440-39,150-39,150 UNIT	T5	
VIOKACE ORAL TABLET 20,880-78,300-78,300 UNIT	T4	
VOQUEZNA DUAL PAK	T4	PA; QL (112 EA per 14 days)
VOQUEZNA ORAL TABLET 10 MG	T4	PA; QL (31 EA per 31 days)
VOQUEZNA ORAL TABLET 20 MG	T4	PA; QL (62 EA per 31 days)
VOQUEZNA TRIPLE PAK	T4	PA; QL (112 EA per 14 days)
VOWST	T5	PA; QL (12 EA per 14 days)
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT	T3	
ZYMFENTRA	T5	PA; QL (1 EA per 28 days)
Immunology, Vaccines / Biotechnology		
ABRYSVO (PF)	T3	QL (1 EA per 365 days)
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML	T5	PA-BvD; ST
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	T4	PA-BvD; ST
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML	T4	PA-BvD; ST

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

Drug Name	Drug Tier	Requirements/Limits
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML, 60 MCG/0.3 ML	T5	PA-BvD; ST
ARCALYST	T5	PA
AREXVY (PF)	T3	QL (1 EA per 365 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	PA; QL (1 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	PA; QL (1 EA per 28 days)
bcg vaccine, live (pf)	T3	
BESREMI	T5	PA-NS; QL (2 ML per 28 days)
BESREMI PEN	T5	PA-NS; QL (1 ML per 28 days)
BETASERON SUBCUTANEOUS KIT	T5	PA; QL (14 EA per 28 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE	T3	
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
EGRIFTA SV	T5	PA
EGRIFTA WR	T5	PA; QL (4 EA per 28 days)
ENGERIX-B (PF)	T3	PA-BvD
ENGERIX-B PEDIATRIC (PF)	T3	PA-BvD
EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T4	PA-BvD; ST
FULPHILA	T5	ST
FYLNETRA	T5	ST
GAMMAGARD LIQUID	T5	PA
GAMMAGARD LIQUID ERC	T5	PA
GAMMAGARD S-D (IGA < 1 MCG/ML)	T5	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GAMMAPLEX	T5	PA
GAMMAPLEX (WITH SORBITOL)	T5	PA
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GARDASIL 9 (PF)	T3	

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

Drug Name	Drug Tier	Requirements/Limits
GENOTROPIN	T5	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	T4	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML	T5	PA
GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML	T4	ST
GRANIX SUBCUTANEOUS SYRINGE	T4	ST
GRASTEK	T4	PA
HAVRIX (PF)	T3	
HEPLISAV-B (PF)	T3	PA-BvD
HIBERIX (PF)	T3	
HUMATROPE INJECTION CARTRIDGE	T5	PA
IMOVAX RABIES VACCINE (PF)	T3	PA-BvD
INFANRIX (DTAP) (PF)	T3	
IPOL	T3	
IXIARO (PF)	T3	
JYNNEOS (PF)	T3	PA-BvD
KINRIX (PF)	T3	
LEUKINE INJECTION RECON SOLN	T5	PA
MENQUADFI (PF)	T3	
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	T3	
MIRCERA	T4	ST
M-M-R II (PF)	T3	
MRESVIA (PF)	T3	QL (1 ML per 365 days)
NEULASTA SUBCUTANEOUS SYRINGE	T5	ST
NEUPOGEN	T5	ST
NGENLA	T5	PA
NIVESTYM	T5	
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	T5	PA

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

Drug Name	Drug Tier	Requirements/Limits
NYVEPRIA	T5	ST
OCTAGAM	T5	PA
ODACTRA	T4	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
PANZYGA	T5	PA
PEDIARIX (PF)	T3	
PEDVAX HIB (PF)	T3	
PEGASYS	T5	PA
PENBRAYA (PF)	T3	
PENMENVY MEN A-B-C-W-Y (PF)	T3	
PENTACEL (PF)	T3	
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	T5	PA; QL (1 ML per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	T5	PA; QL (1 ML per 28 days)
PRIORIX (PF)	T3	
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	T5	PA-BvD
PROQUAD (PF)	T3	
QIVIGY	T5	PA
QUADRACEL (PF)	T3	
RABAVERT (PF)	T3	PA-BvD
REBIF (WITH ALBUMIN)	T5	PA; QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	T5	PA; QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	T5	PA; QL (4.2 ML per 365 days)
REBIF TITRATION PACK	T5	PA; QL (8.4 ML per 365 days)
RECOMBIVAX HB (PF)	T3	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
RELEUKO SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML	T4	ST
RELEUKO SUBCUTANEOUS SYRINGE 480 MCG/0.8 ML	T5	ST
RETACRIT	T3	PA-BvD
ROLVEDON	T5	ST
ROTARIX	T3	
ROTATEQ VACCINE	T3	
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	T5	PA
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	T3	QL (2 EA per 999 days)
SHINGRIX (PF) INTRAMUSCULAR SYRINGE	T3	QL (1 ML per 999 days)
SKYTROFA	T5	PA
SOGROYA	T5	PA
STIMUFEND	T5	ST
TENIVAC (PF)	T3	
TICOVAC	T3	
TRUMENBA	T3	
TWINRIX (PF)	T3	
TYPHIM VI INTRAMUSCULAR SYRINGE	T3	
UDENYCA	T5	ST
UDENYCA AUTOINJECTOR	T5	ST
VAQTA (PF)	T3	
VARIVAX (PF)	T3	
VAXCHORA VACCINE	T3	QL (200 ML per 365 days)
VIMKUNYA (PF)	T3	
VIVOTIF	T3	
XOLREMDI	T5	PA; QL (124 EA per 31 days)
YF-VAX (PF)	T3	
YIMMUGO	T5	PA
ZARXIO	T5	
ZIEXTENZO	T5	ST
ZOMACTON SUBCUTANEOUS RECON SOLN 5 MG	T4	PA

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

Drug Name	Drug Tier	Requirements/Limits
Miscellaneous Supplies		
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	PA
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T2	PA
insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge	T3	
pen needle, diabetic needle 29 gauge x 1/2"	T4	PA
Musculoskeletal / Rheumatology		
ABRILADA(CF) PEN	T5	PA; QL (4 EA per 28 days)
ABRILADA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.4 ML	T5	PA; QL (2 EA per 28 days)
ABRILADA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	T5	PA; QL (4 EA per 28 days)
ACTEMRA ACTPEN	T5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
ACTONEL ORAL TABLET 150 MG, 35 MG	T4	
adalimumab-aacf subcutaneous pen injector kit	T5	PA; QL (2 EA per 28 days)
adalimumab-aacf subcutaneous syringe kit	T5	PA; QL (2 EA per 28 days)
ADALIMUMAB-AACF(CF) PEN CROHNS	T5	PA; QL (12 EA per 365 days)
ADALIMUMAB-AACF(CF) PEN PS-UV	T5	PA; QL (8 EA per 365 days)
adalimumab-aaty subcutaneous auto-injector, kit 40 mg/0.4 ml	T5	PA; QL (4 EA per 28 days)
adalimumab-aaty subcutaneous auto-injector, kit 80 mg/0.8 ml	T5	PA; QL (2 EA per 28 days)
adalimumab-aaty subcutaneous syringe kit 20 mg/0.2 ml	T5	PA; QL (2 EA per 28 days)
adalimumab-aaty subcutaneous syringe kit 40 mg/0.4 ml	T5	PA; QL (4 EA per 28 days)
ADALIMUMAB-AATY(CF) AI CROHNS	T5	PA; QL (6 EA per 365 days)
adalimumab-adaz subcutaneous pen injector	T5	PA; QL (1.6 ML per 28 days)
adalimumab-adaz subcutaneous syringe 10 mg/0.1 ml	T5	PA; QL (0.2 ML per 28 days)
adalimumab-adaz subcutaneous syringe 20 mg/0.2 ml	T5	PA; QL (0.4 ML per 28 days)
adalimumab-adaz subcutaneous syringe 40 mg/0.4 ml	T5	PA; QL (1.6 ML per 28 days)
adalimumab-adbm subcutaneous pen injector kit	T5	PA; QL (4 EA per 28 days)
adalimumab-adbm subcutaneous syringe kit 10 mg/0.2 ml, 20 mg/0.4 ml	T5	PA; QL (2 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
adalimumab-adbm subcutaneous syringe kit 40 mg/0.4 ml, 40 mg/0.8 ml	T5	PA; QL (4 EA per 28 days)
adalimumab-bwwd	T5	PA; QL (1.6 ML per 28 days)
adalimumab-fkjp subcutaneous pen injector kit	T5	PA; QL (4 EA per 28 days)
adalimumab-fkjp subcutaneous syringe kit 20 mg/0.4 ml	T5	PA; QL (2 EA per 28 days)
adalimumab-fkjp subcutaneous syringe kit 40 mg/0.8 ml	T5	PA; QL (4 EA per 28 days)
adalimumab-ryvk subcutaneous auto-injector, kit 40 mg/0.4 ml	T5	PA; QL (4 EA per 28 days)
adalimumab-ryvk subcutaneous auto-injector, kit 80 mg/0.8 ml	T5	PA; QL (2 EA per 28 days)
adalimumab-ryvk subcutaneous syringe kit	T5	PA; QL (4 EA per 28 days)
alendronate oral solution	T2	
alendronate oral tablet 10 mg, 35 mg, 70 mg	T1	
allopurinol oral tablet 100 mg, 300 mg	T1	
allopurinol oral tablet 200 mg	T4	
AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML, 80 MG/0.8 ML	T5	PA; QL (1.6 ML per 28 days)
AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.8 ML	T5	PA; QL (3.2 EA per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML, 20 MG/0.2 ML	T5	PA; QL (0.4 ML per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 40 MG/0.8 ML	T5	PA; QL (3.2 EA per 28 days)
ATELVIA	T4	
auranofin	T5	
AVTOZMA AUTOINJECTOR	T5	PA; QL (3.6 ML per 28 days)
AVTOZMA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
BILDYOS	T3	PA; QL (1 ML per 180 days)
BONSITY	T5	PA; QL (2.24 ML per 28 days)
BOSAYA	T4	PA; QL (1 ML per 180 days)
colchicine oral capsule	T4	QL (62 EA per 31 days)
colchicine oral tablet	T2	QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
CONEXXENCE	T4	PA; QL (1 ML per 180 days)
CUPRIMINE	T5	
CYLTEZO(CF) PEN	T5	PA; QL (4 EA per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	T5	PA; QL (2 EA per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML, 40 MG/0.8 ML	T5	PA; QL (4 EA per 28 days)
DEPEN TITRATABS	T5	
ENBREL MINI	T5	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)	T5	PA; QL (8 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (8 ML per 28 days)
ENOBY	T3	PA; QL (1 ML per 180 days)
EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	T5	PA; QL (2.34 ML per 28 days)
EVISTA	T4	
febuxostat	T4	PA
FORTEO	T5	PA; QL (2.24 ML per 28 days)
FOSAMAX ORAL TABLET 70 MG	T4	
FOSAMAX PLUS D	T4	
GLOPERBA	T4	QL (300 ML per 30 days)
HADLIMA	T5	PA; QL (3.2 ML per 28 days)
HADLIMA PUSHTOUCH	T5	PA; QL (3.2 ML per 28 days)
HADLIMA(CF)	T5	PA; QL (1.6 ML per 28 days)
HADLIMA(CF) PUSHTOUCH	T5	PA; QL (1.6 ML per 28 days)
HUMIRA PEN	T5	PA; QL (4 EA per 28 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	T5	PA; QL (4 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS	T5	PA; QL (6 EA per 365 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA; QL (6 EA per 365 days)
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	T5	PA; QL (4 EA per 28 days)
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	T5	PA; QL (2 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	T5	PA; QL (4 EA per 28 days)
HYRIMOZ PEN CROHN'S-UC STARTER	T5	PA; QL (4.8 ML per 365 days)
HYRIMOZ PEN PSORIASIS STARTER	T5	PA; QL (3.2 ML per 365 days)
HYRIMOZ(CF) PEN	T5	PA; QL (1.6 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML	T5	PA; QL (0.2 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML	T5	PA; QL (0.4 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ibandronate oral	T2	
JUBBONTI	T3	PA; QL (1 ML per 180 days)
KEVZARA SUBCUTANEOUS PEN INJECTOR	T5	PA; QL (2.28 ML per 28 days)
KEVZARA SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
leflunomide	T2	
LEQSELVI	T5	PA; QL (62 EA per 31 days)
milnacipran oral tablet	T4	PA
MITIGARE	T4	QL (62 EA per 31 days)
OLUMIANT	T5	PA; QL (31 EA per 31 days)
ORENCIA CLICKJECT	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	T5	PA; QL (2.8 ML per 28 days)
OSPOMYV	T4	PA; QL (1 ML per 180 days)
OTEZLA	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (110 EA per 365 days)
OTEZLA XR	T5	PA; QL (30 EA per 30 days)
OTEZLA XR INITIATION	T5	PA; QL (82 EA per 365 days)
penicillamine	T5	
probenecid	T2	

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

Drug Name	Drug Tier	Requirements/Limits
probenecid-colchicine	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)
raloxifene	T3	
RASUVO (PF)	T4	PA
RINVOQ LQ	T5	PA; QL (372 ML per 31 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	T5	PA; QL (31 EA per 31 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	T5	PA; QL (168 EA per 365 days)
risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg	T3	
risedronate oral tablet,delayed release (dr/ec)	T3	
SAVELLA ORAL TABLET	T4	PA
SIMLANDI(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	T5	PA; QL (4 EA per 28 days)
SIMLANDI(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 80 MG/0.8 ML	T5	PA; QL (2 EA per 28 days)
SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML	T5	PA; QL (2 EA per 28 days)
SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	T5	PA; QL (4 EA per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
STOBOCLO	T4	PA; QL (1 ML per 180 days)
teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)	T5	PA; QL (2.24 ML per 28 days)
tofacitinib oral solution	T5	PA; QL (310 ML per 31 days)
tofacitinib oral tablet	T3	PA; QL (62 EA per 31 days)
tofacitinib oral tablet extended release 24 hr 11 mg	T3	PA; QL (31 EA per 31 days)
tofacitinib oral tablet extended release 24 hr 22 mg	T5	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
TYENNE AUTOINJECTOR	T5	PA; QL (3.6 ML per 28 days)
TYENNE SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
TYMLOS	T5	PA; QL (1.56 ML per 30 days)
ULORIC	T4	PA
XELJANZ ORAL SOLUTION	T5	PA; QL (310 ML per 31 days)
XELJANZ ORAL TABLET	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
YUFLYMA(CF) AI CROHN'S-UC-HS	T5	PA; QL (6 EA per 365 days)
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	T5	PA; QL (4 EA per 28 days)
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 80 MG/0.8 ML	T5	PA; QL (2 EA per 28 days)
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	T5	PA; QL (4 EA per 28 days)
YUSIMRY(CF) PEN	T5	PA; QL (3.2 ML per 28 days)
Obstetrics / Gynecology		
ABIGALE	T2	
ABIGALE LO	T4	
ACTIVELLA	T4	
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
ANGELIQ	T4	
ANNOVERA	T4	
APRI	T2	
ARANELLE (28)	T4	
ASHLYNA	T4	
AUBRA EQ	T4	
AVIANE	T2	
AZURETTE (28)	T4	
BALCOLTRA	T4	
BALZIVA (28)	T4	
BEYAZ	T4	
BIJUVA	T4	
BLISOVI 24 FE	T4	
BLISOVI FE 1.5/30 (28)	T4	
BRIELLYN	T4	

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

Drug Name	Drug Tier	Requirements/Limits
CAMILA	T2	
CAMRESE LO	T4	
CLEOCIN VAGINAL	T4	
CLIMARA	T4	
CLIMARA PRO	T4	
clindamycin phosphate vaginal	T2	
CLINDESSE	T4	
COMBIPATCH	T4	
conjugated estrogens	T3	
CRINONE VAGINAL GEL 8 %	T4	PA
CRYSELLE (28)	T2	
CYRED EQ	T2	
DEBLITANE	T4	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML	T4	
DEPO-ESTRADIOL	T4	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	T4	
DEPO-PROVERA INTRAMUSCULAR SYRINGE	T4	
DEPO-SUBQ PROVERA 104	T3	
DIVIGEL	T4	
DOLISHALE	T4	
DOTTI	T2	
drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4)	T2	
drospirenone-ethinyl estradiol	T2	
DUAVEE	T4	
ELESTRIN	T4	
ELURYNG	T3	
ENILLORING	T4	
ENSKYCE	T4	
ERRIN	T2	
ESTARYLLA	T2	
ESTRACE VAGINAL	T4	
estradiol oral	T1	
estradiol transdermal gel in metered-dose pump	T4	
estradiol transdermal gel in packet	T4	

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

Drug Name	Drug Tier	Requirements/Limits
estradiol transdermal patch semiweekly	T2	
estradiol transdermal patch weekly	T2	
estradiol vaginal cream	T2	
estradiol vaginal tablet	T4	
estradiol valerate	T2	
estradiol-norethindrone acet	T2	
ESTRING	T4	
etonogestrel-ethinyl estradiol	T3	
EVAMIST	T4	
FALMINA (28)	T4	
FEIRZA	T4	
FEMLYV	T4	
FEMRING	T4	
FINZALA	T4	
FYAVOLV	T2	
GALBRIELA	T4	
GALLIFREY	T2	
GEMMILY	T4	
GYNAZOLE-1	T4	
HAILEY 24 FE	T2	
HAILEY FE 1/20 (28)	T4	
HEATHER	T2	
ICLEVIA	T4	
IMVEXXY MAINTENANCE PACK	T3	
IMVEXXY STARTER PACK	T3	
INCASSIA	T2	
INTRAROSA	T4	PA; QL (28 EA per 28 days)
INTROVALE	T4	
ISIBLOOM	T2	
JAIMIESS	T4	
JASMIEL (28)	T4	
JINTELI	T2	
JOYEAUX	T4	
JULEBER	T4	
JUNEL 1.5/30 (21)	T2	
JUNEL 1/20 (21)	T2	
JUNEL FE 1.5/30 (28)	T2	

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

Drug Name	Drug Tier	Requirements/Limits
JUNEL FE 1/20 (28)	T2	
JUNEL FE 24	T2	
KAITLIB FE	T4	
KARIVA (28)	T2	
KELNOR 1/35 (28)	T4	
KURVELO (28)	T2	
KYLEENA	T4	
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)	T2	
LARIN 1.5/30 (21)	T4	
LARIN 1/20 (21)	T4	
LARIN FE 1.5/30 (28)	T4	
LARIN FE 1/20 (28)	T4	
LESSINA	T2	
LEVONEST (28)	T4	
levonorgest-eth.estradiol-iron	T4	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	T2	
levonorgestrel-ethinyl estrad oral tablet 90-20 mcg (28)	T4	
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month	T2	
levonorg-eth estrad triphasic	T2	
LILETTA	T3	
LO LOESTRIN FE	T4	
LOESTRIN 1.5/30 (21)	T4	
LOESTRIN 1/20 (21)	T4	
LOESTRIN FE 1.5/30 (28-DAY)	T4	
LOESTRIN FE 1/20 (28-DAY)	T4	
LOJAIMIESS	T4	
LORYNA (28)	T4	
LUIZZA	T4	
LYLEQ	T2	
LYLLANA	T2	
LYNKUET	T4	PA; QL (62 EA per 31 days)
LYZA	T2	
MARLISSA (28)	T4	
medroxyprogesterone	T2	

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

Drug Name	Drug Tier	Requirements/Limits
MELEYA	T4	
MENOSTAR	T4	
metronidazole vaginal gel 0.75 % (37.5mg/5 gram)	T3	
MIBELAS 24 FE	T4	
MICONAZOLE-3 VAGINAL SUPPOSITORY	T2	
MICROGESTIN 1.5/30 (21)	T2	
MICROGESTIN 1/20 (21)	T2	
MICROGESTIN FE 1.5/30 (28)	T2	
MICROGESTIN FE 1/20 (28)	T2	
MILI	T2	
MIMVEY	T2	
MINIVELLE	T4	
MINZOYA	T4	
MIRENA	T4	
MYFEMBREE	T5	PA; QL (31 EA per 31 days)
NATAZIA	T4	
NECON 0.5/35 (28)	T4	
NEXPLANON	T3	
NEXTSTELLIS	T4	
NIKKI (28)	T4	
NORA-BE	T4	
norelgestromin-ethin.estradiol	T4	
norethindrone (contraceptive)	T2	
norethindrone acetate	T2	
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-20 mg-mcg, 1-5 mg-mcg	T2	
norethindrone-e.estradiol-iron oral capsule	T4	
norethindrone-e.estradiol-iron oral tablet,chewable	T2	
norgestimate-ethinyl estradiol	T2	
NORTREL 0.5/35 (28)	T4	
NORTREL 1/35 (21)	T4	
NORTREL 1/35 (28)	T4	
NORTREL 7/7/7 (28)	T2	
NUVARING	T4	
NUVESSA	T4	

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

Drug Name	Drug Tier	Requirements/Limits
NYLIA 1/35 (28)	T2	
NYLIA 7/7/7 (28)	T2	
ORIAHNN	T5	PA; QL (56 EA per 28 days)
ORQUIDEA	T4	
OSPHENA	T4	PA; QL (31 EA per 31 days)
PHEXX	T4	
PIMTREA (28)	T2	
PORTIA 28	T4	
PREMARIN ORAL	T4	ST
PREMARIN VAGINAL	T3	
PREMPHASE	T4	
PREMPRO	T4	
progesterone micronized oral	T2	
PROMETRIUM	T4	
PROVERA ORAL TABLET 5 MG	T4	
RECLIPSEN (28)	T4	
RIVELSA	T4	
ROSYRAH	T4	
SAFYRAL	T4	
SETLAKIN	T2	
SHAROBEL	T4	
SKYLA	T4	
SLYND	T4	
SPRINTEC (28)	T2	
SYEDA	T4	
TARINA 24 FE	T4	
TARINA FE 1-20 EQ (28)	T4	
terconazole	T2	
TILIA FE	T4	
tranexamic acid oral	T2	
TRI-ESTARYLLA	T4	
TRI-LEGEST FE	T4	
TRI-LO-ESTARYLLA	T4	
TRI-LO-SPRINTEC	T2	
TRI-MILI	T2	
TRI-SPRINTEC (28)	T2	
TRI-VYLIBRA	T4	

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

Drug Name	Drug Tier	Requirements/Limits
TRI-VYLIBRA LO	T4	
TURQOZ (28)	T4	
TWIRLA	T4	
TYBLUME	T4	
TYDEMY	T4	
VAGIFEM	T4	
VALTYA	T4	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VEOZAH	T4	PA; QL (31 EA per 31 days)
VESTURA (28)	T2	
VIENVA	T2	
VIORELE (28)	T4	
VIVELLE-DOT	T4	
VYFEMLA (28)	T4	
VYLIBRA	T4	
WYMZYA FE	T4	
XACIATO	T4	
XARAH FE	T4	
XELRIA FE	T4	
XULANE	T2	
YASMIN (28)	T4	
YAZ (28)	T4	
YUVAFEM	T4	
ZAFEMY	T2	
ZOVIA 1-35 (28)	T4	
Ophthalmology		
acetazolamide	T2	
ACULAR	T4	
ACULAR LS	T4	
ACUVAIL (PF)	T4	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.15 %	T4	
ALREX	T4	
apraclonidine	T2	
atropine ophthalmic (eye) drops 1 %	T2	

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

Drug Name	Drug Tier	Requirements/Limits
AZASITE	T4	
azelastine ophthalmic (eye)	T2	
AZOPT	T4	
bacitracin-polymyxin b	T2	
bepotastine besilate	T4	PA
BEPREVE	T4	PA
besifloxacin	T4	
BESIVANCE	T4	
betaxolol ophthalmic (eye)	T2	
BETIMOL OPHTHALMIC (EYE) DROPS 0.5 %	T4	
bimatoprost ophthalmic (eye) drops 0.01 %	T4	QL (7.5 ML per 45 days)
bimatoprost ophthalmic (eye) drops 0.03 %	T2	
brimonidine ophthalmic (eye) drops 0.1 %	T3	
brimonidine ophthalmic (eye) drops 0.15 %, 0.2 %	T2	
brimonidine-timolol	T3	
brinzolamide	T4	
bromfenac ophthalmic (eye) drops 0.07 %, 0.075 %	T4	
bromfenac ophthalmic (eye) drops 0.09 %	T2	
BROMSITE	T4	
carteolol	T2	
CEQUA	T4	ST; QL (60 EA per 30 days)
CILOXAN OPHTHALMIC (EYE) OINTMENT	T4	
ciprofloxacin hcl ophthalmic (eye)	T1	
COMBIGAN	T3	
COSOPT	T4	
COSOPT (PF)	T4	
cromolyn ophthalmic (eye)	T2	
cyclosporine ophthalmic (eye)	T3	QL (60 EA per 30 days)
CYSTADROPS	T5	PA; QL (20 ML per 28 days)
CYSTARAN	T5	PA; QL (60 ML per 28 days)
dexamethasone sodium phosphate ophthalmic (eye)	T2	
diclofenac sodium ophthalmic (eye)	T1	
difluprednate	T4	

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

Drug Name	Drug Tier	Requirements/Limits
dorzolamide	T2	
dorzolamide-timolol	T2	
dorzolamide-timolol (pf) ophthalmic (eye) dropperette	T4	
DUREZOL	T4	
epinastine	T2	
erythromycin ophthalmic (eye)	T2	
EYSUVIS	T4	QL (8.3 ML per 30 days)
FLAREX	T4	
fluorometholone	T2	
flurbiprofen sodium	T2	
FML FORTE	T4	
FML LIQUIFILM	T4	
gatifloxacin	T3	
gentamicin ophthalmic (eye) drops	T1	
ILEVRO	T3	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	T4	
ISTALOL	T4	
IYUZEH (PF)	T4	ST; QL (30 EA per 30 days)
ketorolac ophthalmic (eye)	T2	
latanoprost	T1	
levobunolol ophthalmic (eye) drops 0.5 %	T1	
levofloxacin ophthalmic (eye) drops 0.5 %	T3	
LOTEMAX	T4	
LOTEMAX SM	T4	
loteprednol etabonate	T4	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
MAXIDEX	T4	
MAXITROL OPHTHALMIC (EYE) DROPS,SUSPENSION	T4	
methazolamide oral tablet 25 mg	T2	
methazolamide oral tablet 50 mg	T4	
MIEBO (PF)	T4	QL (3 ML per 30 days)
moxifloxacin ophthalmic (eye) drops	T3	
NATACYN	T4	
neomycin-bacitracin-poly-hc	T2	

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

Drug Name	Drug Tier	Requirements/Limits
neomycin-bacitracin-polymyxin	T2	
neomycin-polymyxin b-dexameth	T2	
neomycin-polymyxin-gramicidin	T2	
neomycin-polymyxin-hc ophthalmic (eye)	T2	
NEVANAC	T4	
OCUFLOX	T4	
ofloxacin ophthalmic (eye)	T2	
OXERVATE	T5	PA; QL (112 ML per 56 days)
PHOSPHOLINE IODIDE	T5	PA; QL (5 ML per 25 days)
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	T2	
pilocarpine hcl ophthalmic (eye) drops 1.25 %	T4	PA; QL (5 ML per 25 days)
polymyxin b sulf-trimethoprim	T1	
PRED MILD	T4	
prednisolone acetate	T1	
prednisolone sodium phosphate ophthalmic (eye)	T2	
PROLENSA	T3	
RESTASIS	T3	QL (60 EA per 30 days)
RESTASIS MULTIDOSE	T3	QL (5.5 ML per 27 days)
RHOPRESSA	T3	ST
ROCKLATAN	T3	ST
SIMBRINZA	T4	
sulfacetamide sodium ophthalmic (eye) drops	T2	
sulfacetamide-prednisolone	T2	
tafluprost (pf)	T4	
timolol	T4	
timolol maleate (pf)	T4	
timolol maleate ophthalmic (eye) drops	T1	
timolol maleate ophthalmic (eye) drops, once daily	T3	
timolol maleate ophthalmic (eye) gel forming solution	T2	
TIMOPTIC OCUDOSE (PF)	T4	
TOBRADEX	T3	
TOBRADEX ST	T3	
tobramycin ophthalmic (eye)	T1	
tobramycin-dexamethasone	T2	

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

Drug Name	Drug Tier	Requirements/Limits
tobramycin-lotepred	T4	
TOBREX OPHTHALMIC (EYE) OINTMENT	T4	
TRAVATAN Z	T4	
travoprost	T3	
trifluridine	T2	
TRYPTYR	T4	ST; QL (60 EA per 30 days)
TYRVAYA	T4	ST; QL (8.4 ML per 30 days)
VERKAZIA	T5	PA; QL (120 EA per 30 days)
VEVYE	T4	ST; QL (2 ML per 30 days)
VIGAMOX	T4	
VYZULTA	T4	ST; QL (5 ML per 31 days)
XALATAN	T4	
XDEMVY	T5	PA; QL (10 ML per 42 days)
XIIDRA	T3	QL (60 EA per 30 days)
ZERVIATE	T4	PA
ZIOPTAN (PF)	T4	ST
ZIRGAN	T4	ST
ZOLYMBUS	T4	ST; QL (30 EA per 30 days)
ZYLET	T4	
Respiratory And Allergy		
acetylcysteine	T2	PA-BvD
ADCIRCA	T5	PA; QL (62 EA per 31 days)
ADEMPAS	T5	PA; QL (93 EA per 31 days)
ADVAIR DISKUS	T4	ST; QL (60 EA per 30 days)
ADVAIR HFA	T3	QL (12 GM per 30 days)
AIRSUPRA	T4	PA; QL (32.1 GM per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	T3	QL (17 GM per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)	T3	QL (13.4 GM per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)	T4	ST; QL (36 GM per 30 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml	T2	PA-BvD
albuterol sulfate oral syrup	T1	
albuterol sulfate oral tablet	T2	

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

Drug Name	Drug Tier	Requirements/Limits
ALVESCO	T4	QL (12.2 GM per 30 days)
ALYFTREK ORAL TABLET 10-50-125 MG	T5	PA; QL (56 EA per 28 days)
ALYFTREK ORAL TABLET 4-20-50 MG	T5	PA; QL (84 EA per 28 days)
ALYQ	T4	PA; QL (62 EA per 31 days)
ambrisentan	T5	PA; QL (31 EA per 31 days)
ANDEMBRY AUTOINJECTOR	T5	PA; QL (1.2 ML per 28 days)
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
arformoterol	T4	PA-BvD
ARNUITY ELLIPTA	T4	QL (30 EA per 30 days)
ASMANEX HFA	T3	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	T3	QL (1 EA per 30 days)
ATROVENT HFA	T4	ST; QL (25.8 GM per 30 days)
AUVI-Q	T4	ST
azelastine-fluticasone	T4	QL (23 GM per 30 days)
beclomethasone dipropionate inhalation aerosol 40 mcg/actuation	T4	ST; QL (8.7 GM per 30 days)
beclomethasone dipropionate inhalation aerosol 80 mcg/actuation	T4	ST; QL (17.4 GM per 30 days)
BERINERT INTRAVENOUS KIT	T5	PA
BEVESPI AEROSPHERE	T4	QL (10.7 GM per 30 days)
bosentan oral tablet	T5	PA; QL (62 EA per 31 days)
bosentan oral tablet for suspension	T5	PA; QL (124 EA per 31 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BREYNA	T4	ST; QL (10.3 GM per 30 days)
BREZTRI AEROSPHERE	T3	QL (10.7 GM per 30 days)
BRINSUPRI	T5	PA; QL (31 EA per 31 days)
budesonide inhalation	T4	PA-BvD
budesonide-formoterol	T3	QL (10.2 GM per 30 days)
carbinoxamine maleate	T4	PA
CARBZAH	T4	PA
cetirizine oral solution 1 mg/ml	T1	QL (310 ML per 31 days)
CINRYZE	T5	PA; QL (20 EA per 28 days)
CLARINEX ORAL TABLET	T4	QL (31 EA per 31 days)
CLARINEX-D 12 HOUR	T4	

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

Drug Name	Drug Tier	Requirements/Limits
clemastine oral syrup	T2	PA
clemastine oral tablet	T4	
CLEMSZA	T4	
COMBIVENT RESPIMAT	T3	QL (4 GM per 30 days)
CORPHENA	T5	PA
cromolyn inhalation	T4	PA-BvD
cyproheptadine oral syrup	T2	PA
cyproheptadine oral tablet	T2	PA
DALIRESP	T4	QL (31 EA per 31 days)
DAWNZERA	T5	PA; QL (0.8 ML per 28 days)
desloratadine oral solution	T5	PA; QL (310 ML per 31 days)
desloratadine oral tablet	T1	QL (31 EA per 31 days)
desloratadine oral tablet,disintegrating	T4	QL (31 EA per 31 days)
DUAKLIR PRESSAIR	T4	QL (1 EA per 30 days)
DULERA	T3	QL (13 GM per 30 days)
DYMISTA	T4	ST; QL (23 GM per 30 days)
EKTERLY	T5	PA; QL (8 EA per 31 days)
epinephrine injection auto-injector	T3	
EPIPEN 2-PAK	T4	ST
EPIPEN JR 2-PAK	T4	ST
ESBRIET ORAL TABLET	T5	PA; QL (93 EA per 31 days)
FASENRA PEN	T5	PA; QL (1 ML per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	T5	PA; QL (0.5 ML per 56 days)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	T5	PA; QL (1 ML per 28 days)
FIRAZYR	T5	PA; QL (18 ML per 30 days)
flunisolide	T2	QL (50 ML per 25 days)
fluticasone furoate	T4	QL (30 EA per 30 days)
fluticasone furoate-vilanterol	T3	QL (60 EA per 30 days)
fluticasone propionate inhalation blister with device 100 mcg/actuation, 50 mcg/actuation	T4	ST; QL (60 EA per 30 days)
fluticasone propionate inhalation blister with device 250 mcg/actuation	T4	ST; QL (240 EA per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation	T4	ST; QL (12 GM per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation	T4	ST; QL (24 GM per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation	T4	ST; QL (10.6 GM per 30 days)
fluticasone propionate nasal	T1	QL (16 GM per 30 days)
fluticasone propion-salmeterol inhalation aerosol powdr breath activated	T4	ST; QL (1 EA per 30 days)
fluticasone propion-salmeterol inhalation blister with device	T4	ST; QL (60 EA per 30 days)
fluticasone propion-salmeterol inhalation hfa aerosol inhaler	T4	QL (12 GM per 30 days)
formoterol fumarate	T4	PA-BvD
HAEGARDA	T5	PA
hydroxyzine hcl oral solution 10 mg/5 ml	T4	PA
hydroxyzine hcl oral tablet	T4	PA
hydroxyzine pamoate	T2	PA
icatibant	T5	PA; QL (18 ML per 30 days)
INCRUSE ELLIPTA	T4	ST; QL (30 EA per 30 days)
ipratropium bromide inhalation hfa aerosol inhaler	T3	QL (25.8 GM per 30 days)
ipratropium bromide inhalation solution	T1	PA-BvD
ipratropium-albuterol	T2	PA-BvD
JASCAYD	T5	PA; QL (62 EA per 31 days)
KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 5.8 MG, 50 MG, 75 MG	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL GRANULES IN PACKET 25 MG	T5	PA; QL (62 EA per 31 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
KARBINAL ER	T4	PA
LETAIRIS	T5	PA; QL (31 EA per 31 days)
levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/3 ml	T2	PA-BvD
levalbuterol hcl inhalation solution for nebulization 1.25 mg/0.5 ml	T4	PA-BvD
levalbuterol tartrate	T3	QL (30 GM per 30 days)
levocetirizine oral solution	T4	QL (310 ML per 31 days)
levocetirizine oral tablet	T1	QL (31 EA per 31 days)
macitentan	T4	PA; QL (31 EA per 31 days)
mometasone nasal	T3	QL (34 GM per 30 days)
montelukast oral granules in packet	T2	QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
montelukast oral tablet	T1	QL (31 EA per 31 days)
montelukast oral tablet,chewable	T1	QL (31 EA per 31 days)
NEFFY	T4	ST
nintedanib	T5	PA; QL (62 EA per 31 days)
NUCALA SUBCUTANEOUS AUTO-INJECTOR	T5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN	T5	PA; QL (3 EA per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.4 ML per 28 days)
OFEV	T5	PA; QL (62 EA per 31 days)
OHTUVAYRE	T5	PA; QL (150 ML per 30 days)
OMNARIS	T4	QL (12.5 GM per 30 days)
OPSUMIT	T5	PA; QL (31 EA per 31 days)
OPSYNVI	T5	PA; QL (31 EA per 31 days)
ORKAMBI ORAL GRANULES IN PACKET	T5	PA; QL (62 EA per 31 days)
ORKAMBI ORAL TABLET	T5	PA; QL (124 EA per 31 days)
ORLADEYO ORAL CAPSULE	T5	PA; QL (31 EA per 31 days)
PERFOROMIST	T4	PA-BvD
pirfenidone oral capsule	T5	PA; QL (279 EA per 31 days)
pirfenidone oral tablet	T5	PA; QL (93 EA per 31 days)
PROAIR RESPICLICK	T4	ST; QL (2 EA per 30 days)
promethazine oral	T4	PA
promethazine rectal	T2	
PROMETHEGAN RECTAL SUPPOSITORY 25 MG, 50 MG	T2	
PULMICORT	T4	PA-BvD
PULMICORT FLEXHALER	T4	QL (1 EA per 30 days)
PULMOZYME	T5	PA
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION	T4	QL (6.8 GM per 30 days)
QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION	T4	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	T3	QL (10.6 GM per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	T3	QL (21.2 GM per 30 days)
REVATIO ORAL TABLET	T5	PA; QL (372 EA per 31 days)
roflumilast oral tablet 250 mcg	T4	QL (31 EA per 31 days)
roflumilast oral tablet 500 mcg	T3	QL (31 EA per 31 days)
RUCONEST	T5	PA
RYALTRIS	T4	ST; QL (31 GM per 30 days)
RYCLORA	T4	PA
RYVENT	T4	PA
SAJAZIR	T5	PA; QL (18 ML per 30 days)
SEREVENT DISKUS	T3	QL (60 EA per 30 days)
sildenafil (pulm.hypertension) oral suspension for reconstitution	T5	PA; QL (784 ML per 31 days)
sildenafil (pulm.hypertension) oral tablet	T3	PA; QL (372 EA per 31 days)
SINGULAIR ORAL TABLET	T4	QL (31 EA per 31 days)
SINGULAIR ORAL TABLET,CHEWABLE	T4	QL (31 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER	T4	ST; QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T3	QL (4 GM per 30 days)
SYMBICORT	T4	ST; QL (10.2 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
tadalafil (pulm. hypertension)	T4	PA; QL (62 EA per 31 days)
TADLIQ	T5	PA; QL (310 ML per 31 days)
TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (2 ML per 28 days)
TAKHZYRO SUBCUTANEOUS SYRINGE 300 MG/2 ML (150 MG/ML)	T5	PA; QL (4 ML per 28 days)
terbutaline oral tablet 2.5 mg	T4	
terbutaline oral tablet 5 mg	T2	
TEZSPIRE SUBCUTANEOUS PEN INJECTOR	T5	PA; QL (1.91 ML per 28 days)
THEO-24	T3	
theophylline oral solution	T2	
theophylline oral tablet extended release 12 hr	T2	
theophylline oral tablet extended release 24 hr	T2	
tiotropium bromide	T4	ST; QL (30 EA per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
TRACLEER ORAL TABLET	T5	PA; QL (62 EA per 31 days)
TRACLEER ORAL TABLET FOR SUSPENSION	T5	PA; QL (124 EA per 31 days)
TRELEGY ELLIPTA	T3	QL (60 EA per 30 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	T5	PA; QL (56 EA per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	T5	PA; QL (84 EA per 28 days)
TUDORZA PRESSAIR	T4	ST; QL (1 EA per 30 days)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 32 MCG, 32-64 MCG, 48 MCG, 48-64 MCG, 48-80 MCG, 64 MCG, 80 MCG	T5	PA
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16(112)-32(112) -48(28) MCG	T5	PA; QL (504 EA per 365 days)
umeclidinium	T4	ST; QL (30 EA per 30 days)
umeclidinium-vilanterol	T4	ST; QL (60 EA per 30 days)
VENTOLIN HFA	T3	QL (36 GM per 30 days)
WINREVAIR	T5	PA
WIXELA INHUB	T4	ST; QL (60 EA per 30 days)
XHANCE	T4	PA; QL (32 ML per 30 days)
XOLAIR	T5	PA
XOPENEX HFA	T4	ST; QL (30 GM per 30 days)
YUPELRI	T5	PA-BvD
YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 106 MCG	T5	PA; QL (224 EA per 28 days)
YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 26.5 MCG, 53 MCG	T5	PA; QL (140 EA per 28 days)
YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 79.5 MCG	T5	PA; QL (112 EA per 28 days)
zafirlukast oral tablet 10 mg	T2	QL (93 EA per 31 days)
zafirlukast oral tablet 20 mg	T2	QL (62 EA per 31 days)
zileuton	T5	PA; QL (124 EA per 31 days)
Urologicals		
alfuzosin	T2	QL (31 EA per 31 days)
AVODART	T5	QL (31 EA per 31 days)
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg	T2	

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

Drug Name	Drug Tier	Requirements/Limits
bethanechol chloride oral tablet 50 mg	T3	
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T3	
darifenacin	T3	QL (31 EA per 31 days)
dutasteride	T2	QL (31 EA per 31 days)
dutasteride-tamsulosin	T4	QL (31 EA per 31 days)
ELMIRON	T5	
fesoterodine	T4	QL (31 EA per 31 days)
finasteride oral tablet 5 mg	T2	
flavoxate	T2	
GEMTESA	T4	QL (31 EA per 31 days)
JALYN	T5	QL (31 EA per 31 days)
mirabegron oral suspension,extended rel recon	T4	ST; QL (300 ML per 30 days)
mirabegron oral tablet extended release 24 hr	T4	ST; QL (31 EA per 31 days)
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON	T3	QL (300 ML per 30 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	T3	QL (31 EA per 31 days)
oxybutynin chloride oral syrup	T2	
oxybutynin chloride oral tablet	T2	
oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg	T2	QL (31 EA per 31 days)
oxybutynin chloride oral tablet extended release 24hr 15 mg	T3	QL (62 EA per 31 days)
OXYTROL	T4	QL (8 EA per 28 days)
potassium citrate oral tablet extended release	T2	
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET	T5	PA
PROSCAR	T4	
RIVFLOZA SUBCUTANEOUS SOLUTION	T5	PA; QL (1 ML per 28 days)
RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML	T5	PA; QL (0.8 ML per 28 days)
RIVFLOZA SUBCUTANEOUS SYRINGE 160 MG/ML	T5	PA; QL (1 ML per 28 days)
silodosin	T4	
solifenacin	T3	QL (31 EA per 31 days)
tadalafil oral tablet 2.5 mg	T4	PA; QL (62 EA per 31 days)
tadalafil oral tablet 5 mg	T4	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
tamsulosin	T1	
tolterodine oral capsule,extended release 24hr	T3	QL (31 EA per 31 days)
tolterodine oral tablet	T3	QL (62 EA per 31 days)
TOVIAZ	T4	QL (31 EA per 31 days)
trospium oral capsule,extended release 24hr	T4	QL (31 EA per 31 days)
trospium oral tablet	T2	QL (93 EA per 31 days)
UROCIT-K 10	T4	
UROCIT-K 15	T4	
UROXATRAL	T4	QL (31 EA per 31 days)
Vitamins, Hematinics / Electrolytes		
AQNEURSA	T5	PA; QL (124 EA per 31 days)
calcium acetate(phosphat bind)	T2	PA-BvD
CLINIMIX 5%/D15W SULFITE FREE	T4	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T4	PA-BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	T4	PA-BvD
CLINIMIX E 4.25%/D10W SUL FREE	T4	PA-BvD
CLINIMIX E 4.25%/D5W SULF FREE	T4	PA-BvD
CLINIMIX E 5%/D15W SULFIT FREE	T4	PA-BvD
CLINIMIX E 5%/D20W SULFIT FREE	T4	PA-BvD
CLINISOL SF 15 %	T4	PA-BvD
CLINOLIPID	T4	PA-BvD
DOJOLVI	T5	PA
electrolyte-a	T4	PA-BvD
fluoride (sodium) oral tablet	T2	
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	T4	PA-BvD
ISOLYTE S PH 7.4	T3	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T4	PA-BvD
KLOR-CON	T4	
KLOR-CON 10	T1	
KLOR-CON 8	T1	
KLOR-CON M10	T1	
KLOR-CON M15	T1	
KLOR-CON M20	T1	
magnesium sulfate injection	T2	
NUTRILIPID	T4	PA-BvD
PLASMA-LYTE A	T4	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
PLENAMINE	T4	PA-BvD
POKONZA	T5	PA
potassium chlorid-d5-0.45%nacl intravenous parenteral solution 10 meq/l, 20 meq/l, 40 meq/l	T2	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	T2	
potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml	T2	
potassium chloride intravenous	T2	
potassium chloride oral capsule, extended release	T1	
potassium chloride oral liquid	T2	
potassium chloride oral packet 20 meq	T2	
potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq	T1	
potassium chloride oral tablet extended release 15 meq	T4	
potassium chloride oral tablet,er particles/crystals	T1	
potassium chloride-0.45 % nacl	T2	
PREMASOL 10 %	T4	PA-BvD
PRENATAL VITAMIN PLUS LOW IRON	T2	PA
PROSOL 20 %	T4	PA-BvD
sodium chloride 0.45 % intravenous	T2	
sodium chloride 3 % hypertonic	T2	
sodium chloride 5 % hypertonic	T2	
TPN ELECTROLYTES	T4	
TRAVASOL 10 %	T4	PA-BvD
TROPHAMINE 10 %	T4	PA-BvD

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Section:
Prior Authorization

Abilify

Products Affected

- **ABILIFY ORAL TABLET**

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

Acitretin

Products Affected

- *acitretin*

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

Acthar H.P.

Products Affected

- **ACTHAR**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pending CMS Review
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Acthar SelfJect

Products Affected

- **ACTHAR SELFJECT**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pending CMS Review
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Actimmune

Products Affected

- **ACTIMMUNE**

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

Adalimumab

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review

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

Adbry

Products Affected

- **ADBRY**

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

Afinitor

Products Affected

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

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

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

Agamree

Products Affected

- **AGAMREE**

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

Aimovig

Products Affected

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

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

Airsupra

Products Affected

- **AIRSUPRA**

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

Ajovy

Products Affected

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

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

Akeega

Products Affected

- **AKEEGA**

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

Aklief Acne

Products Affected

- **AKLIEF**

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two generic topical non-retinoid acne medications (e.g., clindamycin-benzoyl peroxide)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Alecensa

Products Affected

- **ALECENSA**

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

Alkindi

Products Affected

- **ALKINDI SPRINKLE**

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

Alpha1-Proteinase Inhibitors

Products Affected

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

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

Alunbrig

Products Affected

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

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

Alyftrek

Products Affected

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

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

Ambrisentan PAH

Products Affected

- *ambrisentan*
- **LETAIRIS**

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

Amitiza

Products Affected

- **AMITIZA**

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

Amlodipine Liquid

Products Affected

- **KATERZIA**
- **NORLIQVA**
- **SDAMLO ORAL POWDER IN CONTAINER 10 MG, 2.5 MG, 5 MG**

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

Ampyra

Products Affected

- **AMPYRA**
- *dalfampridine*

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

Anabolic Steroids

Products Affected

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

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

Ancobon

Products Affected

- **ANCOBON**

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

Andembry

Products Affected

- **ANDEMBRY AUTOINJECTOR**

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

Anticholinergic Amitriptyline

Products Affected

- *amitriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure or documentation of intolerance or contraindication to 2 non-high risk alternative drugs for the same indication is required (e.g. SSRIs and SNRIs). If safer alternatives for the same indication are not available, then no trial of alternatives is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Anticholinergic Amitriptyline/Chlordiazepoxide

Products Affected

- *amitriptyline-chlordiazepoxide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure or documentation of intolerance or contraindication to 2 non-high risk alternative drugs for the same indication is required (e.g. SSRIs and SNRIs). If safer alternatives for the same indication are not available, then no trial of alternatives is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Anticholinergic Amitriptyline/Perphenazine

Products Affected

- *perphenazine-amitriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure or documentation of intolerance or contraindication to 2 non-high risk alternative drugs for the same indication is required (e.g. SSRIs and SNRIs). If safer alternatives for the same indication are not available, then no trial of alternatives is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Anticholinergic Aspirin/Caffeine/Orphenadrine

Products Affected

- **NORGESIC**
- **NORGESIC FORTE**
- *orphenadrine-asa-caffeine oral tablet 25-385-30 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Anticholinergic Benztropine

Products Affected

- *benztropine oral*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Anticholinergic Clomipramine

Products Affected

- **ANAFRANIL**
- *clomipramine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure or documentation of intolerance or contraindication to 2 non-high risk alternative drugs for the same indication is required (e.g. SSRIs and SNRIs). If safer alternatives for the same indication are not available, then no trial of alternatives is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Anticholinergic Cyproheptadine

Products Affected

- *cyproheptadine oral syrup*
- *cyproheptadine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Anticholinergic Doxepin

Products Affected

- *doxepin oral capsule*
- *doxepin oral concentrate*
- *doxepin oral tablet*
- **SILENOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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. When daily dose is less than or equal to 6mg, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure or documentation of intolerance or contraindication to 2 non-high risk alternative drugs for the same indication is required (e.g. SSRIs and SNRIs). If safer alternatives for the same indication are not available, then no trial of alternatives is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Anticholinergic Hydroxyzine

Products Affected

- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Anticholinergic Imipramine

Products Affected

- *imipramine hcl*
- *imipramine pamoate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure or documentation of intolerance or contraindication to 2 non-high risk alternative drugs for the same indication is required (e.g. SSRIs and SNRIs). If safer alternatives for the same indication are not available, then no trial of alternatives is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Anticholinergic Nortriptyline

Products Affected

- *nortriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure or documentation of intolerance or contraindication to 2 non-high risk alternative drugs for the same indication is required (e.g. SSRIs and SNRIs). If safer alternatives for the same indication are not available, then no trial of alternatives is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Anticholinergic Orphenadrine

Products Affected

- *orphenadrine citrate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Anticholinergic Paroxetine

Products Affected

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

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

Anticholinergic Promethazine

Products Affected

- *promethazine oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The following information (1-3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Anzupgo

Products Affected

- **ANZUPGO**

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

Apokyn

Products Affected

- **APOKYN**
- *apomorphine*

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

Aqneursa

Products Affected

- **AQNEURSA**

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

Aqvesme

Products Affected

- **AQVESME**

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

Arikayce

Products Affected

- **ARIKAYCE**

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

Aripiprazole

Products Affected

- *aripiprazole oral solution*
- *aripiprazole oral tablet,disintegrating*

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

Atoncy

Products Affected

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

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

Atorvaliq

Products Affected

- **ATORVALIQ**

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

Attruby ATTR-CM

Products Affected

- **ATTRUBY**

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

Aubagio

Products Affected

- **AUBAGIO**
- *teriflunomide*

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

Augtyro

Products Affected

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

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

Austedo

Products Affected

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

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

Auvelity

Products Affected

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

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

Avmapki-Fakzynja

Products Affected

- **AVMAPKI-FAKZYNJA**

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

Avonex

Products Affected

- **AVONEX INTRAMUSCULAR PEN INJECTOR KIT**
- **AVONEX INTRAMUSCULAR SYRINGE KIT**

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

Ayvakit

Products Affected

- **AYVAKIT**

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

Baclofen Solution

Products Affected

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

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

Bafiertam

Products Affected

- **BAFIERTAM**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying multiple sclerosis agents
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 years
Other Criteria	Therapeutic failure or intolerance to generic dimethyl fumarate is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Balversa

Products Affected

- **BALVERSA**

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

Banzel

Products Affected

- **BANZEL ORAL SUSPENSION**
- **BANZEL ORAL TABLET 200 MG, 400 MG**
- *rufinamide oral suspension*
- *rufinamide oral tablet 200 mg, 400 mg*

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

Baxfendy

Products Affected

- **BAXFENDY**

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

Benlysta

Products Affected

- **BENLYSTA SUBCUTANEOUS**

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

Benzo Potentiator Alprazolam

Products Affected

- **ALPRAZOLAM INTENSOL**
- *alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg*
- *alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- **XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG**
- **XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 2 MG**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Benzo Potentiator Chlordiazepoxide

Products Affected

- *chlordiazepoxide hcl*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Benzo Potentiator Clonazepam

Products Affected

- *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg* **MG, 2 MG**
- *clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- **KLONOPIN ORAL TABLET 0.5 MG, 1**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Benzo Potentiator Clorazepate

Products Affected

- *clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Benzo Potentiator Diazepam

Products Affected

- **DIAZEPAM INTENSOL**
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*
- *diazepam oral tablet*
- **VALIUM**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Benzo Potentiator Flurazepam

Products Affected

- *flurazepam*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	When used concomitantly with an opioid agonist & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of an opioid agonist & centrally acting skeletal muscle relaxant, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Benzo Potentiator Lorazepam

Products Affected

- **ATIVAN ORAL TABLET 0.5 MG, 1 MG, 2 MG**
- **LORAZEPAM INTENSOL**
- *lorazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- **LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1 MG, 1.5 MG, 2 MG, 3 MG**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Benzo Potentiator Oxazepam

Products Affected

- *oxazepam*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Benzo Potentiator Temazepam

Products Affected

- **RESTORIL**
- *temazepam*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	When used concomitantly with an opioid agonist & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of an opioid agonist & centrally acting skeletal muscle relaxant, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Benzo Potentiator Triazolam

Products Affected

- *triazolam*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	When used concomitantly with an opioid agonist & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of an opioid agonist & centrally acting skeletal muscle relaxant, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Bepreve

Products Affected

- *bepotastine besilate*
- **BEPREVE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of ocular itching associated with allergic conjunctivitis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Therapeutic failure, intolerance, or contraindication to generic azelastine ophthalmic drops is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Berinert

Products Affected

- **BERINERT INTRAVENOUS KIT**

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

Besremi

Products Affected

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

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

Betaseron

Products Affected

- **BETASERON SUBCUTANEOUS KIT**

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

Bimzelx

Products Affected

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

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

Bonjesta

Products Affected

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

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

Bosentan PAH

Products Affected

- *bosentan oral tablet* **SUSPENSION**
- *bosentan oral tablet for suspension*
- **TRACLEER ORAL TABLET**
- **TRACLEER ORAL TABLET FOR**

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

Bosulif

Products Affected

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

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

Bosutinib

Products Affected

- *bosutinib oral tablet 400 mg*

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

Braftovi

Products Affected

- **BRAFTOVI**

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Brekiya

Products Affected

- **BREKIYA**

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

Brinsupri

Products Affected

- **BRINSUPRI**

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

Brukinsa

Products Affected

- **BRUKINSA ORAL TABLET**

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

Bucapsol

Products Affected

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

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

Buphenyl

Products Affected

- *sodium phenylbutyrate*

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

Buspirone

Products Affected

- *buspirone oral tablet 12.5 mg, 2.5 mg*

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

Bylvay

Products Affected

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

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

Cablivi

Products Affected

- **CABLIVI INJECTION KIT**

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

Cabometyx

Products Affected

- **CABOMETYX**

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

Cabreo Acne

Products Affected

- **CABTREO**

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two generic topical non-retinoid acne medications (e.g., clindamycin-benzoyl peroxide)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Calquence

Products Affected

- **CALQUENCE (ACALABRUTINIB MAL)**

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

Camzyos

Products Affected

- **CAMZYOS**

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

Caplyta

Products Affected

- **CAPLYTA**

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

Caprelsa

Products Affected

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

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

Carac

Products Affected

- *fluorouracil topical cream 0.5 %*

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

Carbaglu

Products Affected

- **CARBAGLU**
- *carglumic acid*

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

Carbinoxamine

Products Affected

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

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

Cardamyst

Products Affected

- **CARDAMYST**

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

Cayston

Products Affected

- **CAYSTON**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Therapeutic failure, contraindication, intolerance, or resistance to generic inhaled tobramycin is required. For reauthorization, attestation of decrease in sputum density of pseudomonas aeruginosa, increase in FEV1 or decrease in number of hospitalizations or pulmonary exacerbations
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cerdelga

Products Affected

- **CERDELGA**

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

CF drugs

Products Affected

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

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

Cholbam

Products Affected

- **CHOLBAM**

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

Cialis

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of benign prostatic hyperplasia (BPH) and trial/failure of 2 of the following medications: dutasteride, doxazosin, tamsulosin, terazosin, finasteride, alfuzosin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Cialis, intolerance to generic tadalafil is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cibinqo

Products Affected

- **CIBINQO**

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

Cimzia

Products Affected

- **CIMZIA POWDER FOR RECONST MG/ML X 2)**
- **CIMZIA STARTER KIT**
- **CIMZIA SUBCUTANEOUS SYRINGE KIT 200 MG/ML, 400 MG/2 ML (200**

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

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

Cinryze

Products Affected

- **CINRYZE**

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

Citalopram Capsule

Products Affected

- *citalopram oral capsule*

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

Clemastine Syrup

Products Affected

- *clemastine oral syrup*

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

Clonidine ER ADHD

Products Affected

- *clonidine hcl oral tablet extended release 12 hr*

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

Clotic

Products Affected

- **CLOTIC**

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

Cobenfy

Products Affected

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

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

Cometriq

Products Affected

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

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

Copiktra

Products Affected

- **COPIKTRA**

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

Corlanor

Products Affected

- *ivabradine oral tablet 5 mg, 7.5 mg*

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

Cosentyx

Products Affected

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

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Cotellic

Products Affected

- **COTELLIC**

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

Crenessity

Products Affected

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

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

Crinone

Products Affected

- **CRINONE VAGINAL GEL 8 %**

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

Ctexli

Products Affected

- **CTEXLI**

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

Cuvrior

Products Affected

- **CUVRIOR**

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

Cysteamine Ophthalmic Drops

Products Affected

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

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

Danziten

Products Affected

- **DANZITEN**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Daraprim

Products Affected

- **DARAPRIM**
- *pyrimethamine*

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

Daurismo

Products Affected

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

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

Dawnzera

Products Affected

- **DAWNZERA**

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

Daybue

Products Affected

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

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

Daytrana

Products Affected

- **DAYTRANA**
- *methylphenidate transdermal*

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

Deferasirox

Products Affected

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

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Denosumab (Onco)

Products Affected

- **AUKELSO**
- **BILPREVDA**
- **BOMYNTRA**
- **OSENVELT**
- **WYOST**
- **XGEVA**

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

Denosumab (Osteo)

Products Affected

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

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

Desloratadine Solution

Products Affected

- *desloratadine oral solution*

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

Desmoda

Products Affected

- **DESMODA**

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

Dexchlorpheniramine

Products Affected

- **CORPHENA**
- **RYCLORA**

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

Diacomit

Products Affected

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

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

Dicyclomine

Products Affected

- *dicyclomine oral tablet 40 mg*

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

Differin Acne

Products Affected

- *adapalene topical cream*
- *adapalene topical gel 0.3 %*
- *adapalene topical swab*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two generic topical non-retinoid acne medications (e.g., clindamycin-benzoyl peroxide)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Dificid

Products Affected

- **DIFICID ORAL TABLET**

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

Dihydroergotamine

Products Affected

- *dihydroergotamine nasal*
- **TRUDHESA**

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

Dojolvi

Products Affected

- **DOJOLVI**

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

Doptelet

Products Affected

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

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

Doptelet Sprinkle

Products Affected

- **DOPTELET SPRINKLE**

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

Doxepin Cream

Products Affected

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

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

Drizalma

Products Affected

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

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

Duexis

Products Affected

- *ibuprofen-famotidine*

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

Dulaglutide

Products Affected

- **TRULICITY**

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

Duobrii

Products Affected

- **DUOBRII**

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

Dupixent

Products Affected

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

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

Duvyzat

Products Affected

- **DUVYZAT**

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

Ebglyss

Products Affected

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

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

Egrifta

Products Affected

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

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

Ekterly

Products Affected

- **EKTERLY**

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

Elyxyb

Products Affected

- **ELYXYB**

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

Emflaza

Products Affected

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

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

Emgality

Products Affected

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

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

Empaveli

Products Affected

- **EMPAVELI**

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

Emrosi Rosacea

Products Affected

- **EMROSI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of rosacea with inflammatory lesions (papules and pustules) -AND- trial, contraindication or intolerance to metronidazole cream, lotion, or gel -AND- trial, contraindication or intolerance to generic doxycycline IR-DR 40 mg.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Enbumyst

Products Affected

- **ENBUMYST**

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

Endari

Products Affected

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

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

Ensacove

Products Affected

- **ENSACOVE**

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

Enspryng

Products Affected

- **ENSPRYNG**

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

Entresto Sprinkle

Products Affected

- **ENTRESTO SPRINKLE**

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

Entyvio

Products Affected

- **ENTYVIO PEN**

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Eohilia

Products Affected

- **EOHILIA**

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

Epclusa

Products Affected

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

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

Epidiolex

Products Affected

- **EPIDIOLEX**

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

Epiduo Acne

Products Affected

- *adapalene-benzoyl peroxide topical gel with pump 0.3-2.5 %*
- **EPIDUO FORTE**

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two generic topical non-retinoid acne medications (e.g., clindamycin-benzoyl peroxide)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Eprontia

Products Affected

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

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

Ergomar

Products Affected

- **ERGOMAR**

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

Ergotamine-Caffeine

Products Affected

- **CAFERGOT**
- *ergotamine-caffeine*

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

Erivedge

Products Affected

- **ERIVEDGE**

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

Erleada

Products Affected

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

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

Escitalopram Capsule

Products Affected

- *escitalopram oxalate oral capsule*

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

Etanercept

Products Affected

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

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

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Eucrisa

Products Affected

- **EUCRISA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-2): 1) mild to moderate atopic dermatitis 2) if the member is 2 years of age or older, therapeutic failure, contraindication or intolerance to topical generic tacrolimus or topical generic pimecrolimus.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Atopic Dermatitis, patients 2 years of age and older must have a trial/failure, intolerance, or contraindication to Vtama. Reauthorization or continuation of therapy will be approved when documentation of improvement or response to therapy is provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Evekeo

Products Affected

- *amphetamine sulfate*
- **EVEKEO**

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

Evenity

Products Affected

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

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

Evrysdi

Products Affected

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

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

Exxua

Products Affected

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

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

Fabhalta

Products Affected

- **FABHALTA**

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

Fanapt

Products Affected

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

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

Fasenra

Products Affected

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

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

Fecal Microbiota Products

Products Affected

- **VOWST**

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

Ferriprox

Products Affected

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

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

Fetzima

Products Affected

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

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

Filspari

Products Affected

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

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

Filsuvez

Products Affected

- **FILSUVEZ**

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

Fintepla

Products Affected

- **FINTEPLA**

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

Firazyr

Products Affected

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

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

Firdapse

Products Affected

- **FIRDAPSE**

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

Firmagon

Products Affected

- **FIRMAGON KIT W DILUENT SYRINGE**

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

Flector

Products Affected

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

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

Flolipid

Products Affected

- **FLOLIPID**

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

Forteo

Products Affected

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

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

Forzinity

Products Affected

- **FORZINITY**

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

Fotivda

Products Affected

- **FOTIVDA**

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

Fruzaqla

Products Affected

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

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

Fulvicin PG

Products Affected

- *griseofulvin ultramicrosize oral tablet 165 mg*

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

Furoscix

Products Affected

- **FUROSCIX**

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

Gabapentin

Products Affected

- *gabapentin oral capsule 200 mg*
- **NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG**
- **NEURONTIN ORAL SOLUTION**
- **NEURONTIN ORAL TABLET 600 MG, 800 MG**
- **RELGAABI ORAL CAPSULE 200 MG**

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

Gabarone

Products Affected

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

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

Galafold

Products Affected

- **GALAFOLD**

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

Gattex

Products Affected

- **GATTEX 30-VIAL**

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

Gavreto

Products Affected

- **GAVRETO**

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

Gilenya

Products Affected

- *fingolimod*
- **GILENYA**

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

Gilotrif

Products Affected

- **GILOTRIF**

PA Criteria	Criteria Details
Exclusion Criteria	Tumors with resistant EGFR mutations.
Required Medical Information	Documentation of metastatic non-small cell lung cancer (NSCLC) -AND- one of the following, as detected by an FDA-approved test (1-3): 1) disease harbors EGFR exon 19 deletions 2) disease harbors EGFR exon 21 (L858R) substitution mutation 3) disease harbors non-resistant EGFR mutation (i.e., S768I, L861Q, G719X) -OR- documentation of squamous metastatic NSCLC and member has experienced progression on platinum-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Gimoti

Products Affected

- **GIMOTI**

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

Glatiramer

Products Affected

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

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

Gleevec

Products Affected

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

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

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Gleostine

Products Affected

- **GLEOSTINE**
- *lomustine*

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

Glycate

Products Affected

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

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

Gocovri

Products Affected

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

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

Gomekli

Products Affected

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

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

Gralise

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of postherpetic neuralgia (PHN). When used concomitantly with an opioid agonist, attestation of intent to monitor & address concomitant drug-drug interaction adverse events is also required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Intolerance to generic immediate-release gabapentin is required. For brand Gralise, intolerance to generic gabapentin extended-release tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Grastek

Products Affected

- **GRASTEK**

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

Guanfacine ER ADHD

Products Affected

- *guanfacine oral tablet extended release 24 hr*
- **INTUNIV ER**

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

Haegarda

Products Affected

- **HAEGARDA**

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

Harliku

Products Affected

- **HARLIKU**

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

Harvoni

Products Affected

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

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

Hemady

Products Affected

- **HEMADY**

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

Hemangeol

Products Affected

- **HEMANGEOL**

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

Hepcludex

Products Affected

- **HEPCLUDEX**

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

Hernexeos

Products Affected

- **HERNEXEOS**

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

Hetlioz

Products Affected

- **HETLIOZ**

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

Hetlioz LQ

Products Affected

- **HETLIOZ LQ**

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

Homozygous FH

Products Affected

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

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

Horizant

Products Affected

- **HORIZANT**

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

Hyftor

Products Affected

- **HYFTOR**

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

Hypnotic Potentiator Estazolam

Products Affected

- *estazolam*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	When used concomitantly with an opioid agonist, both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of an opioid agonist, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hypnotic Potentiator Eszopiclone

Products Affected

- *eszopiclone*
- **LUNESTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	When used concomitantly with an opioid agonist, both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of an opioid agonist, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hypnotic Potentiator Zaleplon

Products Affected

- *zaleplon oral capsule 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	When used concomitantly with an opioid agonist, both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of an opioid agonist, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hypnotic Potentiator Zolpidem

Products Affected

- **AMBIEN**
- **AMBIEN CR**
- **EDLUAR**
- *zolpidem*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	When used concomitantly with an opioid agonist, both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of an opioid agonist, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hyrnuo

Products Affected

- **HYRNUO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For non-squamous non-small cell lung cancer (NSCLC), all of the following (1-3): 1) disease is locally advanced or metastatic, 2) disease harbors HER2 (ERBB2) tyrosine kinase domain activating mutations, as detected by an FDA-approved test, and 3) member has received at least one prior systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ibrance

Products Affected

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

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

Ibsrela

Products Affected

- **IBSRELA**

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

Ibtrozi

Products Affected

- **IBTROZI**

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

Iclusig

Products Affected

- **ICLUSIG**

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

Icotyde

Products Affected

- **ICOTYDE**

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

Idhifa

Products Affected

- **IDHIFA**

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

Ilumya

Products Affected

- **ILUMYA**

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

Imbruvica

Products Affected

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

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

Imkeldi

Products Affected

- **IMKELDI**

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

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Immune Globulins

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Inbrija

Products Affected

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

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

Increlex

Products Affected

- **INCRELEX**

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

Ingrezza

Products Affected

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

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

Inhaled Treprostinil PAH

Products Affected

- **TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 32-64 MCG, 48 MCG, 48-64 MCG, 48-80 MCG, 64 MCG, 80 MCG**
- **YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG**

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

Inluriyo

Products Affected

- **INLURIYO**

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

Inlyta

Products Affected

- **INLYTA**

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

Inqovi

Products Affected

- **INQOVI**

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

Inrebic

Products Affected

- **INREBIC**

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

Insulin Supplies

Products Affected

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

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

Interferon Alfa

Products Affected

- **PEGASYS**

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

Interleukin-1b Blockers

Products Affected

- **ARCALYST**

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

Intrarosa

Products Affected

- **INTRAROSA**

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

Iqirvo

Products Affected

- **IQIRVO**

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

Iressa

Products Affected

- *gefitinib*
- **IRESSA**

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

Isturisa

Products Affected

- **ISTURISA ORAL TABLET 1 MG, 5 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- patient is not a candidate for surgery or surgery has not been curative.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, both of the following are required (1 and 2: 1) patient remains not a candidate for required surgery or the surgery has not been curative, and 2) attestation of decrease in urinary free cortisol levels from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Itovebi

Products Affected

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

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

Itraconazole

Products Affected

- *itraconazole*

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

Ivermectin Oral

Products Affected

- *ivermectin oral*
- **STROMECTOL**

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

Iwilfin

Products Affected

- **IWILFIN**

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

Jakafi

Products Affected

- **JAKAFI**

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

Jakafi XR

Products Affected

- **JAKAFI XR**

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

Jascayd

Products Affected

- **JASCAYD**

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

Javadin

Products Affected

- **JAVADIN**

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

Jaypirca

Products Affected

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

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

Jideytro

Products Affected

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

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

Joenja

Products Affected

- **JOENJA ORAL TABLET 70 MG**

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

Journavx

Products Affected

- **JOURNAVX**

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

Jynarque

Products Affected

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

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

Kalydeco

Products Affected

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

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

Kerendia

Products Affected

- **KERENDIA**

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

Kesimpta

Products Affected

- **KESIMPTA PEN**

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

Keveyis

Products Affected

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

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

Kevzara

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For polymyalgia rheumatica (PMR), one of the following (1-3): 1) inadequate response to corticosteroids, 2) intolerance to corticosteroid taper, or 3) used in combination with corticosteroid tapering course. For polyarticular juvenile idiopathic arthritis, weight greater than or equal to 63 kg -AND- one of the following (4-5): 4) inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide), or 5) requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	Deny if less than 18 years of age for rheumatoid arthritis and polymyalgia rheumatica.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq/Rinvoq LQ. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Khindivi

Products Affected

- **KHINDIVI**

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

Kineret

Products Affected

- **KINERET**

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

Kisqali

Products Affected

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

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

Klisyri

Products Affected

- **KLISYRI (250 MG)**

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

Komzifti

Products Affected

- **KOMZIFTI**

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

Korlym

Products Affected

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

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

Koselugo

Products Affected

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

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

Krazati

Products Affected

- **KRAZATI**

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

Kuvan

Products Affected

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

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

Kygevvi

Products Affected

- **KYGEVVI**

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

Lasix Onyu

Products Affected

- **LASIX ONYU**

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

Latuda

Products Affected

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

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

Lazcluze

Products Affected

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

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

Lenvima

Products Affected

- **LENVIMA**

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

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Leqembi Iqlik

Products Affected

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

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

Leqembi Iqlik Initiation

Products Affected

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

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

Leqselvi

Products Affected

- **LEQSELVI**

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

Lerochol

Products Affected

- **LEROCHOL**

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

Leukine

Products Affected

- **LEUKINE INJECTION RECON SOLN**

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

Leukotriene Modifiers

Products Affected

- *zileuton*

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

Lidoderm

Products Affected

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

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

Lifyorli

Products Affected

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

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

Lipfendra

Products Affected

- **LIPFENDRA**

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

Liraglutide

Products Affected

- *liraglutide*

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

Litfulo

Products Affected

- **LITFULO**

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

Livdelzi

Products Affected

- **LIVDELZI**

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

Livmarli

Products Affected

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

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Livtencity

Products Affected

- **LIVTENCITY**

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

Loargys

Products Affected

- **LOARGYS**

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

Lodoco

Products Affected

- **LODOCO**

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

Lonsurf

Products Affected

- **LONSURF**

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

Lorbrena

Products Affected

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

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

Lotronex

Products Affected

- *alosetron oral tablet 0.5 mg, 1 mg*

PA Criteria	Criteria Details
Exclusion Criteria	For irritable bowel syndrome (IBS): Exclude if male gender
Required Medical Information	Documentation of chronic severe diarrhea-predominant IBS -AND- trial and failure or intolerance to one anti-diarrheal (e.g. loperamide), anti-spasmodic, or tricyclic antidepressant, or contraindication to all
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 weeks initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation that symptoms of IBS continue to persist AND positive clinical response.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Lovaza

Products Affected

- **LOVAZA**

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

Lumakras

Products Affected

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

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

Lumryz

Products Affected

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

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

Lupkynis

Products Affected

- **LUPKYNIS**

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

Lybalvi

Products Affected

- **LYBALVI**

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

Lynkuet

Products Affected

- **LYNKUET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documenation of moderate to severe vasomotor symptoms due to menopause -AND- one of the following (1 or 2): 1) therapeutic failure, contraindication, or intolerance to a generic hormone therapy product, or 2) attestation that hormone therapy is not clinically appropriate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Lynparza

Products Affected

- **LYNPARZA**

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

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

Lyrica

Products Affected

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

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

Lyrica CR

Products Affected

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

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

Lytgobi

Products Affected

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

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

Macitentan PAH

Products Affected

- *macitentan*
- **OPSUMIT**

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

Macitentan/Tadalafil PAH

Products Affected

- **OPSYNVI**

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

Mavenclad

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying multiple sclerosis agents. Treatment duration greater than 24 months.
Required Medical Information	Documentation of relapse-remitting multiple sclerosis (MS) or active secondary progressive disease -AND- therapeutic failure or intolerance to 1 other disease modifying therapy (DMT) for MS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	For brand Mavenclad, intolerance to generic cladribine is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Mavyret

Products Affected

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

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

Mayzent

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying multiple sclerosis agents. Presence of CYP2C9*3/*3 genotype.
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- The CYP2C9 genotype was determined by testing for CYP2C9 variants.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Megace

Products Affected

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

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

Mekinist

Products Affected

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

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Mektovi

Products Affected

- **MEKTOVI**

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

Mesalamine Active

Products Affected

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

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

Mesalamine Remission

Products Affected

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

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

Methamphetamine

Products Affected

- *methamphetamine*

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

Metronidazole

Products Affected

- *metronidazole oral tablet 125 mg*

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

Metyrosine

Products Affected

- *metyrosine*

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

Miglustat1

Products Affected

- *miglustat*
- **YARGESA**
- **ZAVESCA**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pending CMS Review
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Miplyffa

Products Affected

- **MIPLYFFA**

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

Modeyso

Products Affected

- **MODEYSO**

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

Motegrity

Products Affected

- **MOTEGRITY**
- *prucalopride*

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

Motpoly XR

Products Affected

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

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

MTX Injection

Products Affected

- **RASUVO (PF)**

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

Mulpleta

Products Affected

- **MULPLETA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of thrombocytopenia and chronic liver disease - AND- beneficiary is scheduled to undergo a procedure -AND- trial and failure or intolerance to Doptelet -AND- Platelet count of less than 50x10*9/L
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Myalept

Products Affected

- **MYALEPT**

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

Myasthenia Gravis

Products Affected

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

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

Mycapssa

Products Affected

- **MYCAPSSA**

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

Myfembree

Products Affected

- **MYFEMBREE**

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

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

Myqorzo

Products Affected

- **MYQORZO**

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Namzaric

Products Affected

- *memantine-donepezil*
- **NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and intolerance to generic memantine and generic donepezil
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nayzilam

Products Affected

- **NAYZILAM**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizure clusters or acute repetitive seizures -AND- the member is currently receiving antiepileptic maintenance therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nemluvio

Products Affected

- **NEMLUVIO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prurigo nodularis -OR- Documentation of moderate to severe atopic dermatitis and one of the following (1-3): 1) trial and failure or intolerance to at least one topical corticosteroid or one topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus), 2) severe atopic dermatitis and the member is incapable of applying topical therapies due to the extent of body surface area involvement, or 3) severe atopic dermatitis and topical therapies are contraindicated due to severely damaged skin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Prurigo nodularis: 6 months initial, 12 months reauth. Atopic Dermatitis: 12 months
Other Criteria	For prurigo nodularis, must follow recommended dosing guidelines based upon weight. For atopic dermatitis, must follow recommended dosing based on FDA approved dosing guidelines. For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For prurigo nodularis reauthorization, attestation of reduction in itch or number of nodules or lesions from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Nereus

Products Affected

- **NEREUS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of prevention of vomiting induced by motion.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	Therapeutic failure, contraindication, or intolerance to generic scopolamine patch and 1 generic first generation antihistamine (e.g., meclizine).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nerlynx

Products Affected

- **NERLYNX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of early-stage, HER2-positive breast cancer -AND- meets all of the following: 1)member has received adjuvant trastuzumab-based therapy 2) member is using neratinib as a single agent. Documentation of advanced HER-2 positive, or metastatic HER2-positive breast cancer and meets all of the following 1) using neratinib in combination with capecitabine 2) member has received two or more prior anti-HER2 based regimens in the metastatic setting.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nexavar

Products Affected

- **NEXAVAR**
- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For locally recurrent or metastatic, progressive, differentiated thyroid carcinoma, refractory to radioactive iodine treatment
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Nexavar, intolerance to generic sorafenib is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nexletol

Products Affected

- **NEXLETOL**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pending CMS Review
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nexlizet

Products Affected

- **NEXLIZET**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pending CMS Review
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ngenla

Products Affected

- **NGENLA**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nilotinib Tartrate

Products Affected

- *nilotinib d-tartrate*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ninlaro

Products Affected

- **NINLARO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of multiple myeloma -AND- previous treatment with at least 1 prior therapy -AND- used in combination with lenalidomide and dexamethasone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nitisinone

Products Affected

- *nitisinone*
- **NITYR**
- **ORFADIN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hereditary tyrosinemia type 1 (HT-1) confirmed by biochemical or genetic testing -AND- dietary restriction of tyrosine and phenylalanine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Nityr and Brand Orfadin capsule, intolerance to generic nitisinone capsules is required. For Orfadin suspension, intolerance to generic nitisinone capsules or an inability to swallow capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Northera

Products Affected

- *droxidopa oral capsule 100 mg, 200 mg, 300 mg*
- **NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG**

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

Nourianz

Products Affected

- **NOURIANZ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease experiencing off episodes -AND- Used as adjunct to levodopa/carbidopa -AND- trial/failure, contraindication or intolerance to one of the following generic products: ropinirole, pramipexole, entacapone, selegiline, or rasagiline
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nubeqa

Products Affected

- **NUBEQA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of non-metastatic castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer -AND- one of the following (1-2): 1) using in combination with a GnRH analog 2) member has had a bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nucala

Products Affected

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

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

Nuedexta

Products Affected

- **NUEDEXTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation supporting improvement in symptoms is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nuplazid

Products Affected

- **NUPLAZID**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hallucinations and delusions associated with Parkinson's disease psychosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nurtec

Products Affected

- **NURTEC ODT**

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

Nuvigil

Products Affected

- *armodafinil*
- **NUVIGIL**

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

Octreotide

Products Affected

- *octreotide acetate injection solution*
- **SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML**

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

Odactra

Products Affected

- **ODACTRA**

PA Criteria	Criteria Details
Exclusion Criteria	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy
Required Medical Information	Documentation of allergic rhinitis due to house dust mites -AND- allergic rhinitis with or without conjunctivitis has been confirmed by skin testing for licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to D. pteronyssinus or D. Farina -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
Age Restrictions	Deny if less than 5 years of age or greater than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector. For reauthorization, attestation of improved allergy symptoms is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Odomzo

Products Affected

- **ODOMZO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced basal cell carcinoma (laBCC) that has recurred following surgery or radiation therapy or for use in patients who are not candidates for surgery or radiation therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ofev

Products Affected

- *nintedanib*
- **OFEV**

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

Ogsiveo

Products Affected

- **OGSIVEO ORAL TABLET 100 MG, 150 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of progressing desmoid tumor(s) requiring systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ohtuvayre

Products Affected

- **OHTUVAYRE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of chronic obstructive pulmonary disease (COPD) -AND- Inadequate symptom control despite regular treatment for at least 3 months of at least two maintenance COPD controllers (e.g. LABA/LAMA, LAMA/LABA/ICS), or intolerance/contraindication to these agents.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Ohtuvayre covered under Part B when using via nebulizer in the home setting.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ojemda

Products Affected

- **OJEMDA ORAL SUSPENSION FOR RECONSTITUTION**
- **OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4), 500 MG/WEEK (100 MG X 5), 600 MG/WEEK (100 MG X 6)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory pediatric low-grade glioma -AND- one of the following (1-2): 1) BRAF fusion or rearrangement, or 2) BRAF V600K mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ojjaara

Products Affected

- **OJJAARA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis -AND- attestation of anemia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Olpruva

Products Affected

- **OLPRUVA ORAL PELLETS IN PACKET 2 GRAM, 3 GRAM, 4 GRAM, 5 GRAM, 6 GRAM, 6.67 GRAM**

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of acute hyperammonemia in urea cycle disorders
Required Medical Information	Documentation of chronic management of urea cycle disorders involving deficiencies of carbamylphosphate synthetase, argininosuccinic acid synthetase, or ornithine transcarbamylase -AND- use as an adjunctive therapy to dietary management.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Intolerance to generic sodium phenylbutyrate is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Olumiant

Products Affected

- **OLUMIANT**

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

Omvoh

Products Affected

- **OMVOH PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML, 300MG/3ML(100MG /ML-200 MG/2ML)**
- **OMVOH SUBCUTANEOUS SYRINGE 200 MG/2 ML, 300MG/3ML(100MG /ML-200 MG/2ML)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation of receiving or currently undergoing 3 doses of IV Omvoh within 3 months of initiating therapy with Omvoh SC.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For moderate to severe ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq. For moderate to severe active Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, and Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Onapgo

Products Affected

- **ONAPGO**

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

Onfi

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- **ONFI ORAL SUSPENSION**
- **ONFI ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- therapeutic failure or intolerance of a previous antiepileptic therapy
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Onfi, intolerance to generic clobazam is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ongentys

Products Affected

- **ONGENTYS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease experiencing off episodes -AND- Used as adjunct to levodopa/carbidopa -AND- trial/failure, contraindication or intolerance to the following (1. and 2.): 1) entacapone 2) one of the following generic products: rasagiline, pramipexole, ropinirole, selegiline
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ontralfy

Products Affected

- **ONTRALFY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of spasticity -AND- Inability to swallow tizanidine tablets and capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, both of the following are required (1, 2): 1) documentation of member experiencing a new episode of spasticity, 2) member still unable to swallow tizanidine tablets or capsules.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Onureg

Products Affected

- **ONUREG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute myeloid leukemia that has achieved first complete remission or complete remission with incomplete blood count recovery following intensive induction chemotherapy -AND- Inability to complete intensive curative therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Onyda XR

Products Affected

- **ONYDA XR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of ADHD -AND- trial/failure, intolerance or contraindication to a stimulant
Age Restrictions	Deny if less than 6 years of age or greater than 17 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Inability to swallow tablets or capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Acetaminophen/Butalbital/Caffeine/Codeine

Products Affected

- *butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Acetaminophen/Codeine

Products Affected

- *acetaminophen-codeine oral solution 120-12 mg/5 ml*
- *acetaminophen-codeine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Acetaminophen/Hydrocodone

Products Affected

- *hydrocodone-acetaminophen oral solution 10-300 mg/15 ml, 7.5-325 mg/15 ml*
- *hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Acetaminophen/Oxycodone

Products Affected

- **NALOCET**
- *oxycodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg*
- **PERCOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG**
- **PROLATE ORAL SOLUTION**
- **PROLATE ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Acetaminophen/Tramadol

Products Affected

- *tramadol-acetaminophen*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Aspirin/Butalbital/Caffeine/Codeine

Products Affected

- **ASCOMP WITH CODEINE**
- *codeine-butalbital-asa-caff*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Buprenorphine (LA)

Products Affected

- **BELBUCA**
- *buprenorphine*
- **BUTRANS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Codeine

Products Affected

- *codeine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Fentanyl (LA)

Products Affected

- *fentanyl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Hydrocodone (LA)

Products Affected

- *hydrocodone bitartrate oral capsule, oral only, er 12hr*
- *hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr*
- **HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Hydrocodone/Ibuprofen

Products Affected

- *hydrocodone-ibuprofen*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Hydromorphone

Products Affected

- **DILAUDID ORAL LIQUID**
- **DILAUDID ORAL TABLET 2 MG, 4 MG, 8 MG**
- *hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml*
- *hydromorphone oral liquid*
- *hydromorphone oral tablet 2 mg, 4 mg, 8 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months

PA Criteria	Criteria Details
Other Criteria	Infusible opioid agonists will be covered under Part B when administered via an external infusion pump while meeting criteria outlined in Local Coverage Determination (LCD): External Infusion Pumps (L33794), or an implantable infusion pump while meeting criteria outlined in National Coverage Determination (NCD): Infusion Pumps (280.14).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Hydromorphone (LA)

Products Affected

- *hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Levorphanol

Products Affected

- *levorphanol tartrate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Meperidine

Products Affected

- **DEMEROL (PF) INJECTION SYRINGE 25 MG/ML**
- **DEMEROL INJECTION**
- *meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*
- *meperidine oral solution*
- *meperidine oral tablet 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Methadone (LA)

Products Affected

- *methadone oral solution 10 mg/5 ml, 5 mg/5 ml*
- *methadone oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Morphine

Products Affected

- *morphine concentrate oral solution*
- *morphine oral solution 10 mg/5 ml (2 mg/ml), 20 mg/5 ml (4 mg/ml)*
- *morphine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Morphine (LA)

Products Affected

- *morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg*
- *morphine oral capsule,extend.release pellets 10 mg, 100 mg, 20 mg, 50 mg, 60 mg, 80 mg*
- *morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg*
- **MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG,**

60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.

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

Opioid Oxycodone

Products Affected

- *oxycodone oral capsule*
- *oxycodone oral concentrate*
- *oxycodone oral solution*
- *oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg*
- *oxycodone oral tablet, oral only*
- **ROXICODONE ORAL TABLET 15 MG, 30 MG**

- **ROXYBOND**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Opioid Oxycodone (LA)

Products Affected

- **OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG**
- **XTAMPZA ER**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Oxymorphone

Products Affected

- *oxymorphone oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Oxymorphone (LA)

Products Affected

- *oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Tapentadol

Products Affected

- **NUCYNTA**
- *tapentadol oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Tapentadol (LA)

Products Affected

- **NUCYNTA ER**
- *tapentadol oral tablet extended release 12 hr*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Tramadol

Products Affected

- *tramadol oral tablet 100 mg, 25 mg, 50 mg, 75 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opioid Tramadol (LA)

Products Affected

- **CONZIP**
- *tramadol oral capsule,er biphase 24 hr 17-83*
- *tramadol oral capsule,er biphase 24 hr 25-75 100 mg, 200 mg*
- *tramadol oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following are required (1-3): 1) pain requiring treatment is severe, requiring daily, around-the-clock, long-term opioid therapy, 2) member is not opioid naive, 3) attestations that non-opioid alternative therapies have been explored (e.g., NSAIDs), controlled substance history in the state Prescription Drug Monitoring Program (PDMP) has been reviewed, and counseling on the potential adverse effects of opioid analgesics, including the risks of misuse, abuse, and addiction, has been provided. A) When used concomitantly with substance abuse therapy, 1 of the following is required (1-2): 1) documentation of acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control, 2) pain requiring treatment is related to a terminal illness. In absence of substance abuse therapy, these criteria are not required. B) When used concomitantly with a benzodiazepine & centrally acting skeletal muscle relaxant (i.e., carisoprodol), all of the following are required (1-5): 1) documentation of diagnosis, 2) attestation that non-opioid therapies have been considered (e.g., NSAIDs), 3) attestation that non-benzodiazepine therapies have been considered (e.g., SSRIs, SNRIs), 4) trial/failure of 2 other skeletal muscle relaxants (e.g., methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients, 5) attestation of intent to monitor & address concomitant drug-drug interaction adverse events. In absence of a benzodiazepine & centrally acting skeletal muscle relaxant, these criteria are not required. C) When used concomitantly with an opioid potentiator (e.g., gabapentinoid, sedative-hypnotic), both of the following are required (1-2): 1) documentation of diagnosis, 2) attestation of intent to monitor & address concomitant drug-drug interaction adverse events is required. In absence of an opioid potentiator, these criteria are not required.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Concomitant Substance Abuse Therapy: 1 month. All other criteria: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opipza

Products Affected

- **OPIPZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- 1 of the following (1-2): 1) intolerance to generic aripiprazole tablets, 2) inability to swallow oral tablets. For major depressive disorder, documentation of adjunctive therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For major depressive disorder, therapeutic failure, contraindication or intolerance to Vraylar and one other generic antidepressant in addition to the antidepressant currently being used for the treatment of MDD (e.g. SSRI, SNRI, NDRIs, TCA, MAOI). When utilized for the same medically accepted indication, trial and failure of Vraylar.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opzelura

Products Affected

- **OPZELURA**

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

Oracea Rosacea

Products Affected

- **ORACEA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of rosacea with inflammatory lesions (papules and pustules) -AND- trial, contraindication or intolerance to metronidazole cream, lotion, or gel -AND- trial, contraindication or intolerance to generic doxycycline IR-DR 40 mg.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Oral Treprostinil PAH

Products Affected

- **ORENITRAM MONTH 1 TITRATION KT**
- **ORENITRAM MONTH 2 TITRATION KT**
- **ORENITRAM MONTH 3 TITRATION KT**
- **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25**

MG, 1 MG, 2.5 MG, 5 MG

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

Orencia

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Psoriatic Arthritis
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq. For psoriatic arthritis, patients 18 years of age and older must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq/Rinvoq LQ. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq/Rinvoq LQ. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257.
Indications	All FDA-approved Indications.

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

Orgovyx

Products Affected

- **ORGOVYX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced prostate cancer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Oriahnn

Products Affected

- **ORIAHNN**

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of severe hepatic impairment or osteoporosis.
Required Medical Information	Documentation of premenopausal woman with uterine leiomyomas -AND- Experiencing heavy menstrual bleeding -AND- For women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or with out estrogen and progestin does not exceed 24 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 18 months reauthorization
Other Criteria	For reauthorization, attestation of continued experience of heavy menstrual bleeding -AND- Attestation of decrease in menstrual blood loss -AND- for women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or without estrogen and progestin does not exceed 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Orilissa

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of severe hepatic impairment or osteoporosis.
Required Medical Information	Documentation of premenopausal woman with diagnosis of endometriosis with moderate to severe pain -AND- For women of childbearing age, attestation of not pregnant -AND- Inadequate response, failure or contraindication to 2 standard of care treatments (e.g. NSAIDS, combined hormonal contraceptives, progestin, GnRH agonist, Danazol) -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or with out estrogen and progestin does not exceed 24 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 18 months reauthorization
Other Criteria	For reauthorization, Orilissa is continued to be used for pain associated with endometriosis -AND- attestation of reduction in pain -AND- For women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or without estrogen and progestin does not exceed 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Orkambi

Products Affected

- **ORKAMBI ORAL GRANULES IN PACKET**
- **ORKAMBI ORAL TABLET**

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

Orladeyo

Products Affected

- **ORLADEYO ORAL CAPSULE**

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

Orserdu

Products Affected

- **ORSERDU ORAL TABLET 345 MG, 86 MG**

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

Osphena

Products Affected

- **OSPHENA**

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

Otezla

Products Affected

- **OTEZLA**
- **OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)**
- **OTEZLA XR**
- **OTEZLA XR INITIATION**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For plaque psoriasis, all of the following (1-2): 1) member is greater than or equal to 18 years of age with mild-to-severe disease -OR- if the member is greater than or equal to 6 years of age and less than 18 years, weight is greater than or equal to 20 kg for Otezla or 50 kg for Otelza XR, and member has moderate-to-severe disease -AND- 2) inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For oral ulcers associated with Behcet's Disease, inadequate response or intolerance to one systemic therapy for prevention of recurrent oral ulcers. For psoriatic arthritis, if the member is greater than or equal to 6 years of age and less than 18 years and weight is greater than or equal to 20 kg for Otezla or 50 kg for Otelza XR.
Age Restrictions	Deny if less than 6 years of age for plaque psoriasis or psoriatic arthritis. Deny if less than 18 years of age for Behcet's Disease.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Oxervate

Products Affected

- **OXERVATE**

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

Ozempic Oral

Products Affected

- **OZEMPIC ORAL**

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

Palsonify

Products Affected

- **PALSONIFY**

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

Palynziq

Products Affected

- **PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML, 2.5 MG/0.5 ML, 20 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of phenylketonuria -AND- all of the following criteria (1-3): 1) Baseline Phe level greater than 600 micromoles/L, 2) Failure or intolerance to existing management (i.e. sapropterin dihydrochloride)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of reduction in baseline pretreatment Phe levels -OR- blood Phe levels are less than or equal to 600 micromoles/L -OR- attestation that additional therapy with Palynziq is needed to allow adequate trial of maximum dose of 60mg per day for 16 weeks or member is not currently on 60mg per day dose.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Panretin

Products Affected

- **PANRETIN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous lesions in patients with AIDS-related Kaposi Sarcoma (KS) who are not receiving systemic therapy for KS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Paroxetine Capsule

Products Affected

- *paroxetine mesylate(menop.sym)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Attestation of counseling on risk-benefit profile and potential anticholinergic adverse effects
Age Restrictions	Automatic approval if less than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pemazyre

Products Affected

- **PEMAZYRE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of unresectable locally advanced cholangiocarcinoma or metastatic cholangiocarcinoma -AND- all of the following (1-2): 1) disease harbors FGFR2 fusion or other rearrangement as detected by an FDA-approved test 2) member has experienced therapeutic failure or intolerance to at least on prior therapy. Documentation of relapsed or refractory myeloid/lymphoid neoplasms -AND- disease harbors an FGFR1 rearrangement.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Pen Needles

Products Affected

- *pen needle, diabetic needle 29 gauge x 1/2"*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For non-preferred pen needle products, trial/failure or contraindication to preferred Embecta pen needles with NDC starting with 83017 is required. Embecta pen needles with NDC starting with 83017 will receive automatic approval.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Pentasa

Products Affected

- *mesalamine oral capsule, extended release 500 mg*
- **PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG**

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

Pheburane

Products Affected

- **PHEBURANE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- intolerence to generic sodium phenylbutyrate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Phenoxybenzamine

Products Affected

- *phenoxybenzamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of excessive sweating and hypertension associated with pheochromocytoma supported by one of the following (1. or 2.): 1. Elevated metanephrines in plasma or urine. 2. Tumor evidence from CT scan or MRI
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Phospholine Iodide

Products Affected

- **PHOSPHOLINE IODIDE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For diagnosis of elevated intraocular pressure (IOP), the following criteria apply (1 and 2): therapeutic failure or intolerance to generic latanoprost, 2) therapeutic failure, contraindication, or intolerance to one generic ophthalmic alternative that lowers IOP (a. through f.): a) prostaglandin analog, b) ophthalmic beta-blocker, c) alpha-adrenergic agonist, d) carbonic anhydrase inhibitor, e) ophthalmic cholinergic agonist, f) combination products of these classes
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Piqray

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) HR-positive, HER2-negative tumor status, 2) PIK3CA mutation positive as detected by an FDA-approved test, 3) disease progression on or after an endocrine-based regimen, 4) Concomitant therapy with fulvestrant
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pirfenidone

Products Affected

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

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

Plegridy

Products Affected

- **PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML**
- **PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML**

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

Pokonza

Products Affected

- **POKONZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of treatment or prophylaxis of hypokalemia -AND- Inability to swallow solid oral dosage forms -AND- For members 18 years of age and older, intolerance to potassium chloride oral tablets and potassium chloride oral capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Pomalyst

Products Affected

- *pomalidomide*
- **POMALYST**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of multiple myeloma, and combination use with dexamethasone, and previous trial of at least 2 therapies including lenalidomide and a proteasome inhibitor, and disease progression on or within 60 days of completion of the last therapy -OR- Documentation of AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV negative
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Pomalyst, intolerance to generic pomalidomide is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ponvory

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying multiple sclerosis agents
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Posaconazole Powder Packet

Products Affected

- **NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For aspergillus or candida infection prophylaxis, high risk of developing invasive Aspergillosis or Candidiasis infection due to being severely immunocompromised (e.g., hematopoietic stem cell transplant recipients with graft versus host disease, those with hematologic malignancies with prolonged neutropenia from chemotherapy) -AND- weight less than or equal to 40 kg. For invasive aspergillosis infection, trial/failure or contraindication to voriconazole -AND- inability to swallow tablets or capsules.
Age Restrictions	Deny if less than 2 years of age or greater than 17 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Posaconazole Suspension

Products Affected

- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For aspergillus or candida infection prophylaxis, high risk of developing invasive Aspergillosis or Candidiasis infection due to being severely immunocompromised (e.g., hematopoietic stem cell transplant recipients with graft versus host disease, those with hematologic malignancies with prolonged neutropenia from chemotherapy). For oropharyngeal candidiasis treatment, trial/failure or intolerance to generic fluconazole or generic itraconazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of intolerance to generic posaconazole delayed-release tablets or an inability to swallow tablets is required when being utilized for the same FDA approved indication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Posaconazole Tablet

Products Affected

- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For aspergillus or candida infection prophylaxis, high risk of developing invasive Aspergillosis or Candidiasis infection due to being severely immunocompromised (e.g., hematopoietic stem cell transplant recipients with graft versus host disease, those with hematologic malignancies with prolonged neutropenia from chemotherapy) -AND- weight greater than 40 kg. For invasive aspergillosis infection, trial/failure or contraindication to voriconazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Praluent

Products Affected

- **PRALUENT PEN**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pending CMS Review
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Preferred Adalimumab

Products Affected

- **HADLIMA**
- **HADLIMA PUSHTOUCH**
- **HADLIMA(CF)**
- **HADLIMA(CF) PUSHTOUCH**
- **SIMLANDI(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML, 80 MG/0.8 ML**
- **SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For uveitis, inadequate response or intolerance to 1 immunosuppressant or corticosteroid, or all are contraindicated.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, and Ankylosing Spondylitis or less than 12 years of age for Hidradenitis Suppurative or Less than 6 years of age for Crohn's disease or Less than 5 years of age for Ulcerative Colitis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Uveitis
Prescriber Restrictions	
Coverage Duration	Plan Year

PA Criteria	Criteria Details
Other Criteria	For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis therapy without concomitant methotrexate, doses above plan quantity limit will be approved aligned with recommended weekly dosing regimen. For pediatric ulcerative colitis and hidradenitis suppurativa, doses above plan quantity limit will be approved to align with recommended dosing regimen. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit. These criteria are applicable to Hadlima with NDC starting with 78206, and Simlandi with NDC starting with 51759.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Preferred Denosumab (Onco)

Products Affected

- **XTRENBO**

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

Preferred Denosumab (Osteo)

Products Affected

- **ENOBY**

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

Preferred Ustekinumab

Products Affected

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

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

Prenatal Vitamins

Products Affected

- **PRENATAL VITAMIN PLUS LOW IRON**

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

Pretomanid

Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. Criteria will be applied consistent with the current ATS/CDC/ERS/IDSA Clinical Practice Guideline for the Treatment of Drug-Susceptible and Drug-Resistant Tuberculosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of disease improvement -AND- member requires additional antimicrobial therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Prevymis Oral Pellets

Products Affected

- **PREVYMIS ORAL PELLETS IN PACKET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	Deny if less than 6 months of age with HSCT. Deny if less than 12 years of age with kidney transplant.
Prescriber Restrictions	
Coverage Duration	7 months
Other Criteria	One of the following is required (1-2): 1) inability to swallow tablets, 2) unable to use Prevymis (letermovir) tablets due to body weight dosing limitations.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Procysbi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- previous trial and failure, intolerance, or contraindication to Cystagon (cysteamine bitartrate immediate-release)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Provigil

Products Affected

- *modafinil*
- **PROVIGIL**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pending CMS Review
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Pulmozyme

Products Affected

- **PULMOZYME**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis -AND- Used in conjunction with standard therapies for management of cystic fibrosis to improve pulmonary function.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Inhalation solutions covered under Part B when administered in the home setting using a covered nebulizer (i.e. DME). For reauthorization, attestation of increase in FEV1 or decrease in number of hospitalizations or pulmonary exacerbations.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Purified Cortrophin Gel

Products Affected

- **CORTROPHIN GEL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Covered for the following indications: 1. Acute exacerbations of multiple sclerosis (MS) for patients receiving concurrent immunomodulator therapy 2. Rheumatic disorders for patients receiving maintenance therapy 3. Collagen diseases for members receiving maintenance therapy 4. Dermatologic diseases, if using for severe psoriasis, then the member is concurrently receiving maintenance therapy 5. Allergic states (i.e. serum sickness and transfusion reaction due to serum protein reaction), if using for atopic dermatitis, then the member is concurrently receiving maintenance therapy 6. Ophthalmic diseases 7. Respiratory diseases 8. Gout 9. Pediatric acquired epileptic aphasia. 10. Proteinuria in nephrotic syndrome and trial/failure or contraindication to two therapies from any of the following different classes: corticosteroids (e.g., cortisone or dexamethasone), calcineurin inhibitors (e.g., cyclosporine or tacrolimus, per DRUGDEX). For covered indications 1 through 9, limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (i.e. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	RA, JRA, and Collagen Diseases: 1 month initial, 6 month reauth. All other indications: 1 month

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

Pyrukynd

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hemolytic anemia with pyruvate kinase deficiency, as supported by one of the following (1-2): 1) mutations in the PKLR gene, 2) reduced activity of the pyruvate kinase enzyme.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 weeks initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of increase in hemoglobin level from baseline -OR- decrease in transfusion burden from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Qelbree

Products Affected

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

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

Qinlock

Products Affected

- **QINLOCK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced gastrointestinal stromal tumor -AND- Prior treatment with imatinib and 2 other kinase inhibitors.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Quinine

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	Treatment or prevention of leg cramps
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	10 days
Other Criteria	Doses for duration greater than 10 days will not be approved
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Qulipta

Products Affected

- **QULIPTA**

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

Radicava ORS

Products Affected

- **RADICAVA ORS STARTER KIT SUSP**

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

Ravicti

Products Affected

- *glycerol phenylbutyrate*

PA Criteria	Criteria Details
Exclusion Criteria	Urea cycle disorders due to N-acetylglutamate synthetase deficiency, Treatment of acute hyperammonemia in urea cycle disorders
Required Medical Information	Documentation of chronic management of a urea cycle disorders (UCDs)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Ravicti, intolerance to generic glycerol phenylbutyrate is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Rebif

Products Affected

- **REBIF (WITH ALBUMIN)**
- **REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8MCG/0.2ML-22 MCG/0.5ML (6)**
- **REBIF TITRATION PACK**

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

Recorlev

Products Affected

- **RECORLEV**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- patient is not a candidate for surgery or surgery has not been curative.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, both of the following are required (1 and 2: 1) patient remains not a candidate for required surgery or the surgery has not been curative, and 2) attestation of decrease in urinary free cortisol levels from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Redemplo

Products Affected

- **REDEMPLO**

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

Relistor

Products Affected

- **RELISTOR ORAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation (OIC) due to any of the following (1-2): 1) chronic non-cancer pain, or 2) chronic pain related to prior cancer or its treatment who do not require frequent (e.g. weekly) opioid dosage escalation -AND- documentation of opioid medication use -AND- trial and failure, contraindication, or intolerance to 2 of the following (3-5): 3) Laxatives, 4) lubiprostone, 5) Movantik
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Relistor SC

Products Affected

- **RELISTOR SUBCUTANEOUS SOLUTION**
- **RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation (OIC) due to any of the following (1-3): 1) chronic non-cancer pain, 2) advanced illness or active cancer in palliative care or 3) chronic pain related to prior cancer or its treatments who do not require frequent (e.g., weekly) opioid dosage escalation -AND- documentation of opioid medication use -AND- trial and failure, contraindication, or intolerance to 2 of the following (4 to 6): 4) Laxatives 5) lubiprostone 6) Movantik.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Repatha

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pending CMS Review
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Retevmo

Products Affected

- **RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic non-small cell lung cancer -AND- disease is classified as RET gene fusion as detected by an FDA approved test. Documentation of advanced or metastatic medullary thyroid cancer -AND- disease is classified as RET mutation as detected by an FDA approved test. Documentation of advanced or metastatic thyroid cancer -AND- all of the following (1-2): 1) disease is classified as RET gene fusion as detected by an FDA approved test 2) if radioactive iodine is appropriate for the member, the member is radioactive iodine-refractory. Documentation of locally advanced or metastatic solid tumor(s) -AND- disease harbors a RET gene fusion, as detected by an FDA-approved test -AND- one of the following (1-2): 1) the member has no satisfactory alternative treatments 2) the member's tumors have progressed following prior systemic treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Revlimid

Products Affected

- *lenalidomide*
- **REVLIMID**

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of chronic lymphocytic leukemia outside of a controlled clinical trial
Required Medical Information	Diagnosis of multiple myeloma in combination with dexamethasone -OR- diagnosis of multiple myeloma, as maintenance following autologous hematopoietic stem cell transplant (auto-HSCT) -OR- diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities -OR- diagnosis of mantle cell lymphoma (MCL) in which disease has relapsed or progressed after two prior therapies, one of which included bortezomib -OR- diagnosis of follicular lymphoma in combination with a rituximab product after previous treatment -OR- diagnosis of marginal zone lymphoma in combination with a rituximab product after previous treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Revlimid, intolerance to generic lenalidomide is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Revuforj

Products Affected

- **REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For relapsed or refractory acute leukemia, member has a lysine methyltransferase 2A gene (KMT2A) translocation, as determined by an FDA-authorized test. For relapsed or refractory acute myeloid leukemia, the member has a susceptible NPM1 mutation -AND- the member has no satisfactory alternative treatment options.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rexulti

Products Affected

- **REXULTI ORAL TABLET**

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

Rezdiffra

Products Affected

- **REZDIFFRA**

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

Rezlidhia

Products Affected

- **REZLIDHIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA approved test
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rezurock

Products Affected

- **REZUROCK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic graft-versus-host disease (cGVHD) -AND- therapeutic failure or intolerance to 2 lines of systemic therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Rhapsido

Products Affected

- **RHAPSIDO**

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

Riluzole

Products Affected

- **TIGLUTIK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of amyotrophic lateral sclerosis (ALS) -AND- Inability to swallow tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Rinvoq

Products Affected

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

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

Rinvoq LQ

Products Affected

- **RINVOQ LQ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or all non-biologic DMARDs are contraindicated or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	For PsA, deny if 18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The member has experienced therapeutic failure or intolerance to at least 1 tumor necrosis factor (TNF) blocker.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Riociguat PAH

Products Affected

- **ADEMPAS**

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

Rivfloza

Products Affected

- **RIVFLOZA SUBCUTANEOUS SOLUTION**
- **RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML, 160 MG/ML**

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

Romvimza

Products Affected

- **ROMVIMZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic tenosynovial giant cell tumor -AND- attestation that surgical resection may cause one of the following (1-2): 1) worsening functional limitation, 2) severe morbidity
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rozlytrek

Products Affected

- **ROZLYTREK ORAL CAPSULE 100 MG, 200 MG**
- **ROZLYTREK ORAL PELLETS IN PACKET**

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

Rubraca

Products Affected

- **RUBRACA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, all of the following (1-2): 1) Disease harbors a deleterious BRCA mutation (germline or somatic) 2) member is in complete or partial response to platinum-based chemotherapy. For metastatic castration-resistant prostate cancer, all of the following (1-3): 1) disease harbors a deleterious BRCA mutation (germline and/or somatic) 2) member has been treated with androgen receptor-directed therapy 3) member is concurrently receiving a gonadotropin-releasing hormone (GnRH) analog or member has had a bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ruconest

Products Affected

- **RUCONEST**

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

Rydapt

Products Affected

- **RYDAPT**

PA Criteria	Criteria Details
Exclusion Criteria	Use as single agent induction therapy for AML
Required Medical Information	Documentation of diagnosis. For a new diagnosis of acute myeloid leukemia, member is using in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy regimens and member is FLT3 mutation positive as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sabril

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of refractory complex partial seizures -AND- documentation of adjunctive therapy -AND- therapeutic failure or intolerance to at least two alternative treatments (e.g. carbamazepine, lamotrigine, levetiracetam, oxcarbazepine, tiagabine) -OR- documentation of use as monotherapy in treatment of infantile spasms
Age Restrictions	Deny if less than 2 years of age in treatment of refractory complex partial seizures -OR- if less than 1 month old and greater than 2 years of age in treatment of infantile spasms
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Sabril, intolerance to generic vigabatrin is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Safety Pen Needles

Products Affected

- **ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For non-preferred safety pen needle products, trial/failure or contraindication to preferred Embecta safety pen needles with NDC starting with 83017 is required. Embecta safety pen needles with NDC starting with 83017 will receive automatic approval.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Samsca

Products Affected

- **SAMSCA ORAL TABLET 15 MG, 30 MG**
- *tolvaptan oral tablet 15 mg, 30 mg*

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

Saphnelo

Products Affected

- **SAPHNELO PEN**
- **SAPHNELO SUBCUTANEOUS**

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

Saphris

Products Affected

- *asenapine maleate*
- **SAPHRIS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis - AND - trial and failure of one of the following: olanzapine, quetiapine, or risperidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Brand Saphris, intolerance to generic asenapine sublingual tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Savella

Products Affected

- *milnacipran oral tablet*
- **SAVELLA ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of fibromyalgia, all of the following are required (1-3): 1) Attestation of widespread bilateral pain above and below the waist for more than 3 months duration, 2) Attestation of presence of fibromyalgia-related symptoms (e.g., cognitive impairment, fatigue, sleep disturbance, neurologic symptoms, exercise intolerance), and 3) therapeutic failure, contraindication, or intolerance to duloxetine and pregabalin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Scemblix

Products Affected

- **SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- one of the following (1-3): 1) the member is newly-diagnosed, 2) member has been previously treated for Ph+ CML in chronic phase, 3) disease is positive for the T3151 mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Secuado

Products Affected

- **SECUADO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- intolerance to generic asenapine sublingual tablets -AND- trial/failure or intolerance to 1 of the following or all are contraindicated (1-3): 1) olanzapine, 2) quetiapine, 3) risperidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Semaglutide

Products Affected

- **OZEMPIC SUBCUTANEOUS**

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

Sephience

Products Affected

- **SEPHIENCE ORAL POWDER IN PACKET 1,000 MG, 250 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of PKU -AND- documented baseline Phe level greater than 6 mg/dL -AND- clinical documentation of current weight -AND- sepiapterin dose does not exceed 60 mg/kg/day.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, initial therapy has resulted in decrease in phenylalanine levels from baseline or current phenylalanine levels within the range of 120-360 micromol/L -AND- clinical documentation of current weight is required -AND- sepiapterin dose does not exceed 60 mg/kg/day. For brand Sephience, therapeutic failure or intolerance to generic sapropterin dihydrochloride is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sertraline Capsule

Products Affected

- *sertraline oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder or obsessive-compulsive disorder -AND- Sertraline 100mg or sertraline 125mg has been received for greater than or equal to 7 days -AND- Intolerance to generic sertraline immediate release tablets -AND-Therapeutic failure, intolerance or contraindication to at least one other antidepressant (e.g. SNRI, SSRI, TCA, MAOI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Seysara

Products Affected

- **SEYSARA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of inflammatory lesions of non-nodular moderate to severe acne -AND- trial and failure or intolerance of at least 1 generic topical acne medication (e.g. adapalene, clindamycin, sulfacetamide, erythromycin) -AND- trial and failure or intolerance of at least 1 generic oral acne antibiotic (e.g. minocycline, azithromycin, trimethoprim)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Signifor

Products Affected

- **SIGNIFOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- patient is not a candidate for pituitary surgery or surgery has not been curative
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, both of the following are required (1 and 2: 1) patient remains not a candidate for required surgery or the surgery has not been curative, and 2) attestation of decrease in urinary free cortisol levels from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sildenafil PAH

Products Affected

- **REVATIO ORAL TABLET**
- *sildenafil (pulm.hypertension) oral suspension for reconstitution*
- *sildenafil (pulm.hypertension) oral tablet*

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

Siliq

Products Affected

- **SILIQ**

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

Simponi

Products Affected

- **SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML**
- **SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. Simponi 50mg: For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide) and Simponi will be used in combination with methotrexate. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). Diagnosis of psoriatic arthritis. Simponi 50mg and 100mg: Diagnosis of moderate to severe ulcerative colitis and if the member is less than 18 years of age, weight is greater than or equal to 15kg.
Age Restrictions	Deny if less than 18 years of age for rheumatoid arthritis, ankylosing spondylitis and psoriatic arthritis.
Prescriber Restrictions	
Coverage Duration	Plan Year

PA Criteria	Criteria Details
Other Criteria	For ulcerative colitis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq/Rinvoq LQ. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, Cosentyx, Rinvoq. For ulcerative colitis patients 18 years of age and older must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq. For ulcerative colitis patients 5 years of age to less than 18 years of age must have therapeutic failure or intolerance to a preferred adalimumab product. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sirturo

Products Affected

- **SIRTURO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. Criteria will be applied consistent with the current ATS/CDC/ERS/IDSA Clinical Practice Guideline for the Treatment of Drug-Susceptible and Drug-Resistant Tuberculosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of disease improvement -AND- member requires additional antimicrobial therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Skyclarys

Products Affected

- **SKYCLARYS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Friedreichs ataxia confirmed by genetic testing (i.e., FXN gene mutation).
Age Restrictions	Deny if less than 16 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Skyrizi

Products Affected

- **SKYRIZI SUBCUTANEOUS PEN INJECTOR**
- **SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML, 55 MG/0.37 ML**
- **SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)**

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

Skytrofa

Products Affected

- **SKYTROFA**

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

Sogroya

Products Affected

- **SOGROYA**

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

Sohonos

Products Affected

- **SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 5 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	Deny if female and less than 8 years of age -OR- if male and less than 10 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of reduction in volume of new heterotopic ossification from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Solaraze

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure, intolerance, or contraindication to one of the following (1 or 2): 1) topical fluorouracil solution or fluorouracil 5% cream 2) topical imiquimod 5% cream
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of 30 day washout period since optimal therapeutic effect may not be evident until 30 days following cessation of therapy AND attestation of previous response to diclofenac sodium 3% topical gel therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Somatropin

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Somavert

Products Affected

- **SOMAVERT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For acromegaly, high pretreatment insulin-like growth factor-1 (IGF-1) based on laboratory reference range -AND- inadequate or partial response to surgery or radiotherapy or not a candidate for surgery or radiotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization of acromegaly, decreased or normalized IGF-1 from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sotyktu

Products Affected

- **SOTYKTU**

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

Sovaldi

Products Affected

- **SOVALDI**

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

Spevigo SC

Products Affected

- **SPEVIGO SUBCUTANEOUS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of generalized pustular psoriasis (GPP) -AND- Previous GPP flares have been experienced -AND- A flare is not currently being experienced -AND- Prevetion for future GPP flares is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sprycel

Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*
- **PHYRAGO ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG**
- **SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Stivarga

Products Affected

- **STIVARGA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic colorectal cancer and trial of a fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy, AND an anti-VEGF therapy AND if RAS wild-type, an anti-EGFR therapy -OR- documentation of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) after treatment with both imatinib and sunitinib -OR- documentation of hepatocellular cancer AND previous treatment with sorafenib
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sucraid

Products Affected

- **SUCRAID**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of congenital-sucrase-isomaltase deficiency (CSID) supported by one of the following (1, 2, or 3): 1) small bowel biopsy with disaccharidase assay showing absent or reduced sucrase activity, reduced or normal isomaltase activity, reduced maltase activity, and reduced or normal lactase activity. 2) genetic testing indicates a mutation in the sucrase-isomaltase gene. 3) sucrase deficiency evidenced by sucrose breath hydrogen test or carbon-sucrose breath test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sunosi

Products Affected

- **SUNOSI**

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

Sutent

Products Affected

- *sunitinib malate*
- **SUTENT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For gastrointestinal stromal tumor (GIST), the member has experienced therapeutic failure, intolerance, or contraindication to imatinib. For a high risk of recurrent renal cell carcinoma, member has had a nephrectomy and sunitinib is to be used as adjuvant treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Sutent, intolerance to generic sunitinib is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Symdeko

Products Affected

- **SYMDEKO**

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

Sympazan

Products Affected

- **SYMPAZAN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- therapeutic failure or intolerance of a previous antiepileptic therapy -AND- unable to tolerate generic clobazam
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Symproic

Products Affected

- **SYMPROIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation (OIC) due to any of the following (1-2): 1) chronic non-cancer pain, or 2) chronic pain related to prior cancer or its treatments who do not require frequent (e.g., weekly) opioid dosage escalation -AND- documentation of opioid medication use -AND- trial and failure, contraindication, or intolerance to at least 2 of the following (3-5): 3) Laxatives, 4) lubiprostone, 5) Movantik
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Synarel

Products Affected

- **SYNAREL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For central precocious puberty (CPP), advancement of bone age is beyond chronological age -AND- Basal luteinizing hormone (LH) level greater than 0.2-0.3IU/L or leuprolide-stimulating LH level greater than 3.3-5 IU/L. For female with endometriosis, attestation of not pregnant if of childbearing age -AND- Therapeutic failure, contraindication or intolerance to 2 of the following standard of care treatments: NSAIDs, combination hormonal contraceptive, progestin (i.e. medroxyprogesterone injection), GnRH agonist (i.e. Leuprolide) or danazol
Age Restrictions	Deny if onset of puberty after 8 years of age for females or after 9 years of age for males unless there is medical necessity for treatment of central precocious puberty. Deny if less than 18 years of age for endometriosis.
Prescriber Restrictions	
Coverage Duration	Endometriosis: 6 months, CPP: 6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization for CPP, attestation of pubertal development slowing from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tabrecta

Products Affected

- **TABRECTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer with MET exon 14 skipping mutation as detected by an FDA approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tadalafil PAH

Products Affected

- **ADCIRCA**
- **ALYQ**
- *tadalafil (pulm. hypertension)*
- **TADLIQ**

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

Tafinlar

Products Affected

- **TAFINLAR ORAL CAPSULE**
- **TAFINLAR ORAL TABLET FOR SUSPENSION**

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Tagrisso

Products Affected

- **TAGRISSO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of non-small cell lung cancer (NSCLC) and one of the following (1-5): 1) Adjuvant therapy after tumor resection -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test 2) Locally advanced disease -AND- using as first-line therapy -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test -AND- used in combination with pemetrexed and platinum-based chemotherapy, 3) Metastatic disease -AND- using as first-line therapy -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test -AND- used with or without combination therapy of pemetrexed and platinum-based chemotherapy, 4) Metastatic disease -AND- disease harbors EGFR T790M mutations, as detected by an FDA-approved test -AND- has progressed on or after EGFR TKI therapy, 5) Locally advanced, unresectable (stage III) disease -AND- disease has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy -AND- disease harbors EGFR exon 19 deletions or EGFR exon 21 L858R mutations, as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Takhzyro

Products Affected

- **TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML (150 MG/ML)**

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

Talicia

Products Affected

- **TALICIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of H. Pylori infection confirmed by invasive techniques (e.g. endoscopic) or non-invasive techniques (e.g. urea breath test, stool antigen) -AND- One of the following (1-2): 1) previous treatment using all the components of a first line therapy (e.g. Pylera and a proton pump inhibitor) failed to eradicate the H. Pylori infection, 2) allergy, intolerance, or contraindication to any component of Pylera.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Taltz

Products Affected

- **TALTZ AUTOINJECTOR**
- **TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML, 40 MG/0.5 ML, 80 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs.
Age Restrictions	Deny if less than 18 years of age for Psoriatic Arthritis, Ankylosing Spondylitis and non-radiographic axial spondyloarthritis or less than 6 years of age for Plaque Psoriasis
Prescriber Restrictions	
Coverage Duration	Plan Year

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

Talzenna

Products Affected

- **TALZENNA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of deleterious or suspected deleterious gBRCAm, HER2-negative locally advanced or metastatic breast cancer as a single agent - OR- Documentation of HRR gene-mutated metastatic castration-resistant prostate cancer in combination with enzalutamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tarceva

Products Affected

- *erlotinib*

PA Criteria	Criteria Details
Exclusion Criteria	Use in NSCLC tumors with mutations other than those in FDA-approved indications. Use in combination with platinum based chemotherapy.
Required Medical Information	Documentation of metastatic non-small cell lung cancer (NSCLC) -AND- one of the following, as detected by an FDA-approved test (1-2): 1) disease harbors EGFR exon 19 deletions 2) disease harbors EGFR exon 21 (L858R) substitution mutations -OR- documentation of locally advanced, unresectable or metastatic pancreatic cancer -AND- all of the following (1-2): 1) using erlotinib as first-line therapy 2) using in combination with gemcitabine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Targretin

Products Affected

- *bexarotene oral*
- **TARGRETIN ORAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous manifestations of cutaneous T-cell lymphoma in patients who are refractory to at least one prior systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Targretin, intolerance to generic bexarotene is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Targretin Gel

Products Affected

- *bexarotene topical*
- **TARGRETIN TOPICAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous lesions associated with one (1) of the following stages of cutaneous T-cell lymphoma (CTCL) (1. or 2.): 1) Stage IA or 2) Stage IB - AND- the member has experience therapeutic failure, contraindication, or intolerance to at least one other therapy for CTCL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Targretin gel, intolerance to generic bexarotene gel is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tarpeyo

Products Affected

- **TARPEYO**

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

Tascenso ODT

Products Affected

- **TASCENSO ODT**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying multiple sclerosis agents
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- Inability to swallow capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tasigna

Products Affected

- *nilotinib hcl*
- **TASIGNA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For adult patients with Ph+ chronic myeloid leukemia (CML), member's CML is in the chronic or accelerated phase and the member is no longer responding to or is intolerant to imatinib -OR- member is newly diagnosed in the chronic phase. For pediatric patients, one of the following (1-2): 1) member has chronic phase or accelerated phase Ph+ CML and is is resistant or intolerant to prior tyrosine kinase inhibitor therapy 2) member is newly diagnosed with Ph+ CML in the chronic phase.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Tasigna, documentation of intolerance to generic nilotinib is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tasimelteon

Products Affected

- *tasimelteon*

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

Tavalisse

Products Affected

- **TAVALISSE**

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

Tavneos

Products Affected

- **TAVNEOS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of severe active granulomatosis with polyangiitis or severe active microscopic polyangiitis -AND- Prescriber attests to positive test for anti-PR3 or positive test for anti-MPO -AND- Member will continue to receive concomitant standard of care treatment with immunosuppressives (e.g. mycophenolate mofetil, azathioprine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of therapeutic response defined by disease stability or disease improvement -AND- Member will continue to receive concomitant standard of care treatment with immunosuppressives (e.g. mycophenolate mofetil, azathioprine).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tazarotene

Products Affected

- **ARAZLO**
- *tazarotene topical foam*

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

Tazorac

Products Affected

- *tazarotene topical cream*
- *tazarotene topical gel*
- **TAZORAC TOPICAL CREAM**
- **TAZORAC TOPICAL GEL**
- **TRILITAS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of 1 of the following (A or B). A) Documentation of plaque psoriasis -AND- trial and failure or intolerance to at least one topical corticosteroid (e.g. fluocinonide, mometasone, triamcinolone, betamethasone). B) Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two topical acne medications (e.g. adapalene, clindamycin, sulfacetamide, erythromycin) one of which must be generic topical tretinoin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Tazorac cream, intolerance to generic tazarotene cream is required. For brand Tazorac gel, intolerance to generic tazarotene gel is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tecfidera

Products Affected

- *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg* **CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG**
- **TECFIDERA ORAL**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying multiple sclerosis agents
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 years
Other Criteria	For brand Tecfidera, intolerance to generic dimethyl fumarate is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tepmetko

Products Affected

- **TEPMETKO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer with a MET exon 14 skipping alteration
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Testosterone

Products Affected

- **AVEED**
- **DEPO-TESTOSTERONE**
- **JATENZO ORAL CAPSULE 158 MG, 198 MG, 237 MG**
- **KYZATREX ORAL CAPSULE 150 MG, 200 MG**
- **TESTIM**
- *testosterone cypionate*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet*
- *testosterone transdermal solution in metered pump w/app*
- **TLANDO**
- **VOGELXO TRANSDERMAL GEL**
- **VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP**
- **XYOSTED**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pending CMS Review
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tezspire

Products Affected

- **TEZSPIRE SUBCUTANEOUS PEN INJECTOR**

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

Thalomid

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Use as monotherapy for ENL treatment in the presence of moderate to severe neuritis
Required Medical Information	Documentation of multiple myeloma in combination with dexamethasone -OR- documentation for use in the treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) -OR- documentation of therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Thiola

Products Affected

- **THIOLA**
- **THIOLA EC**
- *tiopronin*
- **VENXXIVA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Confirmation of cystinuria by at least one 24-hour urine collection with measurement of urinary cysteine levels greater than 400 mg/day -AND- Attestation of failure of urine alkalization with potassium citrate (to achieve pH of 7.0).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For brand Thiola, brand Thiola EC, or Venxxiva, intolerance to generic tiopronin. For reauthorization, attestation of urine cystine concentration decreased from baseline -OR- decrease in production of cystine stones is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Thrombopoiesis Stimulating Agents

Products Affected

- **ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG**
- *eltrombopag olamine oral powder in packet 12.5 mg, 25 mg*
- *eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg*
- **PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG**
- **PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tibsovo

Products Affected

- **TIBSOVO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- disease is IDH1 mutation positive as detected by an FDA-approved test. For newly-diagnosed acute myeloid leukemia, member is using as monotherapy or in combination with azacitidine -AND- member meets one of the following (1-5): 1) age is greater than or equal to 75 years of age 2) severe cardiac or pulmonary comorbidity 3) reduced renal function 4) hepatic impairment 5) or prescriber attestation that member is not a candidate for intensive induction therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tigan

Products Affected

- *trimethobenzamide oral*

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

Tirzepatide

Products Affected

- **MOUNJARO**

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

Tizanidine

Products Affected

- *tizanidine oral capsule 8 mg*
- **ZANAFLEX ORAL CAPSULE 8 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of spasticity -AND- Intolerance to generic tizanidine tablets (2mg or 4mg) -AND- Intolerance to generic tizanidine capsules (2mg, 4mg, or 6mg)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, documentation of member experiencing a new episode of spasticity is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tocilizumab

Products Affected

- **ACTEMRA ACTPEN**
- **ACTEMRA SUBCUTANEOUS**
- **AVTOZMA AUTOINJECTOR**
- **AVTOZMA SUBCUTANEOUS**
- **TYENNE AUTOINJECTOR**
- **TYENNE SUBCUTANEOUS**

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

Tofacitinib

Products Affected

- *tofacitinib oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe active rheumatoid arthritis, an inadequate response or intolerance to at least one non-biologic DMARD (e.g., leflunomide, methotrexate). For immediate release formulation for polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID).
Age Restrictions	Deny if less than 18 years of age for rheumatoid arthritis, ulcerative colitis, ankylosing spondylitis. Deny if less than 2 years of age for polyarticular juvenile idiopathic arthritis and psoriatic arthritis.
Prescriber Restrictions	
Coverage Duration	Plan Year

PA Criteria	Criteria Details
Other Criteria	The member has experienced inadequate response or intolerance to at least 1 tumor necrosis factor (TNF) blocker. For rheumatoid arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq/Rinvoq LQ. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Rinvoq. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq/Rinvoq LQ. For ulcerative colitis (UC), patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. Doses greater than 10 mg per day will not be approved for rheumatoid arthritis and psoriatic arthritis. Doses greater than 20mg per day will not be approved for ulcerative colitis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tofacitinib ER

Products Affected

- *tofacitinib oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe active rheumatoid arthritis, an inadequate response or intolerance to at least one non-biologic DMARD (e.g., leflunomide, methotrexate). For 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
Prescriber Restrictions	
Coverage Duration	Plan Year

PA Criteria	Criteria Details
Other Criteria	The member has experienced inadequate response or intolerance to at least 1 tumor necrosis factor (TNF) blocker. For rheumatoid arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Rinvoq. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq/Rinvoq LQ. For ulcerative colitis (UC), patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. Doses greater than 11 mg per day will not be approved for rheumatoid arthritis and psoriatic arthritis. Doses greater than 22mg per day will not be approved for ulcerative colitis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tofacitinib Solution

Products Affected

- *tofacitinib oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. Documentation of polyarticular juvenile idiopathic arthritis -AND- Inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	Deny if less than 2 years of age for polyarticular juvenile idiopathic arthritis and psoriatic arthritis.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The member has experienced inadequate response or intolerance to at least 1 tumor necrosis factor (TNF) blocker. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq/Rinvoq LQ. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq/Rinvoq LQ. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Tolsura

Products Affected

- **TOLSURA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Unable to tolerate generic itraconazole capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation the member is still unable to tolerate generic itraconazole capsules
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tonmya

Products Affected

- **TONMYA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of fibromyalgia, all of the following are required (1-3): 1) Attestation of widespread bilateral pain above and below the waist for more than 3 months duration, 2) Attestation of presence of fibromyalgia-related symptoms (e.g., cognitive impairment, fatigue, sleep disturbance, neurologic symptoms, exercise intolerance). 3) therapeutic failure, contraindication, or intolerance to duloxetine and pregabalin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Topical Lidocaine

Products Affected

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

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

Topical Lidocaine-Prilocaine

Products Affected

- *lidocaine-prilocaine topical cream*

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

Torpenz

Products Affected

- **TORPENZ**

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

Tremfya

Products Affected

- **TREMFYA ONE-PRESS**
- **TREMFYA PEN INDUCTION PK(2PEN)**
- **TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML**
- **TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML, 200 MG/2 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy -AND- if the member is 6 years of age to less than 18 years, weight is greater than or equal to 40 kg. For psoriatic arthritis, if the member is 6 years of age to less than 18 years, weight is greater than or equal to 40 kg. For moderate to severe ulcerative colitis or moderate to severe Crohn's disease, attestation of receiving or currently undergoing 3 doses of IV Tremfya within 3 to 4 months of initiating maintenance therapy with Tremfya SC or Tremfya SC is used for induction dosing.
Age Restrictions	Deny if less than 18 years of age for Ulcerative colitis and Crohn's disease. Deny if less than 6 years of age for psoriatic arthritis and plaque psoriasis.
Prescriber Restrictions	
Coverage Duration	Plan Year

PA Criteria	Criteria Details
Other Criteria	For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For psoriasis, patients must have therapeutic failure or intolerance to 2 preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, and Skyrizi SC. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq/Rinvoq LQ. For ulcerative colitis (UC), patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq. For moderate to severe active Crohn's disease (CD), patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, and Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tretinoin Acne

Products Affected

- **ALTRENO**
- **ATRALIN**
- **RETIN-A**
- **RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %**
- *tretinoin*
- *tretinoin microspheres topical gel*
- *tretinoin microspheres topical gel with pump*

0.08 %

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two generic topical non-retinoid acne medications (e.g., clindamycin-benzoyl peroxide)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Trientine

Products Affected

- *trientine oral capsule 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Wilson's Disease -AND- intolerant of penicillamine (e.g., generic penicillamine capsule or tablet).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Intolerance to generic trientine hydrochloride 250mg capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Trikafta

Products Affected

- **TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL**
- **TRIKAFTA ORAL TABLETS, SEQUENTIAL**

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

Trintellix

Products Affected

- **TRINTELLIX**

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

Trulance

Products Affected

- **TRULANCE**

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

Truqap

Products Affected

- **TRUQAP**

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

Trutakna

Products Affected

- **TRUTAKNA**

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

Tryngolza

Products Affected

- **TRYNGOLZA**

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

Tryvio

Products Affected

- **TRYVIO**

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

Tukysa

Products Affected

- **TUKYSA ORAL TABLET 150 MG, 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For advanced unresectable HER2-positive breast cancer or metastatic HER2-positive breast cancer, member will be using in combination with trastuzumab and capecitabine -AND- member has received one or more prior anti-HER2 based regimens in the metastatic setting. For RAS wild-type HER2-positive unresectable or metastatic colorectal cancer, member will be using in combination with trastuzumab -AND- member has experienced disease progression following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Turalio

Products Affected

- **TURALIO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic tenosynovial giant cell tumor associated with severe morbidity and functional limitations -AND- patient is not amenable to improvement with surgery or not a candidate for surgery
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Twyneo Acne

Products Affected

- **TWYNEO**

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two generic topical non-retinoid acne medications (e.g., clindamycin-benzoyl peroxide)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tykerb

Products Affected

- *lapatinib*
- **TYKERB**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For advanced HER2-positive, or metastatic HER2-positive breast cancer, the member has received prior therapy with an anthracycline, a taxane, and trastuzumab -AND- will be using in combination with capecitabine. For HR+, metastatic breast cancer, the member is post-menopausal -AND- the member's cancer over expresses the HER2 receptor -AND- the member will be using lapatinib in combination with letrozole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Tykerb, intolerance to generic lapatinib is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tymlos

Products Affected

- **TYMLOS**

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

Ubrelvy

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of acute treatment of migraine with or without aura -AND- trial and failure of one generic triptan or all triptans are contraindicated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in migraine symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Uloric

Products Affected

- *febuxostat*
- **ULORIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of chronic management of hyperuricemia due to gout -And- trial/failure, intolerance or contraindication to allopurinol.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Uptravi

Products Affected

- **UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG PACK**
- **UPTRAVI ORAL TABLETS,DOSE**

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

Ustekinumab

Products Affected

- **IMULDOSA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **OTULFI SUBCUTANEOUS SOLUTION**
- **OTULFI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **PYZCHIVA AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 45 MG/0.5 ML, 90 MG/ML**
- **PYZCHIVA SUBCUTANEOUS SOLUTION**
- **PYZCHIVA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **SELARSDI SUBCUTANEOUS SOLUTION**
- **SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **STARJEMZA SUBCUTANEOUS SOLUTION**
- **STARJEMZA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **STELARA SUBCUTANEOUS SOLUTION**
- **STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- *ustekinumab subcutaneous solution*
- *ustekinumab subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml*
- *ustekinumab-aauz subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml*
- *ustekinumab-aekn subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml*
- *ustekinumab-ttwe subcutaneous solution*
- *ustekinumab-ttwe subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml*
- **WEZLANA SUBCUTANEOUS SOLUTION**
- **WEZLANA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Valchlor

Products Affected

- **VALCHLOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received at least one prior skin-directed therapy (e.g. topical corticosteroids, topical chemotherapy, local radiation and topical retinoids).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Valtoco

Products Affected

- **VALTOCO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizure clusters or acute repetitive seizures -AND- the member is currently receiving antiepileptic maintenance therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vanflyta

Products Affected

- **VANFLYTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- disease is FLT3-ITD-positive as detected by an FDA-approved test -AND- one of the following (1-3): 1) member is receiving induction therapy and is using Vanflyta in combination with standard cytarabine and anthracycline induction therapy 2) member is receiving consolidation therapy and is using Vanflyta in combination with standard cytarabine consolidation therapy 3) member is receiving maintenance therapy and is using Vanflyta as monotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vanrafia

Products Affected

- **VANRAFIA**

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

Velsipity

Products Affected

- **VELSIPITY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Venbysi XR

Products Affected

- *venlafaxine besylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- venlafaxine extended-release product at a total daily dose greater than or equal to 75 mg has been received for greater than or equal to 4 days.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Venclexta

Products Affected

- **VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG**
- **VENCLEXTA STARTING PACK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For newly-diagnosed AML, member is using in combination with azacitidine, decitabine, or cytarabine -AND- age greater than or equal to 75 years or presence of at least one comorbidity that precludes use of intensive induction chemotherapy (i.e. severe cardiac or pulmonary comorbidity, reduced renal function, hepatic impairment, or physician attestation) is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Veozah

Products Affected

- **VEOZAH**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documenation of moderate to severe vasomotor symptoms due to menopause -AND- one of the following (1 or 2): 1) therapeutic failure, contraindication, or intolerance to a generic hormone therapy product, or 2) attestation that hormone therapy is not clinically appropriate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Verkazia

Products Affected

- **VERKAZIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- therapeutic failure or intolerance to 2 of the following medication classes or all are contraindicated: 1) generic ophthalmic antihistamines (e.g., olopatadine), 2) generic ophthalmic mast cell stabilizers (e.g., cromolyn sodium), 3) Generic ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Verquvo

Products Affected

- **VERQUVO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of heart failure (NYHA Class II to IV) -AND- Left ventricular ejection fraction less than 45% -AND- Hospitalization for heart failure or received outpatient IV diuretics for heart failure -AND- Used in combination with a angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker or Entresto -AND- Used in combination with bisoprolol, carvedilol IR/ER or metoprolol succinate ER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Verzenio

Products Affected

- **VERZENIO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- disease is classified as HR-positive, HER2-negative. For early breast cancer that is at high risk of recurrence and is node-positive, all of the following (1-2): 1) used in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) 2) used as adjuvant treatment. For advanced or metastatic breast cancer, used as initial endocrine-based therapy and used in combination with an aromatase inhibitor -OR- used after documented disease progression following endocrine therapy and used in combination with fulvestrant -OR- used after documented disease progression and used following endocrine therapy and prior chemotherapy in the metastatic setting and will be used as monotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Viberzi

Products Affected

- **VIBERZI**

PA Criteria	Criteria Details
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Documentation of diarrhea predominant, irritable bowel syndrome (IBS-D) -AND- trial/failure or intolerance to one of the following medications for IBS-D or documentation of contraindication to all: antidiarrheal (e.g., loperamide), antispasmodic (e.g., dicyclomine, hyoscyamine), tricyclic antidepressant (e.g., amitriptyline, nortriptyline).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation that symptoms of IBS-D continue to persist AND positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Victoza

Products Affected

- **VICTOZA 3-PAK**

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

Vigafyde

Products Affected

- **VIGAFYDE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of use as monotherapy in treatment of infantile spasms
Age Restrictions	Deny if less than 1 month old and greater than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Intolerance to generic vigabatrin packets for oral solution is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Viibryd

Products Affected

- **VIIBRYD ORAL TABLET**
- *vilazodone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder -AND- Therapeutic failure, intolerance or contraindication to one generic antidepressant (e.g. SSRI, TCA, MAOI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Viibryd, intolerance to generic vilazodone is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vijoice

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of severe manifestations of PIK3CA Related Overgrowth Spectrum (PROS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vimovo

Products Affected

- *naproxen-esomeprazole*

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

Vitrakvi

Products Affected

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

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

Vivjoa

Products Affected

- **VIVJOA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of recurrent vulvovaginal candidiasis defined as at least 3 episodes of vulvovaginal candidiasis in less than one year -AND Documentation the member is NOT of reproductive potential defined as postmenopausal or another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy) -AND- the member has experienced therapeutic failure, contraindication, or intolerance to a six-month maintenance course of oral fluconazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vivlodex

Products Affected

- *meloxicam submicronized*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Intolerance to generic meloxicam tablets -AND- trial and failure or intolerance to one additional generic NSAID
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vonjo

Products Affected

- **VONJO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis -AND- attestation of a platelet count of less than 50 x 10*9/L.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voquezna

Products Affected

- **VOQUEZNA ORAL TABLET 10 MG, 20 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For healing of erosive esophagitis (EE) and relief of heartburn associated with EE, therapeutic failure, contraindication, or intolerance to omeprazole and pantoprazole. For relief of heartburn associated with non-erosive gasteroesophageal reflux disease (GERD), therapeutic failure, contraindication, or intolerance to omeprazole and pantoprazole. For treatment of H. Pylori infection confirmed by invasive techniques (e.g. endoscopic) or non-invasive techniques (e.g. urea breath test, stool antigen), used in combination with amoxicillin (with or without clarithromycin) -AND- allergy, intolerance, or contraindication to any component of bismuth quadruple therapy (i.e. bismuth subcitrate, metronidazole, tetracycline hydrochloride or omeprazole).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	H.pylori tx: 14days. EE Initial-8wks, Reauth-6mo. Non-erosive GERD Initial-4wks, Reauth-20wks
Other Criteria	For Erosive Esophagitis (EE) reauthorization, all of the following are required (1-3): 1) using for maintenance of EE healing and relief of heartburn associated with EE, 2) positive clinical response to an initial treatment course, 3) EE continues to require treatment for maintenance. For Non-erosive GERD reauthorization, all of the following are required (4-5): 4) non-erosive GERD requires additional therapy, 5) experienced symptom improvement or control during the initial 4-week treatment course.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Voquezna Dual Pak

Products Affected

- **VOQUEZNA DUAL PAK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of H. Pylori infection confirmed by invasive techniques (e.g. endoscopic) or non-invasive techniques (e.g. urea breath test, stool antigen)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voquezna Triple Pak

Products Affected

- **VOQUEZNA TRIPLE PAK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of H. Pylori infection confirmed by invasive techniques (e.g. endoscopic) or non-invasive techniques (e.g. urea breath test, stool antigen)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voranigo

Products Affected

- **VORANIGO ORAL TABLET 10 MG, 40 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following (1-3): 1) grade 2 astrocytoma or grade 2 oligodendroglioma, 2) disease harbors a susceptible isocitrate dehydrogenase (IDH)-1 or IDH-2 mutation, as detected by an FDA-approved test, 3) will be used following surgery including biopsy, sub-total resection, or gross total resection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voriconazole

Products Affected

- **VFEND IV**
- *voriconazole intravenous recon soln*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation that the beneficiary cannot take oral voriconazole
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of continued indicators of active disease (e.g. histopathology, positive cultures) is required
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vosevi

Products Affected

- **VOSEVI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member has a contraindication to or is otherwise not a candidate for one of the following regimens recommended by the AASLD/IDSA guidelines containing the following agents: sofosbuvir/velpatasvir (i.e. Epclusa authorized generic), Mavyret.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Votrient

Products Affected

- *pazopanib oral tablet 200 mg*
- **VOTRIENT**

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of adipocytic soft tissue sarcoma or gastrointestinal stromal tumor
Required Medical Information	Documentation of diagnosis. For advanced soft-tissue sarcoma, trial/failure of at least one prior chemotherapy regimen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Votrient, intolerance to generic pazopanib is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Voxzogo

Products Affected

- **VOXZOGO**

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

Voydeya

Products Affected

- **VOYDEYA**

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

Voyxact

Products Affected

- **VOYXACT**

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

Vtama

Products Affected

- **VTAMA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-2): 1) Documentation of plaque psoriasis -AND- 2) trial and failure, contraindication, or intolerance to one generic, formulary vitamin D analog (e.g., calcipotriene, calcitriol) -OR- the member has psoriasis on the face -OR- Documentation of all of the following (3-4): 3) Atopic dermatitis, 4) trial and failure, intolerance, or contraindication to topical generic tacrolimus or topical generic pimecrolimus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vuity

Products Affected

- *pilocarpine hcl ophthalmic (eye) drops 1.25 %*

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

Vumerity

Products Affected

- **VUMERITY**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying multiple sclerosis agents
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 years
Other Criteria	Therapeutic failure or intolerance to generic dimethyl fumarate is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vykat XR

Products Affected

- **VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 25 MG, 75 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Prader-Willi Syndrome (PWS) confirmed by documentation of genetic analysis with identification of abnormal DNA methylation of chromosome 15q11.2-q13 -AND- Experiencing hyperphagia due to PWS diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of a decrease in hyperphagic and food-related behaviors is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vyndamax ATTR-CM

Products Affected

- **VYNDAMAX**

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

Vyvgart Hytrulo

Products Affected

- **VYVGART HYTRULO SUBCUTANEOUS SYRINGE**

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

Wainua

Products Affected

- **WAINUA SUBCUTANEOUS AUTO-INJECTOR**

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

Wakix

Products Affected

- **WAKIX**

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

Wayrilz

Products Affected

- **WAYRILZ**

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

Wegovy

Products Affected

- **WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML**

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

Wegovy Oral

Products Affected

- **WEGOVY ORAL**

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

Welireg

Products Affected

- **WELIREG**

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

Winlevi Acne

Products Affected

- **WINLEVI**

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two generic topical non-retinoid acne medications (e.g., clindamycin-benzoyl peroxide)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Winrevair

Products Affected

- **WINREVAIR**

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

Xalkori

Products Affected

- **XALKORI ORAL CAPSULE**
- **XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For metastatic non-small cell lung cancer (NSCLC), disease is ALK-positive as detected by an FDA-approved test or ROS1-positive as detected by an FDA-approved test. For relapsed or refractory anaplastic large cell lymphoma (ALCL), disease is ALK-positive. For unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT), disease is ALK-positive.
Age Restrictions	Deny if less than 1 year of age or greater than 21 years of age for ALCL.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For crizotinib oral pellets and NSCLC, inability to swallow capsules is required. For crizotinib oral pellets and ALCL / IMT, inability to swallow oral capsules -OR- body surface area less than 1.34 m2 is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xcopri

Products Affected

- **XCOPRI MAINTENANCE PACK**
- **XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG**
- **XCOPRI TITRATION PACK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of partial-onset seizures -AND- Therapeutic failure, intolerance or contraindication to 1 other anti-epileptic drug (e.g. carbamazepine, levetiracetam)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xdemvy

Products Affected

- **XDEMVY**

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

Xeljanz

Products Affected

- **XELJANZ ORAL TABLET**
- **XELJANZ XR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe active rheumatoid arthritis, an inadequate response or intolerance to at least one non-biologic DMARD (e.g., leflunomide, methotrexate). For immediate release formulation for polyarticular juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID).
Age Restrictions	Deny if less than 18 years of age for rheumatoid arthritis, ulcerative colitis, ankylosing spondylitis. For extended release, deny if less than 18 years of age for psoriatic arthritis. For immediate release, deny if less than 2 years of age for polyarticular juvenile idiopathic arthritis and psoriatic arthritis.
Prescriber Restrictions	
Coverage Duration	Plan Year

PA Criteria	Criteria Details
Other Criteria	The member has experienced inadequate response or intolerance to at least 1 tumor necrosis factor (TNF) blocker. Intolerance to generic tofacitinib is required. For rheumatoid arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq/Rinvoq LQ. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Rinvoq. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq/Rinvoq LQ. For ulcerative colitis (UC), patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257. Doses greater than 10 mg per day (immediate release) and 11 mg per day (extended release) will not be approved for rheumatoid arthritis and psoriatic arthritis. Doses greater than 20mg per day (immediate release) and 22 mg per day (extended release) will not be approved for ulcerative colitis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xeljanz Solution

Products Affected

- **XELJANZ ORAL SOLUTION**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. Documentation of polyarticular juvenile idiopathic arthritis -AND- Inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	Deny if less than 2 years of age for polyarticular juvenile idiopathic arthritis and psoriatic arthritis.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The member has experienced inadequate response or intolerance to at least 1 tumor necrosis factor (TNF) blocker. Intolerance to generic tofacitinib is required. For polyarticular juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to a preferred adalimumab product, and Rinvoq/Rinvoq LQ. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Cosentyx, Otezla/Otezla XR, Skyrizi SC, Rinvoq/Rinvoq LQ. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Xenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*
- **XENAZINE ORAL TABLET 12.5 MG, 25 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation that the beneficiary is not actively suicidal
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Xenazine, intolerance to generic tetrabenazine is required. In patients with comorbid depression, attestation of adequate treatment for depression is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xermelo

Products Affected

- **XERMELO**

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

Xhance

Products Affected

- **XHANCE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic rhinosinusitis with nasal polyps or chronic rhinosinusitis without nasal polyps -AND- Therapeutic failure, intolerance or contraindication 2 corticosteroid nasal sprays.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xifaxan

Products Affected

- **XIFAXAN ORAL TABLET 550 MG**

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

Xolair

Products Affected

- **XOLAIR**

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

Xolremdi

Products Affected

- **XOLREMDI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of WHIM syndrome (warts, hypogammaglobulinemia, infections, myelokathexis).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of reduction in incidence of infections is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xospata

Products Affected

- **XOSPATA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- member is FLT3 mutation-positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xpovio

Products Affected

- **XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK)**

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

Xtandi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For castration-resistant prostate cancer and metastatic castration sensitive-prostate cancer, the member is using in combination with a GnRH analog or the member has had a bilateral orchiectomy. For non-metastatic castration-sensitive prostate cancer, the member has biochemical recurrence at high risk for metastasis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xyrem

Products Affected

- *sodium oxybate*
- **XYREM**

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

Xywav

Products Affected

- **XYWAV**

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

Yonsa

Products Affected

- **YONSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- using in combination with methylprednisolone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Yorvipath

Products Affected

- **YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML, 294 MCG/0.98 ML, 420 MCG/1.4 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of hypoparathyroidism -AND- albumin-corrected serum calcium greater than or equal to 7.8 mg/dL -AND- trial and failure of an active form of vitamin D (e.g. calcitriol, alfacalcidol).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of normalization or improvement in total serum calcium from baseline is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Yuflyma

Products Affected

- **YUFLYMA(CF) AI CROHN'S-UC-HS**
- **YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML, 80 MG/0.8 ML**
- **YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML**

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

Yuviwel

Products Affected

- **YUVIWEL SUBCUTANEOUS RECON SOLN 1.3 MG, 2.8 MG, 5.5 MG**

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

Zavzpret

Products Affected

- **ZAVZPRET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute migraine headaches with or without aura -AND- Therapeutic failure, contraindication or intolerance to one generic triptan -AND- Inability to swallow capsules/tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in migraine symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zejula

Products Affected

- **ZEJULA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer, member is in complete or partial response to first-line platinum-based therapy -AND- disease is associated with homologous recombination deficiency-positive status, defined by at least one of the following (1 or 2): 1) a deleterious or suspected deleterious BRCA mutation or 2) genomic instability. For recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer, all of the following (1-2): 1) disease harbors a deleterious or suspected deleterious germline BRCA mutation 2) member is in a complete or partial response to platinum-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zelboraf

Products Affected

- **ZELBORAF**

PA Criteria	Criteria Details
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	Documentation of diagnosis. For unresectable or metastatic melanoma, member has a BRAF V600E mutation. For Erdheim-Chester Disease, member has a BRAF V600 mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zelsuvmi

Products Affected

- **ZELSUVMI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of molluscum contagiosum
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	For reauthorization, attestation that the member has previously experienced complete or partial clearance of molluscum contagiosum lesions with Zelsuvmi -AND- additional course of therapy is required for recurrence of molluscum contagiosum
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zenbexus

Products Affected

- **ZENBEXUS**

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

Zepbound

Products Affected

- **ZEPBOUND SUBCUTANEOUS PEN INJECTOR**

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

Zepbound Kwikpen

Products Affected

- **ZEPBOUND KWIKPEN**

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

Zeposia

Products Affected

- **ZEPOSIA**
- **ZEPOSIA STARTER KIT (28-DAY)**
- **ZEPOSIA STARTER PACK (7-DAY)**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying multiple sclerosis agents
Required Medical Information	Documentation of diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Ulcerative Colitis: Plan Year, Multiple Sclerosis: 24 months
Other Criteria	For moderate to severe active ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zerviate

Products Affected

- **ZERVIATE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of ocular itching associated with allergic conjunctivitis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Therapeutic failure, intolerance, or contraindication to generic azelastine ophthalmic drops is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ziana Acne

Products Affected

- *clindamycin-tretinoin*
- **ZIANA**

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two generic topical non-retinoid acne medications (e.g., clindamycin-benzoyl peroxide)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zokinvy

Products Affected

- **ZOKINVY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- BSA of at least 0.39 m*2. For Hutchinson-Gilford Progeria Syndrome (HGPS), a mutation in the LMNA gene is required. For Processing-Deficient Progeroid Lamionpathy (PL), 1 of the following is required (1-3): 1) heterozygous LMNA mutation and progerin-like protein accumulation, 2) homozygous ZMPSTE24 mutations, or 3) compound heterozygous ZMPSTE24 mutations.
Age Restrictions	Deny if less than 12 months of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zolinza

Products Affected

- **ZOLINZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following 2 systemic therapies. Systemic therapies include bexarotene, interferon alpha, extracorporeal photochemotherapy, PUVA, single agent or combination chemotherapies (e.g. cyclophosphamide, vinblastine, romidepsin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zolpidem Capsule

Products Affected

- *zolpidem*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of insomnia characterized by difficulties with sleep onset -AND- therapeutic failure or intolerance to 2 of the following (1-3): 1) eszopiclone, 2) zaleplon, 3) generic zolpidem tablets/zolpidem ER tablets. When used concomitantly with an opioid agonist, attestation of intent to monitor & address concomitant drug-drug interaction adverse events is also required.
Age Restrictions	Deny if greater than 64 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zonisade

Products Affected

- **ZONISADE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of partial-onset seizures -AND- Documentation of adjunctive therapy -AND- Inability to swallow capsules -AND- Therapeutic failure/intolerance to 2 or contraindication to all of the following (1-6): 1) generic carbamazepine suspension/chewable tablet/extended-release capsule, 2) generic gabapentin capsules/solution, 3) generic lacosamide solution, 4) generic levetiracetam solution, 5) generic oxcarbazepine suspension, 6) generic pregabalin capsules/solution.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zoryve 0.05 Cream

Products Affected

- **ZORYVE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-2). 1) Documentation of mild to moderate atopic dermatitis -AND- 2) therapeutic failure, contraindication or intolerance to topical generic tacrolimus or topical generic pimecrolimus.
Age Restrictions	Deny if less than 2 years of age or greater than 5 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Atopic Dermatitis, patients must have a trial/failure, intolerance, or contraindication to Vtama.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zoryve 0.15 Cream

Products Affected

- **ZORYVE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-2). 1) Documentation of mild to moderate atopic dermatitis -AND- 2) therapeutic failure, contraindication or intolerance to topical generic tacrolimus or topical generic pimecrolimus.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Atopic Dermatitis, patients must have a trial/failure, intolerance, or contraindication to Vtama.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zoryve Cream

Products Affected

- **ZORYVE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-2). 1) Documentation of plaque psoriasis -AND- 2) trial and failure, contraindication, or intolerance to one generic, formulary vitamin D analog (e.g., calcipotriene, calcitriol) -OR- the member has psoriasis on the face.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Plaque Psoriasis, patients 18 years of age and older must have a trial/failure, intolerance, or contraindication to Vtama.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zoryve Foam

Products Affected

- **ZORYVE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3). 1) Documentation of seborrheic dermatitis -AND- 2) trial and failure or intolerance to at least one generic, formulary topical corticosteroid or seborrheic dermatitis on facial or intertriginous areas -AND- 3) if the member is 12 years of age or older, trial and failure, contraindication, or intolerance to one generic, topical antifungal agent for seborrheic dermatitis (e.g., ketoconazole, ciclopirox). -OR- Documentation of all of the following (4-5). 4) Documentation of plaque psoriasis -AND- 5) trial and failure, contraindication, or intolerance to one generic, formulary vitamin D analog (e.g., calcipotriene, calcitriol) or the member has psoriasis on the face.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Plaque Psoriasis, patients 18 years of age and older must have a trial/failure, intolerance, or contraindication to Vtama.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ztalmy

Products Affected

- **ZTALMY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizures associated with CDKL5 deficiency confirmed by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZTLido

Products Affected

- **ZTLIDO**

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

Zunveyl

Products Affected

- **ZUNVEYL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis - AND- therapeutic failure or intolerance to generic galantamine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zurzuvae

Products Affected

- **ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of postpartum depression -AND- attestation of symptom onset began during the third trimester of pregnancy or up to 4 weeks post-delivery -AND- less than or equal to 12 months postpartum.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zykadia

Products Affected

- **ZYKADIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- ALK mutations, as detected by an FDA approved test.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zymfentra

Products Affected

- **ZYMFENTRA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation of receiving or currently undergoing at least 3 doses of IV infliximab within 10 weeks of initiating therapy with Zymfentra.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For moderate to severe active ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, Rinvoq. For moderate to severe active Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, a preferred ustekinumab SC product, Skyrizi SC, and Rinvoq. Please Note: Preferred adalimumab products include Hadlima with NDC starting with 78206 and Simlandi with NDC starting with 51759. Preferred ustekinumab products include Steqema with NDC starting with 72606 and Yesintek with NDC starting with 83257.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Zytiga

Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*
- **ABIRTEGA**
- **ZYTIGA ORAL TABLET 250 MG, 500 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- using in combination with prednisone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Zytiga and generic abiraterone (other than Abirtega), intolerance to Abirtega is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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TYKERB 637
TYMLOS 638
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 32-64 MCG, 48 MCG, 48-64 MCG, 48-80 MCG, 64 MCG, 80 MCG ... 258
UBRELVY ORAL TABLET 100 MG, 50 MG 639
ULORIC 640
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG 641
UPTRAVI ORAL TABLETS,DOSE PACK 641

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ustekinumab subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml 642
ustekinumab-aauz subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml 642
ustekinumab-aekn subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml 642
ustekinumab-ttwe subcutaneous solution ... 642
ustekinumab-ttwe subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml 642
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VALIUM 69
VALTOCO 645
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VANRAFIA 647
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VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG 650
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VENXXIVA 604
VEOZAH 651
VERKAZIA 652
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VERZENIO 654
VFEND IV 670
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VICTOZA 3-PAK 656
vigabatrin 539
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VIJOICE ORAL TABLET 125 MG, 250 MG/DAY (200 MG X1-50 MG X1), 50 MG 659
vilazodone 658
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VOQUEZNA DUAL PAK 667
VOQUEZNA ORAL TABLET 10 MG, 20 MG 665
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VOYDEYA 674
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VYNDAMAX 680
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WAINUA SUBCUTANEOUS AUTO-INJECTOR 682
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WEGOVY ORAL 686
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WEZLANA SUBCUTANEOUS SOLUTION 642
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WINLEVI 688
WINREVAIR 689
WYOST 137
XALKORI ORAL CAPSULE 690
XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG 690
XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG 65
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 2 MG 65
XCOPRI MAINTENANCE PACK 691

XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG 691
XCOPRI TITRATION PACK 691
XDEMVY 692
XELJANZ ORAL SOLUTION 695
XELJANZ ORAL TABLET 693
XELJANZ XR 693
XENAZINE ORAL TABLET 12.5 MG, 25 MG 697
XERMELO 698
XGEVA 137
XHANCE 699
XIFAXAN ORAL TABLET 550 MG 700
XOLAIR 701
XOLREMDI 702
XOSPATA 703
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK) 704
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XTANDI ORAL CAPSULE 705
XTANDI ORAL TABLET 40 MG, 80 MG 705
XTRENBO 496
XYOSTED 601
XYREM 706
XYWAV 707
YARGESA 349
YESINTEK SUBCUTANEOUS SOLUTION 498
YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML 498
YIMMUGO 254
YONSA 708
YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML, 294 MCG/0.98 ML, 420 MCG/1.4 ML 709
YUFLYMA(CF) AI CROHN'S-UC-HS 710
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML, 80 MG/0.8 ML 710
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML 710
YULITHIRA 9
YUSIMRY(CF) PEN 6
YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG 258
YUVIWEL SUBCUTANEOUS RECON SOLN 1.3 MG, 2.8 MG, 5.5 MG 711
zaleplon oral capsule 10 mg, 5 mg 241
ZANAFLEX ORAL CAPSULE 8 MG 609
ZAVESCA 349
ZAVZPRET 712
ZEJULA 713
ZELBORAF 714
ZELSUVMI 715
ZELVYSIA 297
ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG 19
ZENBEXUS 716
ZEPBOUND KWIKPEN 718
ZEPBOUND SUBCUTANEOUS PEN INJECTOR 717
ZEPOSIA 719
ZEPOSIA STARTER KIT (28-DAY) 719
ZEPOSIA STARTER PACK (7-DAY) 719
ZERVIATE 720
ZIANA 721
ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML, 23 MG/0.574 ML, 32.4 MG/0.81 ML 357
zileuton 309
ZOKINVY 722
ZOLINZA 723
zolpidem 242, 724
ZOMACTON SUBCUTANEOUS RECON SOLN 5 MG 563
ZONALON 150
ZONISADE 725
ZORYVE 726, 727, 728, 729
ZTALMY 730
ZTLIDO 731
ZUNVEYL 732

ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG 733
ZYKADIA 734
ZYMFENTRA 735
ZYTIGA ORAL TABLET 250 MG, 500 MG 737

Section: Step Therapy

Atrovent HFA

Products Affected

- **ATROVENT HFA 17 MCG/ACTUATION AEROSOL INHALER**

Details

Criteria	Require a 1 month trial of generic ipratropium bromide HFA in the last 90 days

Brand ADHD

Products Affected

- **ADDERALL 20 MG TABLET**
- **ADDERALL 5 MG TABLET**
- **ADDERALL 7.5 MG TABLET**
- **ADDERALL XR 10 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 15 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 20 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 25 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 30 MG CAPSULE,EXTENDED RELEASE**
- **ADDERALL XR 5 MG CAPSULE,EXTENDED RELEASE**
- **ADZENYS XR-ODT 12.5 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 15.7 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 18.8 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 3.1 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 6.3 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **ADZENYS XR-ODT 9.4 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- *amphetamine er 12.5 mg extended release-disintegrating 24 hr tablet*
- *amphetamine er 15.7 mg extended release-disintegrating 24 hr tablet*
- *amphetamine er 18.8 mg extended release-disintegrating 24 hr tablet*
- *amphetamine er 3.1 mg extended release-disintegrating 24 hr tablet*
- *amphetamine er 6.3 mg extended release-disintegrating 24 hr tablet*
- *amphetamine er 9.4 mg extended release-disintegrating 24 hr tablet*
- **ARYNTA 10 MG/ML ORAL SOLUTION**
- **AZSTARYS 26.1 MG-5.2 MG CAPSULE**
- **AZSTARYS 39.2 MG-7.8 MG CAPSULE**
- **AZSTARYS 52.3 MG-10.4 MG CAPSULE**
- **CONCERTA 18 MG TABLET,EXTENDED RELEASE**
- **CONCERTA 27 MG TABLET,EXTENDED RELEASE**
- **CONCERTA 36 MG TABLET,EXTENDED RELEASE**
- **CONCERTA 54 MG TABLET,EXTENDED RELEASE**
- **COTEMPLA XR-ODT 17.3 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **COTEMPLA XR-ODT 25.9 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **COTEMPLA XR-ODT 8.6 MG EXTENDED RELEASE DISINTEGRATING TABLET**
- **DEXEDRINE SPANSULE 10 MG CAPSULE,EXTENDED RELEASE**
- *dextroamphetamine sulfate er 10 mg capsule,extended release*
- *dextroamphetamine sulfate er 15 mg capsule,extended release*
- *dextroamphetamine sulfate er 5 mg capsule,extended release*
- *dextroamphetamine-amphetamine er 12.5 mg capsule, 3 bead, ext rel 24hr*
- *dextroamphetamine-amphetamine er 25 mg capsule,3 bead,ext release 24hr*
- *dextroamphetamine-amphetamine er 37.5 mg capsule, 3 bead, ext rel 24hr*
- *dextroamphetamine-amphetamine er 50 mg capsule,3 bead,ext release 24hr*
- **DYANAVEL XR 10 MG TABLET, EXTENDED RELEASE**
- **DYANAVEL XR 15 MG TABLET, EXTENDED RELEASE**
- **DYANAVEL XR 2.5 MG/ML ORAL 24 HR EXTENDED RELEASE**

SUSPENSION
- **DYANAVEL XR 20 MG TABLET, EXTENDED RELEASE**
- **DYANAVEL XR 5 MG TABLET, EXTENDED RELEASE**
- **FOCALIN XR 10 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 15 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 20 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 25 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 30 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 35 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 40 MG CAPSULE,EXTENDED RELEASE**
- **FOCALIN XR 5 MG CAPSULE,EXTENDED RELEASE**
- **JORNAY PM 100 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 20 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 40 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 60 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- **JORNAY PM 80 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE**
- *lisdexamfetamine 10 mg capsule*
- *lisdexamfetamine 10 mg chewable tablet*
- *lisdexamfetamine 20 mg capsule*
- *lisdexamfetamine 20 mg chewable tablet*
- *lisdexamfetamine 30 mg capsule*
- *lisdexamfetamine 30 mg chewable tablet*
- *lisdexamfetamine 40 mg capsule*
- *lisdexamfetamine 40 mg chewable tablet*
- *lisdexamfetamine 50 mg capsule*
- *lisdexamfetamine 50 mg chewable tablet*
- *lisdexamfetamine 60 mg capsule*
- *lisdexamfetamine 60 mg chewable tablet*
- *lisdexamfetamine 70 mg capsule*
- **METADATE CD 10 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 20 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 30 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 40 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 50 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 60 MG CAPSULE,EXTENDED RELEASE**
- **METHYLIN 10 MG/5 ML ORAL SOLUTION**
- **METHYLIN 5 MG/5 ML ORAL SOLUTION**
- *methylphenidate 17.3 mg er,ir disintegrating 24 hr tablet*
- *methylphenidate 25.9 mg er,ir disintegrating 24 hr tablet*
- *methylphenidate 8.6 mg er,ir disintegrating 24 hr tablet*
- *methylphenidate er 10 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 15 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 20 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 30 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 40 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 50 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 60 mg capsule,extended release (40-60) sprinkle*
- **MYDAYIS 12.5 MG CAPSULE EXTENDED RELEASE 24 HR**
- **MYDAYIS 25 MG CAPSULE EXTENDED RELEASE 24 HR**

- **MYDAYIS 37.5 MG CAPSULE EXTENDED RELEASE 24 HR**
- **MYDAYIS 50 MG CAPSULE EXTENDED RELEASE 24 HR**
- **QUILLICHEW ER 20 MG CHEWABLE TABLET, EXTENDED RELEASE**
- **QUILLICHEW ER 30 MG CHEWABLE TABLET, EXTENDED RELEASE**
- **QUILLICHEW ER 40 MG CHEWABLE, EXTENDED RELEASE TABLET**
- **QUILLIVANT XR 5 MG/ML (25 MG/5 ML) ORAL SUSPENSION,EXTEND RELEASE 24HR**
- **RELEXXII 18 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 27 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 36 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 45 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 54 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 63 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 72 MG TABLET,EXTENDED RELEASE**
- **RITALIN 10 MG TABLET**
- **RITALIN 20 MG TABLET**
- **RITALIN 5 MG TABLET**
- **VYVANSE 10 MG CAPSULE**
- **VYVANSE 10 MG CHEWABLE TABLET**
- **VYVANSE 20 MG CAPSULE**
- **VYVANSE 20 MG CHEWABLE TABLET**
- **VYVANSE 30 MG CAPSULE**
- **VYVANSE 30 MG CHEWABLE TABLET**
- **VYVANSE 40 MG CAPSULE**
- **VYVANSE 40 MG CHEWABLE TABLET**
- **VYVANSE 50 MG CAPSULE**
- **VYVANSE 50 MG CHEWABLE TABLET**
- **VYVANSE 60 MG CAPSULE**
- **VYVANSE 60 MG CHEWABLE TABLET**
- **VYVANSE 70 MG CAPSULE**
- **XELSTRYM 13.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**
- **XELSTRYM 18 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**
- **XELSTRYM 4.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**
- **XELSTRYM 9 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**

Details

Criteria	Require a 1 month trial of 2 of the following generic ADHD medications (Step 1 drug) when being utilized for the same medically accepted indication: methylphenidate (i.e. generics of Concerta, Metadate CD, Methylin, Relexxii, Ritalin/Ritalin LA), atomoxetine, dextroamphetamine/amphetamine (i.e. generics of Adderall/Adderal XR), or dexmethylphenidate in the last 180 days.

Brand Albuterol

Products Affected

- *albuterol sulfate hfa 90 mcg/actuation aerosol inhaler (nda020983)* **MCG/ACTUATION BREATH ACTIVATED**
- **PROAIR RESPICLICK 90**

Details

Criteria	Require a 1 month trial of albuterol (generic Proair HFA) in the last 90 days

Brand Epinephrine

Products Affected

- **AUVI-Q 0.1 MG/0.1 ML INJECTION,AUTO-INJECTOR**
- **AUVI-Q 0.15 MG/0.15 ML AUTO-INJECTOR (FOR 33 LB TO 66 LB PATIENTS)**
- **AUVI-Q 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR**
- **EPIPEN 2-PAK 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR**
- **EPIPEN JR 2-PAK 0.15 MG/0.3 ML INJECTION,AUTO-INJECTOR**
- **NEFFY 1 MG/SPRAY (0.1 ML) NASAL SPRAY**
- **NEFFY 2 MG/SPRAY (0.1 ML) NASAL SPRAY**

Details

Criteria	Require a trial of generic epinephrine injection in the last 90 days

Brand Levalbuterol

Products Affected

- **XOPENEX HFA 45 MCG/ACTUATION AEROSOL INHALER**

Details

Criteria	Require a 1 month trial of albuterol (generic Proair HFA) and generic levalbuterol in the last 180 days

Brynovin

Products Affected

- **BRYNOVIN 25 MG/ML ORAL SOLUTION**

Details

Criteria	Pending CMS Review

Carbidopa-Levodopa

Products Affected

- *carbidopa er 23.75 mg-levodopa 95 mg capsule,extended release*
- *carbidopa er 36.25 mg-levodopa 145 mg capsule,extended release*
- *carbidopa er 48.75 mg-levodopa 195 mg capsule,extended release*
- *carbidopa er 61.25 mg-levodopa 245 mg capsule,extended release*
- **CREXONT 35 MG-140 MG CAPSULE, EXTENDED RELEASE**
- **CREXONT 52.5 MG-210 MG CAPSULE, EXTENDED RELEASE**
- **CREXONT 70 MG-280 MG CAPSULE, EXTENDED RELEASE**
- **CREXONT 87.5 MG-350 MG CAPSULE, EXTENDED RELEASE**
- **DHIVY 25 MG-100 MG TABLET**
- **RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE**

Details

Criteria	Require a trial of generic carbidopa/levodopa tablets, carbidopa/levodopa orally disintegrating tablets, carbidopa/levodopa ER tablets, or carbidopa/levodopa/entacapone tablets (Step 1 drug) in the last 90 days

Celecoxib

Products Affected

- **CELEBREX 100 MG CAPSULE**
- **CELEBREX 200 MG CAPSULE**
- **CELEBREX 400 MG CAPSULE**
- **CELEBREX 50 MG CAPSULE**

Details

Criteria	Require a 1 month trial of generic celecoxib and 1 other formulary generic NSAID (Step 1 drugs) in the last 180 days

Clonidine ER

Products Affected

- *clonidine hcl er 0.17 mg tablet,extended release 24 hr*
- **NEXICLON XR 0.17 MG TABLET,EXTENDED RELEASE**

Details

Criteria	Require a 1 month trial of generic clonidine IR tablet (Step 1 drug) in the last 90 days

Colony Stimulating Factors

Products Affected

- **FULPHILA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **FYLNETRA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **GRANIX 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE**
- **GRANIX 300 MCG/ML SUBCUTANEOUS SOLUTION**
- **GRANIX 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE**
- **NEULASTA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE**
- **NEUPOGEN 300 MCG/ML INJECTION SOLUTION**
- **NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE**
- **NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION**
- **NYVEPRIA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **RELEUKO 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE**
- **RELEUKO 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE**
- **ROLVEDON 13.2 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **STIMUFEND 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **UDENYCA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **UDENYCA AUTOINJECTOR 6 MG/0.6 ML SUBCUTANEOUS AUTO-INJECTOR**
- **ZIEXTENZO 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**

Details

Criteria	Require a 1 month trial of Zarxio and Nivestym (step 1 drugs) in the last 180 days when being utilized for the same medically accepted indication and age

DPP4 Agents

Products Affected

- *alogliptin 12.5 mg tablet*
- *alogliptin 12.5 mg-metformin 1,000 mg tablet*
- *alogliptin 12.5 mg-metformin 500 mg tablet*
- *alogliptin 12.5 mg-pioglitazone 30 mg tablet*
- *alogliptin 25 mg tablet*
- *alogliptin 25 mg-pioglitazone 15 mg tablet*
- *alogliptin 25 mg-pioglitazone 30 mg tablet*
- *alogliptin 25 mg-pioglitazone 45 mg tablet*
- *alogliptin 6.25 mg tablet*
- **JANUMET 50 MG-1,000 MG TABLET**
- **JANUMET 50 MG-500 MG TABLET**
- **JANUMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE**
- **JANUMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE**
- **JANUMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE**
- **JANUVIA 100 MG TABLET**
- **JANUVIA 25 MG TABLET**
- **JANUVIA 50 MG TABLET**
- **JENTADUETO 2.5 MG-1,000 MG TABLET**
- **JENTADUETO 2.5 MG-500 MG TABLET**
- **JENTADUETO XR 2.5 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **JENTADUETO XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **TRADJENTA 5 MG TABLET**
- **ZITUVIMET 50 MG-1,000 MG TABLET**
- **ZITUVIMET 50 MG-500 MG TABLET**
- **ZITUVIMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE**
- **ZITUVIMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE**
- **ZITUVIMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE**
- **ZITUVIO 100 MG TABLET**
- **ZITUVIO 25 MG TABLET**
- **ZITUVIO 50 MG TABLET**

Details

Criteria	Require a 1 month trial of saxagliptin, saxagliptin-metformin ER, sitagliptin, sitagliptin-metformin, or sitagliptin-metformin ER in the last 90 days.

DPP4-SGLT2 Combo

Products Affected

- *dapagliflozin 10 mg-saxagliptin 5 mg tablet*
- **STEGLUJAN 5 MG-100 MG TABLET**
- **STEGLUJAN 15 MG-100 MG TABLET**

Details

Criteria	Require a 1 month trial of Glyxambi and Trijardy XR (Step 1 drugs) in the last 180 days.

Dry Eye

Products Affected

- **CEQUA 0.09 % EYE DROPS IN A DROPPERETTE**
- **TRYPTYR 0.003 % EYE DROPS IN A DROPPERETTE**
- **TYRVAYA 0.03 MG/SPRAY NASAL SPRAY**
- **VEVYE 0.1 % EYE DROPS**

Details

Criteria	Require a 1 month trial of Xiidra and one of the following: Restasis or cyclosporine eye drop (i.e. generic Restasis), in the last 180 days

Dymista

Products Affected

- **DYMISTA 137 MCG-50 MCG/SPRAY NASAL SPRAY**

Details

Criteria	Require a 1 month trial of generic azelastine/fluticasone spray in the last 90 days

Edarbi

Products Affected

- **EDARBI 40 MG TABLET**
- **EDARBI 80 MG TABLET**

Details

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

Entresto Tablet

Products Affected

- **ENTRESTO 24 MG-26 MG TABLET**
- **ENTRESTO 49 MG-51 MG TABLET**
- **ENTRESTO 97 MG-103 MG TABLET**

Details

Criteria	Require a 1 month trial of generic sacubitril/valsartan tablets (Step 1 drug) in the last 90 days

Erythroid Stimulants

Products Affected

- **ARANESP 10 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 100 MCG/0.5 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 100 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 150 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 200 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 200 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 25 MCG/0.42 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 25 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 300 MCG/0.6 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 40 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 40 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 500 MCG/ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 60 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 60 MCG/ML (IN POLYSORBATE) INJECTION**
- **EPOGEN 10,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 2,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 20,000 UNIT/2 ML INJECTION SOLUTION**
- **EPOGEN 20,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 3,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 4,000 UNIT/ML INJECTION SOLUTION**
- **MIRCERA 100 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 120 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 150 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 200 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 30 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 50 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 75 MCG/0.3 ML INJECTION SYRINGE**

Details

Criteria	Require a 1 month trial of Procrit and Retacrit (Step 1 drugs) in the last 180 days

Fortamet

Products Affected

- *metformin er 1,000 mg tablet,extended release 24hr (osmotic)*
- *metformin er 500 mg tablet,extended release 24hr (osmotic)*

Details

Criteria	Require a 1 month trial of generic metformin IR tablets and generic metformin ER (i.e. generic Glucophage XR) tablets in the last 180 days

Glumetza

Products Affected

- *metformin er 1,000 mg 24 hr tablet,extended release (gastric reten.)*
- *metformin er 500 mg 24 hr tablet,extended release (gastric retention)*

Details

Criteria	Require a 1 month trial of generic metformin IR tablets and generic metformin ER (i.e. generic Glucophage XR) tablets in the last 180 days

Herpetic Keratitis

Products Affected

- **ZIRGAN 0.15 % EYE GEL**

Details

Criteria	Require a 1 month trial of generic trifluridine eye drops (Step 1 drug) in the last 90 days when utilized for the same medically accepted indication and age

Inhaled LAMA

Products Affected

- **INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION**
- **SPIRIVA WITH HANDIHALER 18 MCG AND INHALATION CAPSULES**
- *tiotropium bromide 18 mcg capsule with inhalation device*
- **TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED**
- **TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED (30 ACTUAT)**
- *umeclidinium 62.5 mcg/actuation blister powder for inhalation*

Details

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

Inhaled LAMA/LABA

Products Affected

- *umeclidinium 62.5 mcg-vilanterol 25 mcg/actuation powdr for inhalation*

Details

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

Lactulose

Products Affected

- **KRISTALOSE 10 GRAM ORAL PACKET**
- **KRISTALOSE 20 GRAM ORAL PACKET**
- *lactulose 10 gram oral packet*
- *lactulose 20 gram oral packet*

Details

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

Metformin IR

Products Affected

- *metformin 625 mg tablet*
- *metformin 750 mg tablet*

Details

Criteria	Require a 1 month trial of generic metformin IR 500mg tablets, 850mg tablets, or 1000mg tablets (step 1 drug) in the last 90 days

Mirabegron ER

Products Affected

- *mirabegron er 25 mg tablet,extended release 24 hr*
- *mirabegron er 50 mg tablet,extended release 24 hr*

Details

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

Mirabegron ER Liquid

Products Affected

- *mirabegron er 8 mg/ml oral suspension,extended release*

Details

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

Mupirocin

Products Affected

- *mupirocin calcium 2 % topical cream*

Details

Criteria	Require a 1 month trial of generic mupirocin ointment (Step 1 drug) in the last 90 days

Pancreatic Enzymes

Products Affected

- **PANCREAZE 10,500 UNIT-35,500 UNIT-61,500 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 16,800 UNIT-56,800 UNIT-98,400 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 2,600 UNIT-8,800 UNIT-15,200 UNIT CAPSULE,DELAYED RELEASE**
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- **PANCREAZE 37,000-97,300-149,900 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 4,200 UNIT-14,200 UNIT-24,600 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 16,000 UNIT-57,500 UNIT-60,500 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 24,000-86,250-90,750 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 4,000 UNIT-14,375 UNIT-15,125 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 8,000 UNIT-28,750 UNIT-30,250 UNIT CAPSULE,DELAYED RELEASE**

Details

Criteria	Require a 1 month trial of Creon or Zenpep (Step 1 drug) in the last 90 days.

Pennsaid

Products Affected

- *diclofenac 20 mg/gram/actuation (2 %) topical soln metered-dose pump*

Details

Criteria	Require a 1 month trial of Diclofenac 1.5% (Step 1 drug) in the last 90 days

Premarin

Products Affected

- **PREMARIN 0.3 MG TABLET**
- **PREMARIN 0.45 MG TABLET**
- **PREMARIN 0.625 MG TABLET**
- **PREMARIN 0.9 MG TABLET**
- **PREMARIN 1.25 MG TABLET**

Details

Criteria	Require a 1 month trial of generic conjugated estrogens tablets in the last 90 days.

Prostaglandins

Products Affected

- **IYUZEH (PF) 0.005 % EYE DROPS IN A DROPPERETTE**
- **VYZULTA 0.024 % EYE DROPS**
- **ZIOPTAN (PF) 0.0015 % EYE DROPS IN A DROPPERETTE**
- **ZOLYMBUS 0.01 % EYE GEL IN A DROPPERETTE**

Details

Criteria	Require a 1 month trial of brand Lumigan (Step 1 drug) plus one other preferred generic glaucoma drug (Step 1 drug) in the last 180 days.

Pulmonary Antiinflammatory

Products Affected

- *beclomethasone dipropionate 40 mcg/actuation aerosol inhaler*
- *beclomethasone dipropionate 80 mcg/actuation aerosol inhaler*
- *fluticasone propionate 100 mcg/actuation blister powder for inhalation*
- *fluticasone propionate 110 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 220 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 250 mcg/actuation blister powder for inhalation*
- *fluticasone propionate 44 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 50 mcg/actuation blister powder for inhalation*

Details

Criteria	Require a 1 month trial of Qvar and Asmanex/Asmanex HFA (Step 1 drugs) in the last 180 days

Pulmonary Antiinflammatory Combo

Products Affected

- **ADVAIR DISKUS 100 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- **ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- **ADVAIR DISKUS 500 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- **BREYNA 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER**
- **BREYNA 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER**
- *fluticasone 100 mcg-salmeterol 50 mcg/dose blistr powdr for inhalation*
- *fluticasone 113 mcg-salmeterol 14 mcg/actuation breath activated powdr*
- *fluticasone 232 mcg-salmeterol 14 mcg/actuation breath activated powdr*
- *fluticasone 250 mcg-salmeterol 50 mcg/dose blistr powdr for inhalation*
- *fluticasone 500 mcg-salmeterol 50 mcg/dose blistr powdr for inhalation*
- *fluticasone 55 mcg-salmeterol 14 mcg/actuation breath activated powder*
- **SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER**
- **SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER**
- **WIXELA INHUB 100 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- **WIXELA INHUB 250 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- **WIXELA INHUB 500 MCG-50 MCG/DOSE POWDER FOR INHALATION**

Details

Criteria	Pending CMS Review

Rapid Acting Insulin

Products Affected

- **AFREZZA (REGULAR INSULIN) 8 UNIT (90)/12 UNIT (90) CARTRIDGE,INHALER**
- **AFREZZA 12 UNIT CARTRIDGE WITH INHALER**
- **AFREZZA 4 UNIT (60)/8 UNIT (60)/12 UNIT (60) CARTRIDGE WITH INHALER**
- **AFREZZA 4 UNIT (90)/8 UNIT (90) CARTRIDGE WITH INHALER**
- **AFREZZA 4 UNIT CARTRIDGE WITH INHALER**
- **AFREZZA 8 UNIT CARTRIDGE WITH INHALER**
- **MERILOG 100 UNIT/ML SUBCUTANEOUS SOLUTION**
- **MERILOG SOLOSTAR 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN**
- **NOVOLOG FLEXPEN U-100 INSULIN ASPART 100 UNIT/ML (3 ML) SUBCUTANEOUS**
- **NOVOLOG PENFILL U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS CARTRIDG**
- **NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS SOLUTION**

Details

Criteria	Require a 1 month trial of Humalog, insulin lispro, Fiasp, Novolog Mix, or Kirsty (Step 1 drug) in the last 90 days

Rho Kinase Inhibitors

Products Affected

- **RHOPRESSA 0.02 % EYE DROPS DROPS**
- **ROCKLATAN 0.02 %-0.005 % EYE**

Details

Criteria	Require a 1 month trial of one preferred glaucoma drug (Step 1 drug) in the last 120 days

Riomet

Products Affected

- *metformin 500 mg/5 ml oral solution*

Details

Criteria	Pending CMS Review

Ryaltris

Products Affected

- **RYALTRIS 665 MCG-25 MCG/SPRAY NASAL SPRAY**

Details

Criteria	Require a 1 month trial of generic fluticasone spray in the last 90 days

SGLT2 Agents

Products Affected

- *dapagliflozin 10 mg-metformin er 1,000 mg tablet,ext rel 24hr*
- *dapagliflozin 10 mg-metformin er 500 mg tablet, ext rel 24hr*
- *dapagliflozin 5 mg-metformin er 1,000 mg tablet, ext rel 24hr*
- *dapagliflozin 5 mg-metformin er 500 mg tablet,ext rel 24hr*
- **FARXIGA 10 MG TABLET**
- **FARXIGA 5 MG TABLET**
- **INPEFA 200 MG TABLET**
- **INPEFA 400 MG TABLET**
- **INVOKAMET 150 MG-1,000 MG TABLET**
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- **INVOKANA 100 MG TABLET**
- **INVOKANA 300 MG TABLET**
- **JARDIANCE 10 MG TABLET**
- **JARDIANCE 25 MG TABLET**
- **SEGLUROMET 2.5 MG-1,000 MG TABLET**
- **SEGLUROMET 2.5 MG-500 MG TABLET**
- **SEGLUROMET 7.5 MG-1,000 MG TABLET**
- **SEGLUROMET 7.5 MG-500 MG TABLET**
- **STEGLATRO 15 MG TABLET**
- **STEGLATRO 5 MG TABLET**

Details

Criteria	Pending CMS Review

Sleeper Meds

Products Affected

- **BELSOMRA 10 MG TABLET**
- **BELSOMRA 15 MG TABLET**
- **BELSOMRA 20 MG TABLET**
- **BELSOMRA 5 MG TABLET**
- **DAYVIGO 10 MG TABLET**
- **DAYVIGO 5 MG TABLET**
- **QUVIVIQ 25 MG TABLET**
- **QUVIVIQ 50 MG TABLET**

Details

Criteria	Pending CMS Review

Soaanz

Products Affected

- **SOAANZ 40 MG TABLET**

Details

Criteria	Require a 1 month trial of generic furosemide tablets and generic torsemide tablets in the last 180 days

Suboxone

Products Affected

- **SUBOXONE 12 MG-3 MG SUBLINGUAL FILM**
- **SUBOXONE 2 MG-0.5 MG SUBLINGUAL FILM**
- **SUBOXONE 4 MG-1 MG SUBLINGUAL FILM**
- **SUBOXONE 8 MG-2 MG SUBLINGUAL FILM**

Details

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

Topical Antifungals

Products Affected

- *econazole nitrate 1 % topical foam*
- **ERTACZO 2 % TOPICAL CREAM**
- **EXELDERM 1 % TOPICAL CREAM**
- **KETODAN 2 % TOPICAL FOAM**
- *naftifine 1 % topical cream*
- *naftifine 2 % topical cream*
- *naftifine 2 % topical gel*
- **NAFTIN 2 % TOPICAL GEL**
- *oxiconazole 1 % topical cream*

Details

Criteria	Require a 1 month trial of generic econazole cream and one of the following: generic ketoconazole cream or ketoconazole shampoo (Step 1 drugs),when being utilized for the same medically accepted indication, in the last 180 days

Topical Psoriasis

Products Affected

- *calcipotriene 0.005 % topical foam*
- *calcipotriene-betamethasone 0.005 %-0.064 % topical ointment*
- *calcipotriene-betamethasone 0.005 %-0.064 % topical suspension*
- *calcitriol 3 mcg/gram topical ointment*
- **ENSTILAR 0.005 %-0.064 % TOPICAL FOAM**
- **SORILUX 0.005 % TOPICAL FOAM**
- **TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION**
- **VECTICAL 3 MCG/GRAM TOPICAL OINTMENT**

Details

Criteria	Require a 1 month trial of generic calcipotriene cream, ointment or solution (Step 1 drug) in the last 90 days when utilized for the same medically accepted indication and age

Topical Rosacea

Products Affected

- *azelaic acid 15 % topical gel*
- *brimonidine 0.33 % topical gel with pump*
- **EPSOLAY 5 % TOPICAL CREAM**
- **FINACEA 15 % TOPICAL FOAM**
- *ivermectin 1 % topical cream*
- **MIRVASO 0.33 % TOPICAL GEL**
- **NORITATE 1 % TOPICAL CREAM**
- *oxymetazoline 1 % topical cream*
- **RHOFADE 1 % TOPICAL CREAM**
- **SOOLANTRA 1 % TOPICAL CREAM**
- **ZILXI 1.5 % TOPICAL FOAM**

Details

Criteria	Require a 1 month trial of generic metronidazole cream, lotion, or gel (Step 1 drug) in the last 90 days.

Ursodiol

Products Affected

- **RELTONE 200 MG CAPSULE**
- **RELTONE 400 MG CAPSULE**
- *ursodiol 200 mg capsule*
- *ursodiol 400 mg capsule*
- **URSOLIGN 150 MG CAPSULE**

Details

Criteria	Require a 1 month trial of generic ursodiol 250mg tablet, 300mg capsule or 500mg tablet (step 1 drug) in the last 90 days

Vabrinty

Products Affected

- **VABRINTY (4 MONTH) 30 MG SUBCUTANEOUS SYRINGE**
- **VABRINTY 22.5 MG (3 MONTH) SUBCUTANEOUS SYRINGE**
- **VABRINTY 45 MG (6 MONTH) SUBCUTANEOUS SYRINGE**
- **VABRINTY 7.5 MG (1 MONTH) SUBCUTANEOUS SYRINGE**

Details

Criteria	Pending CMS Review

Vyscoxa

Products Affected

- **VYSCOXA 10 MG/ML ORAL SUSPENSION**

Details

Criteria	Require a 1 month trial of 2 generic NSAIDs (Step 1 drug) in the last 180 days

Xarelto

Products Affected

- **XARELTO 1 MG/ML ORAL SUSPENSION**
- **XARELTO 10 MG TABLET**
- **XARELTO 15 MG TABLET**
- **XARELTO 2.5 MG TABLET**
- **XARELTO 20 MG TABLET**
- **XARELTO DVT-PE TREATMENT 30-DAY STARTER 15 MG(42)-20 MG(9) TABLET PACK**

Details

Criteria	Require a 1 month trial of Eliquis (Step 1 drug) in the last 90 days when being utilized for the same medically accepted indication and age

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GRANIX 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE..... 12
GRANIX 300 MCG/ML SUBCUTANEOUS SOLUTION..... 12
GRANIX 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE..... 12
INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION.....23
INPEFA 200 MG TABLET..... 40
INPEFA 400 MG TABLET..... 40
INVOKAMET 150 MG-1,000 MG TABLET.....40
INVOKAMET 150 MG-500 MG TABLET.....40
INVOKAMET 50 MG-1,000 MG TABLET.....40
INVOKAMET 50 MG-500 MG TABLET.....40
INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE.....40
INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE.....40
INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE.....40
INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE.....40
INVOKANA 100 MG TABLET.....40
INVOKANA 300 MG TABLET.....40
ivermectin 1 % topical cream.....46
IYUZEH (PF) 0.005 % EYE DROPS IN A DROPPERETTE..... 33
JANUMET 50 MG-1,000 MG TABLET.. 13
JANUMET 50 MG-500 MG TABLET..... 13
JANUMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE..... 13
JANUMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE..... 13
JANUMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE..... 13
JANUVIA 100 MG TABLET..... 13
JANUVIA 25 MG TABLET..... 13
JANUVIA 50 MG TABLET..... 13
JARDIANCE 10 MG TABLET..... 40

JARDIANCE 25 MG TABLET 40
JENTADUETO 2.5 MG-1,000 MG TABLET 13
JENTADUETO 2.5 MG-500 MG TABLET 13
JENTADUETO XR 2.5 MG-1,000 MG TABLET, EXTENDED RELEASE 13
JENTADUETO XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE 13
JORNAY PM 100 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE 2
JORNAY PM 20 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE 2
JORNAY PM 40 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE 2
JORNAY PM 60 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE 2
JORNAY PM 80 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE 2
KETODAN 2 % TOPICAL FOAM 44
KRISTALOSE 10 GRAM ORAL PACKET 25
KRISTALOSE 20 GRAM ORAL PACKET 25
lactulose 10 gram oral packet 25
lactulose 20 gram oral packet 25
lisdexamfetamine 10 mg capsule 2
lisdexamfetamine 10 mg chewable tablet 2
lisdexamfetamine 20 mg capsule 2
lisdexamfetamine 20 mg chewable tablet 2
lisdexamfetamine 30 mg capsule 2
lisdexamfetamine 30 mg chewable tablet 2
lisdexamfetamine 40 mg capsule 2
lisdexamfetamine 40 mg chewable tablet 2
lisdexamfetamine 50 mg capsule 2
lisdexamfetamine 50 mg chewable tablet 2
lisdexamfetamine 60 mg capsule 2
lisdexamfetamine 60 mg chewable tablet 2
lisdexamfetamine 70 mg capsule 2
MERILOG 100 UNIT/ML SUBCUTANEOUS SOLUTION 36
MERILOG SOLOSTAR 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN 36
METADATE CD 10 MG CAPSULE,EXTENDED RELEASE 2
METADATE CD 20 MG CAPSULE,EXTENDED RELEASE 2
METADATE CD 30 MG CAPSULE,EXTENDED RELEASE 2
METADATE CD 40 MG CAPSULE,EXTENDED RELEASE 2
METADATE CD 50 MG CAPSULE,EXTENDED RELEASE 2
METADATE CD 60 MG CAPSULE,EXTENDED RELEASE 2
metformin 500 mg/5 ml oral solution 38
metformin 625 mg tablet 26
metformin 750 mg tablet 26
metformin er 1,000 mg 24 hr tablet,extended release (gastric reten.) 21
metformin er 1,000 mg tablet,extended release 24hr (osmotic) 20
metformin er 500 mg 24 hr tablet,extended release (gastric retention) 21
metformin er 500 mg tablet,extended release 24hr (osmotic) 20
METHYLIN 10 MG/5 ML ORAL SOLUTION 2
METHYLIN 5 MG/5 ML ORAL SOLUTION 2
methylphenidate 17.3 mg er,ir disintegrating 24 hr tablet 2
methylphenidate 25.9 mg er,ir disintegrating 24 hr tablet 2
methylphenidate 8.6 mg er,ir disintegrating 24 hr tablet 2
methylphenidate er 10 mg capsule,extended release (40-60) sprinkle 2
methylphenidate er 15 mg capsule,extended release (40-60) sprinkle 2

methylphenidate er 20 mg capsule,extended release (40-60) sprinkle 2
methylphenidate er 30 mg capsule,extended release (40-60) sprinkle 2
methylphenidate er 40 mg capsule,extended release (40-60) sprinkle 2
methylphenidate er 50 mg capsule,extended release (40-60) sprinkle 2
methylphenidate er 60 mg capsule,extended release (40-60) sprinkle 2
mirabegron er 25 mg tablet,extended release 24 hr 27
mirabegron er 50 mg tablet,extended release 24 hr 27
mirabegron er 8 mg/ml oral suspension,extended release 28
MIRCERA 100 MCG/0.3 ML INJECTION SYRINGE 19
MIRCERA 120 MCG/0.3 ML INJECTION SYRINGE 19
MIRCERA 150 MCG/0.3 ML INJECTION SYRINGE 19
MIRCERA 200 MCG/0.3 ML INJECTION SYRINGE 19
MIRCERA 30 MCG/0.3 ML INJECTION SYRINGE 19
MIRCERA 50 MCG/0.3 ML INJECTION SYRINGE 19
MIRCERA 75 MCG/0.3 ML INJECTION SYRINGE 19
MIRVASO 0.33 % TOPICAL GEL WITH PUMP 46
mupirocin calcium 2 % topical cream 29
MYDAYIS 12.5 MG CAPSULE EXTENDED RELEASE 24 HR 2
MYDAYIS 25 MG CAPSULE EXTENDED RELEASE 24 HR 2
MYDAYIS 37.5 MG CAPSULE EXTENDED RELEASE 24 HR 2
MYDAYIS 50 MG CAPSULE EXTENDED RELEASE 24 HR 2
naftifine 1 % topical cream 44
naftifine 2 % topical cream 44
naftifine 2 % topical gel 44
NAFTIN 2 % TOPICAL GEL 44
NEFFY 1 MG/SPRAY (0.1 ML) NASAL SPRAY 6
NEFFY 2 MG/SPRAY (0.1 ML) NASAL SPRAY 6
NEULASTA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE 12
NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE 12
NEUPOGEN 300 MCG/ML INJECTION SOLUTION 12
NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE 12
NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION 12
NEXICLON XR 0.17 MG TABLET,EXTENDED RELEASE 11
NORITATE 1 % TOPICAL CREAM 46
NOVOLOG FLEXPEN U-100 INSULIN ASPART 100 UNIT/ML (3 ML) SUBCUTANEOUS 36
NOVOLOG PENFILL U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS CARTRIDG 36
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS SOLUTION 36
NYVEPRIA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE 12
oxiconazole 1 % topical cream 44
oxymetazoline 1 % topical cream 46
PANCREAZE 10,500 UNIT-35,500 UNIT-61,500 UNIT CAPSULE,DELAYED RELEASE 30
PANCREAZE 16,800 UNIT-56,800 UNIT-98,400 UNIT CAPSULE,DELAYED RELEASE 30
PANCREAZE 2,600 UNIT-8,800 UNIT-15,200 UNIT CAPSULE,DELAYED RELEASE 30
PANCREAZE 21,000 UNIT-54,700 UNIT-83,900 UNIT CAPSULE,DELAYED RELEASE 30
PANCREAZE 37,000-97,300-149,900 UNIT CAPSULE,DELAYED RELEASE 30

PANCREAZE 4,200 UNIT-14,200 UNIT-24,600 UNIT CAPSULE,DELAYED RELEASE 30
PERTZYE 16,000 UNIT-57,500 UNIT-60,500 UNIT CAPSULE,DELAYED RELEASE 30
PERTZYE 24,000-86,250-90,750 UNIT CAPSULE,DELAYED RELEASE 30
PERTZYE 4,000 UNIT-14,375 UNIT-15,125 UNIT CAPSULE,DELAYED RELEASE 30
PERTZYE 8,000 UNIT-28,750 UNIT-30,250 UNIT CAPSULE,DELAYED RELEASE 30
PREMARIN 0.3 MG TABLET 32
PREMARIN 0.45 MG TABLET 32
PREMARIN 0.625 MG TABLET 32
PREMARIN 0.9 MG TABLET 32
PREMARIN 1.25 MG TABLET 32
PROAIR RESPICLICK 90 MCG/ACTUATION BREATH ACTIVATED 5
QUILLICHEW ER 20 MG CHEWABLE TABLET, EXTENDED RELEASE 2
QUILLICHEW ER 30 MG CHEWABLE TABLET, EXTENDED RELEASE 2
QUILLICHEW ER 40 MG CHEWABLE, EXTENDED RELEASE TABLET 2
QUILLIVANT XR 5 MG/ML (25 MG/5 ML) ORAL SUSPENSION,EXTEND RELEASE 24HR 2
QUVIVIQ 25 MG TABLET 41
QUVIVIQ 50 MG TABLET 41
RELEUKO 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE 12
RELEUKO 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE 12
RELEXXII 18 MG TABLET,EXTENDED RELEASE 2
RELEXXII 27 MG TABLET,EXTENDED RELEASE 2
RELEXXII 36 MG TABLET,EXTENDED RELEASE 2
RELEXXII 45 MG TABLET,EXTENDED RELEASE 2
RELEXXII 54 MG TABLET,EXTENDED RELEASE 2
RELEXXII 63 MG TABLET,EXTENDED RELEASE 2
RELEXXII 72 MG TABLET,EXTENDED RELEASE 2
RELTONE 200 MG CAPSULE 47
RELTONE 400 MG CAPSULE 47
RHOFADE 1 % TOPICAL CREAM 46
RHOPRESSA 0.02 % EYE DROPS 37
RITALIN 10 MG TABLET 2
RITALIN 20 MG TABLET 2
RITALIN 5 MG TABLET 2
ROCKLATAN 0.02 %-0.005 % EYE DROPS 37
ROLVEDON 13.2 MG/0.6 ML SUBCUTANEOUS SYRINGE 12
RYALTRIS 665 MCG-25 MCG/SPRAY NASAL SPRAY 39
RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE 9
RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE 9
RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE 9
RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE 9
SEGLUROMET 2.5 MG-1,000 MG TABLET 40
SEGLUROMET 2.5 MG-500 MG TABLET 40
SEGLUROMET 7.5 MG-1,000 MG TABLET 40
SEGLUROMET 7.5 MG-500 MG TABLET 40
SOAANZ 40 MG TABLET 42
SOOLANTRA 1 % TOPICAL CREAM . 46
SORILUX 0.005 % TOPICAL FOAM 45
SPIRIVA WITH HANDIHALER 18 MCG AND INHALATION CAPSULES ..23
STEGLATRO 15 MG TABLET 40
STEGLATRO 5 MG TABLET 40
STEGLUJAN 15 MG-100 MG TABLET . 14
STEGLUJAN 5 MG-100 MG TABLET ... 14

STIMUFEND 6 MG/0.6 ML SUBCUTANEOUS SYRINGE 12
SUBOXONE 12 MG-3 MG SUBLINGUAL FILM 43
SUBOXONE 2 MG-0.5 MG SUBLINGUAL FILM 43
SUBOXONE 4 MG-1 MG SUBLINGUAL FILM 43
SUBOXONE 8 MG-2 MG SUBLINGUAL FILM 43
SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER 35
SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER 35
TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION 45
tiotropium bromide 18 mcg capsule with inhalation device 23
TRADJENTA 5 MG TABLET 13
TRYPTYR 0.003 % EYE DROPS IN A DROPPERETTE 15
TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED 23
TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED (30 ACTUAT) 23
TYRVAYA 0.03 MG/SPRAY NASAL SPRAY 15
UDENYCA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE 12
UDENYCA AUTOINJECTOR 6 MG/0.6 ML SUBCUTANEOUS AUTO-INJECTOR 12
umeclidinium 62.5 mcg/actuation blister powder for inhalation 23
umeclidinium 62.5 mcg-vilanterol 25 mcg/actuation powdr for inhalation 24
ursodiol 200 mg capsule 47
ursodiol 400 mg capsule 47
URSOLIGN 150 MG CAPSULE 47
VABRINTY (4 MONTH) 30 MG SUBCUTANEOUS SYRINGE 48
VABRINTY 22.5 MG (3 MONTH) SUBCUTANEOUS SYRINGE 48
VABRINTY 45 MG (6 MONTH) SUBCUTANEOUS SYRINGE 48
VABRINTY 7.5 MG (1 MONTH) SUBCUTANEOUS SYRINGE 48
VECTICAL 3 MCG/GRAM TOPICAL OINTMENT 45
VEVYE 0.1 % EYE DROPS 15
VYSCOXA 10 MG/ML ORAL SUSPENSION 49
VYVANSE 10 MG CAPSULE 2
VYVANSE 10 MG CHEWABLE TABLET 2
VYVANSE 20 MG CAPSULE 2
VYVANSE 20 MG CHEWABLE TABLET 2
VYVANSE 30 MG CAPSULE 2
VYVANSE 30 MG CHEWABLE TABLET 2
VYVANSE 40 MG CAPSULE 2
VYVANSE 40 MG CHEWABLE TABLET 2
VYVANSE 50 MG CAPSULE 2
VYVANSE 50 MG CHEWABLE TABLET 2
VYVANSE 60 MG CAPSULE 2
VYVANSE 60 MG CHEWABLE TABLET 2
VYVANSE 70 MG CAPSULE 2
VYZULTA 0.024 % EYE DROPS 33
WIXELA INHUB 100 MCG-50 MCG/DOSE POWDER FOR INHALATION 35
WIXELA INHUB 250 MCG-50 MCG/DOSE POWDER FOR INHALATION 35
WIXELA INHUB 500 MCG-50 MCG/DOSE POWDER FOR INHALATION 35
XARELTO 1 MG/ML ORAL SUSPENSION 50
XARELTO 10 MG TABLET 50
XARELTO 15 MG TABLET 50
XARELTO 2.5 MG TABLET 50
XARELTO 20 MG TABLET 50

XARELTO DVT-PE TREATMENT 30-DAY STARTER 15 MG(42)-20 MG(9) TABLET PACK.....50
XELSTRYM 13.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH.....2
XELSTRYM 18 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH.....2
XELSTRYM 4.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH.....2
XELSTRYM 9 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH.....2
XOPENEX HFA 45 MCG/ACTUATION AEROSOL INHALER..... 7
ZIEXTENZO 6 MG/0.6 ML SUBCUTANEOUS SYRINGE.....12
ZILXI 1.5 % TOPICAL FOAM..... 46
ZIOPTAN (PF) 0.0015 % EYE DROPS IN A DROPPERETTE.....33
ZIRGAN 0.15 % EYE GEL..... 22
ZITUVIMET 50 MG-1,000 MG TABLET.....13
ZITUVIMET 50 MG-500 MG TABLET. 13
ZITUVIMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE.....13
ZITUVIMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE.....13
ZITUVIMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE.....13
ZITUVIO 100 MG TABLET.....13
ZITUVIO 25 MG TABLET.....13
ZITUVIO 50 MG TABLET.....13
ZOLYMBUS 0.01 % EYE GEL IN A DROPPERETTE.....33