2021 Incentive Formulary:

This Incentive Formulary applies to members of an employer/retiree, union, or trust fund health plan

For Medicare Part D: 5 Tier Incentive Formulary

Please click here.

For Medicare Part D: Prior Authorization Criteria

Please click here.

For Medicare Part D: Step Therapy Criteria

Please click here.

For more recent information or other questions, please contact:

Freedom Blue PPO (PA) Customer Service at 1-800-550-8722
Freedom Blue PPO (WV) Customer Service at 1-888-459-4020
Security Blue HMO-POS Customer Service at 1-800-935-2583
Community Blue Medicare HMO Customer Service at 1-888-234-5397
Community Blue Medicare PPO Customer Service at 1-888-757-2946
Community Blue Medicare Plus PPO Customer Service at 1-888-757-2946
Blue Rx PDP Customer Service at 1-800-290-3914

For TTY users, *711 National Relay Service*, Monday through Sunday, 8 a.m. to 8 p.m.

Formulary ID: 21100 Version: 21

Updated: 12/1/2021

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

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

When it refers to "plan" or "our plan," it means Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, Complete Blue PPO, or Blue Rx PDP.

This document includes a list of the drugs (formulary) for our plan which is current as of December 1, 2021. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the cover page.

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, and from time to time during the year.

What is our Plan's Formulary?

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

Can the Formulary (drug list) change?

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

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.

    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to my plan's Formulary?"

- **Drugs removed from the market.** If the Food and DrugAdministration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market toreplace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refillof the drug, at which time the member will receive a 31-day supply of the drug.

    - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to my plan's Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2021 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2021 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of December 1, 2021. To get updated information about the drugs covered by our plans, please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, members will be notified by mail and prospective members will receive an update with this formulary. The most up-to-date formulary is available on our website, www.highmarkblueshield.com/medicare.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 7. 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 7. 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 at the end

of this document. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Our plans require you or your physicianto get prior authorization for certain drugs. This means that you will need to get approval from our plans before you fill your prescriptions. If you don't get approval, our plans may not cover the drug.

- **Quantity Limits:** For certain drugs, our plans limit the amount of the drug that our plans will cover. For example, our plans provide 9 tablets per prescription for 100mg Imitrex. This may be in addition to a standard one-month or three- month supply.

- **Step Therapy:** In some cases, our plans require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plans may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plans will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 7. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. We have posted online document(s) that explain(s) our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the cover page.

You can ask our plans to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to my plan's Formulary?" on page 5 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 Customer Service and ask if your drug is covered.

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

- You can ask Customer Service for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask him or her 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 my plan'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 cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our 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.

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

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

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

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

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

If you are a resident of a long-term care facility and you need a drug that is not on our plan's 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 cover page.

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.

Your Plan's Formulary

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

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., ABELCET) and generic drugs are listed in 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	**Incentive Drug Tier**	**Requirements/ Limits**
Anti - Infectives		
XYZ DRUG	NF	QL- 28

Table of Contents

List of Abbreviations

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

T2: Cost-Sharing Tier 2 includes generic drugs.

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

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

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

LA: Limited access

PA: Prior authorization required

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

PA-NS: Prior authorization required for new starts only

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

ST: Step therapy applies

ST-NS: Step therapy applies to new starts only

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

List of Patterns

lowercase italics: Generic drugs

UPPERCASE BOLD: Brand name drugs

Drug Name	Drug Tier	Requirements/Limits
Anti - Infectives		
abacavir	T3	
abacavir-lamivudine	T4	
abacavir-lamivudine-zidovudine	T5	
ABELCET	T4	PA-BvD
ACTICLATE	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	
AEMCOLO	T4	QL (12 EA per 3 days)
albendazole	T4	
ALBENZA	T4	
amantadine hcl oral capsule	T2	QL (124 EA per 31 days)
amantadine hcl oral solution	T2	
amantadine hcl oral tablet	T2	
AMBISOME	T4	PA-BvD
amikacin injection solution 500 mg/2 ml	T2	
amoxicillin oral capsule	T1	
amoxicillin oral suspension for reconstitution	T1	
amoxicillin oral tablet	T1	
amoxicillin oral tablet,chewable 125 mg, 250 mg	T1	
amoxicillin-pot clavulanate	T2	
amphotericin b	T4	PA-BvD
ampicillin oral capsule 500 mg	T2	
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg	T2	
ampicillin-sulbactam injection	T2	
ANCOBON	T4	
APTIVUS	T5	
ARIKAYCE	T5	PA
atazanavir	T4	
atovaquone	T5	
atovaquone-proguanil	T2	
ATRIPLA	T5	
AVYCAZ	T5	
AZACTAM	T4	

Drug Name	Drug Tier	Requirements/Limits
azithromycin	T2	
aztreonam injection recon soln 1 gram	T2	
BACTRIM	T4	
BACTRIM DS	T4	
BARACLUDE ORAL SOLUTION	T3	
BARACLUDE ORAL TABLET	T5	
BAXDELA INTRAVENOUS	T4	
BAXDELA ORAL	T5	
benznidazole	T4	PA
BETHKIS	T4	PA
BICILLIN C-R	T3	
BICILLIN L-A	T3	
BIKTARVY	T5	QL (31 EA per 31 days)
BILTRICIDE	T4	
CANCIDAS	T5	
caspofungin intravenous recon soln 50 mg	T5	
caspofungin intravenous recon soln 70 mg	T4	
CAYSTON	T5	
cefaclor oral capsule	T2	
cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml	T2	
cefaclor oral tablet extended release 12 hr	T2	
cefadroxil oral capsule	T2	
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	T2	
cefadroxil oral tablet	T2	
cefazolin injection recon soln 1 gram, 10 gram, 500 mg	T2	
cefdinir	T2	
cefepime injection	T2	
cefixime	T2	
cefotetan injection	T2	
cefoxitin	T2	
cefpodoxime	T2	
cefprozil	T2	
ceftazidime	T2	
ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg	T2	
cefuroxime axetil oral tablet	T2	

Drug Name	Drug Tier	Requirements/Limits
cefuroxime sodium injection recon soln 750 mg	T2	
cefuroxime sodium intravenous recon soln 1.5 gram	T2	
cephalexin	T2	
chloroquine phosphate oral tablet 250 mg	T2	PA; QL (50 EA per 30 days)
chloroquine phosphate oral tablet 500 mg	T2	PA; QL (25 EA per 30 days)
CIMDUO	T5	QL (31 EA per 31 days)
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON	T3	
CIPRO ORAL TABLET 250 MG, 500 MG	T4	
ciprofloxacin hcl oral	T1	
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	T2	
clarithromycin	T2	
CLEOCIN HCL	T4	
CLEOCIN INJECTION	T4	
CLEOCIN PEDIATRIC	T4	
clindamycin hcl	T2	
clindamycin in 5 % dextrose	T2	
CLINDAMYCIN PEDIATRIC	T2	
clindamycin phosphate injection	T2	
clindamycin phosphate intravenous solution 600 mg/4 ml	T2	
clotrimazole mucous membrane	T2	
COARTEM	T4	
colistin (colistimethate na)	T4	
COMBIVIR	T5	
COMPLERA	T5	
CRESEMBA ORAL	T5	
CUBICIN	T5	
DALVANCE	T5	
dapsone oral	T3	
daptomycin	T5	
DARAPRIM	T5	PA
DELSTRIGO	T5	QL (31 EA per 31 days)
demeclocycline	T2	
DESCOVY	T5	QL (31 EA per 31 days)
dicloxacillin	T2	

Drug Name	Drug Tier	Requirements/Limits
DIFICID ORAL SUSPENSION FOR RECONSTITUTION	T5	QL (136 ML per 12 days)
DIFICID ORAL TABLET	T5	QL (20 EA per 10 days)
DIFLUCAN	T4	
DORYX MPC	T4	
DORYX ORAL TABLET,DELAYED RELEASE (DR/EC) 200 MG, 50 MG	T4	
DOVATO	T5	QL (31 EA per 31 days)
DOXY-100	T2	
doxycycline hyclate oral capsule	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, 200 mg, 50 mg	T2	
doxycycline hyclate oral tablet,delayed release (dr/ec) 150 mg, 75 mg	T1	
doxycycline hyclate oral tablet,delayed release (dr/ec) 80 mg	T4	
doxycycline monohydrate oral capsule 100 mg, 50 mg	T2	
doxycycline monohydrate oral capsule 150 mg, 75 mg	T4	
doxycycline monohydrate oral suspension for reconstitution	T2	
doxycycline monohydrate oral tablet	T2	
E.E.S. 400 ORAL TABLET	T2	
E.E.S. GRANULES	T4	
EDURANT	T5	
efavirenz	T3	
efavirenz-emtricitabin-tenofov	T5	
efavirenz-lamivu-tenofov disop	T5	QL (31 EA per 31 days)
emtricitabine	T3	
emtricitabine-tenofovir (tdf)	T5	
EMTRIVA ORAL CAPSULE	T4	
EMTRIVA ORAL SOLUTION	T3	
EMVERM	T4	
entecavir	T4	
EPCLUSA ORAL TABLET	T5	PA; QL (28 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
EPIVIR	T4	
EPIVIR HBV ORAL SOLUTION	T3	
EPIVIR HBV ORAL TABLET	T4	
EPZICOM	T5	
ERAXIS(WATER DILUENT)	T4	
ertapenem	T4	
ERYPED 200	T4	
ERYPED 400	T4	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 333 MG	T2	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 500 MG	T3	
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	T2	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	T3	
erythromycin ethylsuccinate oral suspension for reconstitution	T2	
erythromycin ethylsuccinate oral tablet	T2	
erythromycin oral	T2	
ethambutol	T2	
etravirine	T5	
EVOTAZ	T3	
famciclovir	T2	
FIRVANQ	T4	
FLAGYL ORAL CAPSULE	T4	
fluconazole	T2	
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml	T2	
flucytosine	T4	
fosamprenavir	T3	
fosfomycin tromethamine	T4	
FUZEON SUBCUTANEOUS RECON SOLN	T5	
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml	T2	
gentamicin injection solution 40 mg/ml	T1	
GENVOYA	T5	
griseofulvin microsize	T2	
griseofulvin ultramicrosize	T2	

Drug Name	Drug Tier	Requirements/Limits
HARVONI ORAL PELLETS IN PACKET	T5	PA; QL (28 EA per 28 days)
HARVONI ORAL TABLET 90-400 MG	T5	PA; QL (28 EA per 28 days)
HEPSERA	T5	
HIPREX	T4	
HUMATIN	T4	
hydroxychloroquine oral tablet 200 mg	T2	QL (93 EA per 31 days)
imipenem-cilastatin	T2	
IMPAVIDO	T5	
INTELENCE ORAL TABLET 100 MG, 200 MG	T5	
INTELENCE ORAL TABLET 25 MG	T4	
INVANZ INJECTION	T4	
INVIRASE ORAL TABLET	T4	
ISENTRESS	T3	
ISENTRESS HD	T3	
isoniazid oral solution	T2	
isoniazid oral tablet	T1	
itraconazole oral capsule	T2	PA
itraconazole oral solution	T4	PA
ivermectin oral	T2	
JULUCA	T5	
KALETRA ORAL SOLUTION	T5	
KALETRA ORAL TABLET 100-25 MG	T3	
KALETRA ORAL TABLET 200-50 MG	T5	
ketoconazole oral	T2	
KRINTAFEL	T4	
lamivudine	T2	
lamivudine-zidovudine	T2	
LAMPIT	T4	PA
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 intravenous	T2	
levofloxacin oral	T2	
LEXIVA ORAL SUSPENSION	T3	
LEXIVA ORAL TABLET	T5	
linezolid in dextrose 5%	T4	
linezolid oral suspension for reconstitution	T5	
linezolid oral tablet	T4	

Drug Name	Drug Tier	Requirements/Limits
lopinavir-ritonavir oral solution	T5	
lopinavir-ritonavir oral tablet 100-25 mg	T3	
lopinavir-ritonavir oral tablet 200-50 mg	T5	
MACROBID	T4	QL (90 EA per 365 days)
MACRODANTIN ORAL CAPSULE 100 MG	T4	QL (90 EA per 365 days)
MACRODANTIN ORAL CAPSULE 25 MG	T4	QL (360 EA per 365 days)
MACRODANTIN ORAL CAPSULE 50 MG	T4	QL (180 EA per 365 days)
MALARONE	T4	
MALARONE PEDIATRIC	T4	
MAVYRET ORAL TABLET	T5	PA; QL (84 EA per 28 days)
mefloquine	T2	
MEPRON	T5	
meropenem	T2	
methenamine hippurate	T2	
metronidazole in nacl (iso-os)	T2	
metronidazole oral capsule	T2	
metronidazole oral tablet	T1	
micafungin	T5	
minocycline oral capsule	T2	
minocycline oral tablet	T2	
minocycline oral tablet extended release 24 hr	T2	
MINOLIRA ER	T4	
MONDOXYNE NL ORAL CAPSULE 100 MG, 75 MG	T2	
MONUROL	T4	
moxifloxacin oral	T3	
moxifloxacin-sod.chloride(iso)	T4	
MYAMBUTOL ORAL TABLET 400 MG	T4	
MYCAMINE	T5	
MYCOBUTIN	T4	
nafcillin injection	T2	
NEBUPENT	T4	PA-BvD
neomycin	T2	
nevirapine	T2	
nitazoxanide	T4	
nitrofurantoin	T2	QL (1800 ML per 365 days)
nitrofurantoin macrocrystal oral capsule 100 mg	T2	QL (90 EA per 365 days)
nitrofurantoin macrocrystal oral capsule 25 mg	T2	QL (360 EA per 365 days)

Drug Name	Drug Tier	Requirements/Limits
nitrofurantoin macrocrystal oral capsule 50 mg	T2	QL (180 EA per 365 days)
nitrofurantoin monohyd/m-cryst	T2	QL (90 EA per 365 days)
NORVIR ORAL POWDER IN PACKET	T3	
NORVIR ORAL SOLUTION	T3	
NORVIR ORAL TABLET	T4	
NOXAFIL ORAL	T5	
NUZYRA	T5	
nystatin oral	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
ofloxacin oral tablet 300 mg, 400 mg	T2	
ORACEA	T4	
ORAVIG	T4	
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 in dextrose(iso-osm)	T2	
oxacillin injection	T2	
paromomycin	T2	
PASER	T4	
penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml	T4	
penicillin g potassium injection recon soln 20 million unit	T2	
penicillin g procaine intramuscular syringe 1.2 million unit/2 ml	T2	
penicillin g sodium	T2	
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	T2	
PLAQUENIL	T4	QL (93 EA per 31 days)
polymyxin b sulfate	T2	
posaconazole oral tablet,delayed release (dr/ec)	T4	
praziquantel	T4	
pretomanid	T4	PA; QL (31 EA per 31 days)
PREVYMIS ORAL	T4	

Drug Name	Drug Tier	Requirements/Limits
PREZCOBIX	T5	
PREZISTA ORAL SUSPENSION	T5	
PREZISTA ORAL TABLET 150 MG, 600 MG, 800 MG	T5	
PREZISTA ORAL TABLET 75 MG	T3	
PRIFTIN	T4	
primaquine	T3	
PRIMAXIN IV INTRAVENOUS RECON SOLN 500 MG	T4	
pyrazinamide	T2	
pyrimethamine	T5	PA
QUALAQUIN	T4	PA
quinine sulfate	T2	PA; QL (42 EA per 28 days)
RELENZA DISKHALER	T3	
RETROVIR ORAL CAPSULE	T4	
RETROVIR ORAL SYRUP	T4	
REYATAZ ORAL CAPSULE 150 MG, 300 MG	T3	
REYATAZ ORAL CAPSULE 200 MG	T5	
REYATAZ ORAL POWDER IN PACKET	T4	
ribavirin oral capsule	T2	
ribavirin oral tablet 200 mg	T2	
rifabutin	T2	
rifampin	T2	
rimantadine	T2	
ritonavir	T3	
RUKOBIA	T5	QL (62 EA per 31 days)
SELZENTRY ORAL SOLUTION	T5	
SELZENTRY ORAL TABLET 150 MG, 300 MG, 75 MG	T5	
SELZENTRY ORAL TABLET 25 MG	T4	
SEYSARA	T4	
SIRTURO	T5	
SITAVIG	T4	
SIVEXTRO INTRAVENOUS	T5	
SIVEXTRO ORAL	T5	QL (6 EA per 31 days)
sofosbuvir-velpatasvir	T5	PA; QL (28 EA per 28 days)
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 55 MG, 65 MG, 80 MG	T4	

Drug Name	Drug Tier	Requirements/Limits
SOLOSEC	T4	
SOVALDI ORAL PELLETS IN PACKET	T5	PA; QL (28 EA per 28 days)
SOVALDI ORAL TABLET 400 MG	T5	PA; QL (28 EA per 28 days)
SPORANOX	T5	PA
streptomycin	T3	
STRIBILD	T5	
STROMECTOL	T4	
sulfadiazine	T2	
sulfamethoxazole-trimethoprim oral	T1	
SUPRAX ORAL CAPSULE	T3	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML, 200 MG/5 ML	T4	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	T3	
SUPRAX ORAL TABLET,CHEWABLE	T3	
SUSTIVA ORAL CAPSULE	T3	
SUSTIVA ORAL TABLET	T5	
SYMFI	T5	QL (31 EA per 31 days)
SYMFI LO	T5	QL (31 EA per 31 days)
SYMTUZA	T5	QL (31 EA per 31 days)
TAMIFLU ORAL CAPSULE 30 MG	T3	QL (170 EA per 365 days)
TAMIFLU ORAL CAPSULE 45 MG, 75 MG	T3	QL (90 EA per 365 days)
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION	T3	QL (1080 ML per 365 days)
TARGADOX	T4	
TAZICEF INJECTION	T4	
TEFLARO	T5	
TEMIXYS	T5	QL (31 EA per 31 days)
tenofovir disoproxil fumarate	T3	
terbinafine hcl oral	T1	QL (90 EA per 180 days)
tetracycline	T2	
tigecycline	T5	
tinidazole	T2	
TIVICAY ORAL TABLET 10 MG	T4	
TIVICAY ORAL TABLET 25 MG, 50 MG	T5	
TIVICAY PD	T4	
TOBI	T4	PA

Drug Name	Drug Tier	Requirements/Limits
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	T3	PA; QL (224 EA per 56 days)
tobramycin in 0.225 % nacl	T5	PA
tobramycin inhalation	T4	PA
tobramycin sulfate injection solution	T1	
TOLSURA	T5	PA; QL (130 EA per 31 days)
TRECATOR	T4	
trimethoprim	T2	
TRIUMEQ	T5	
TRIZIVIR	T4	
TRUVADA	T5	
TYBOST	T3	
TYGACIL	T5	
UNASYN INJECTION RECON SOLN 15 GRAM, 3 GRAM	T4	
VABOMERE	T4	
valacyclovir	T2	
VALCYTE ORAL RECON SOLN	T4	
VALCYTE ORAL TABLET	T5	
valganciclovir	T3	
VALTREX	T4	
VANCOCIN ORAL CAPSULE 125 MG	T5	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 intravenous recon soln 250 mg	T4	
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	T4	QL (31 EA per 31 days)
VFEND	T5	
VFEND IV	T4	PA
VIBRAMYCIN ORAL CAPSULE 100 MG	T4	
VIBRAMYCIN ORAL SUSPENSION FOR RECONSTITUTION	T4	
VIBRAMYCIN ORAL SYRUP	T4	
VIEKIRA PAK	T5	PA; QL (112 EA per 28 days)
VIRACEPT ORAL TABLET	T5	
VIRAMUNE ORAL SUSPENSION	T4	

Drug Name	Drug Tier	Requirements/Limits
VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HR 400 MG	T4	
VIREAD ORAL POWDER	T3	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	T3	
VIREAD ORAL TABLET 300 MG	T5	
voriconazole intravenous	T5	PA
voriconazole oral suspension for reconstitution	T5	
voriconazole oral tablet	T4	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XENLETA ORAL	T5	
XIFAXAN ORAL TABLET 200 MG	T4	QL (9 EA per 3 days)
XIFAXAN ORAL TABLET 550 MG	T5	PA; QL (62 EA per 31 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	T3	QL (9 EA per 365 days)
ZEMDRI	T5	
ZEPATIER	T5	PA; QL (28 EA per 28 days)
ZERBAXA	T5	
ZIAGEN ORAL SOLUTION	T3	
ZIAGEN ORAL TABLET	T4	
zidovudine	T2	
ZITHROMAX INTRAVENOUS	T4	
ZITHROMAX ORAL PACKET	T4	
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION	T4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG	T4	
ZITHROMAX TRI-PAK	T4	
ZITHROMAX Z-PAK	T4	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML, 3.375 GRAM/50 ML	T3	
ZOVIRAX ORAL SUSPENSION	T4	
ZYVOX INTRAVENOUS PIGGYBACK 600 MG/300 ML	T4	
ZYVOX ORAL	T5	
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)
AFINITOR	T5	PA-NS; QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 5 MG	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG	T5	PA-NS; QL (93 EA per 31 days)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	T5	PA-NS; QL (31 EA per 31 days)
ALUNBRIG ORAL TABLET 30 MG	T5	PA-NS; QL (186 EA per 31 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	T5	PA-NS; QL (30 EA per 365 days)
anastrozole	T2	
ARIMIDEX	T4	
AROMASIN	T5	
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG	T3	PA-BvD
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 5 MG	T5	PA-BvD
AYVAKIT	T5	PA-NS; QL (31 EA per 31 days)
AZASAN	T4	PA-BvD
azathioprine oral tablet 50 mg	T2	PA-BvD
BALVERSA	T5	PA-NS
bexarotene	T5	PA-NS
bicalutamide	T2	
BOSULIF	T5	PA-NS
BRAFTOVI ORAL CAPSULE 75 MG	T5	PA-NS; QL (186 EA per 31 days)
BRUKINSA	T5	PA-NS; QL (124 EA per 31 days)
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CALQUENCE	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA	T5	PA-NS
CASODEX	T4	
CELLCEPT ORAL CAPSULE	T4	PA-BvD
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION	T4	PA-BvD
CELLCEPT ORAL TABLET	T5	PA-BvD
COMETRIQ	T5	PA-NS
COPIKTRA	T5	PA-NS; QL (62 EA per 31 days)
COTELLIC	T5	PA-NS; LA
cyclophosphamide oral	T3	PA-BvD
cyclosporine modified	T2	PA-BvD
cyclosporine oral capsule	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
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	
ELIGARD (3 MONTH)	T4	
ELIGARD (4 MONTH)	T4	
ELIGARD (6 MONTH)	T4	
EMCYT	T3	
ENSPRYNG	T5	PA; QL (1 ML per 28 days)
ENVARSUS XR	T4	PA-BvD
ERIVEDGE	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA	T5	PA-NS; QL (124 EA per 31 days)
erlotinib	T5	PA-NS; QL (31 EA per 31 days)
everolimus (antineoplastic) oral tablet 2.5 mg, 7.5 mg	T5	PA-NS; QL (31 EA per 31 days)
everolimus (antineoplastic) oral tablet 5 mg	T5	PA-NS; QL (62 EA per 31 days)
everolimus (immunosuppressive)	T4	PA-BvD
exemestane	T2	
FARESTON	T4	
FARYDAK	T5	PA-NS
FEMARA	T5	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	T5	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	T4	
flutamide	T2	
FOTIVDA	T5	PA-NS; QL (21 EA per 28 days)
GAVRETO	T5	PA-NS; QL (124 EA per 31 days)
GENGRAF	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)
HYDREA	T4	
hydroxyurea	T2	
IBRANCE	T5	PA-NS; QL (21 EA per 28 days)
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG	T5	PA-NS; QL (31 EA per 31 days)
ICLUSIG ORAL TABLET 45 MG	T5	PA-NS; QL (62 EA per 31 days)
IDHIFA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
IDHIFA ORAL TABLET 50 MG	T5	PA-NS; QL (62 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 TABLET	T5	PA-NS; QL (31 EA per 31 days)
IMURAN	T4	PA-BvD
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
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	T5	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	T5	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	T5	PA-NS; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
KLISYRI	T4	PA
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)
lapatinib	T5	PA-NS
LENVIMA	T5	PA-NS
letrozole	T2	
leucovorin calcium oral	T2	
LEUKERAN	T4	
leuprolide subcutaneous kit	T2	
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	T5	PA-NS; QL (248 EA per 31 days)
LUPKYNIS	T5	PA; QL (186 EA per 31 days)
LUPRON DEPOT	T5	ST
LUPRON DEPOT (3 MONTH)	T5	ST

Drug Name	Drug Tier	Requirements/Limits
LUPRON DEPOT (4 MONTH)	T5	ST
LUPRON DEPOT (6 MONTH)	T5	ST
LYNPARZA	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T3	
MATULANE	T5	
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)	T2	PA
megestrol oral tablet	T2	PA-NS
MEKINIST	T5	PA-NS
MEKTOVI	T5	PA-NS; QL (186 EA per 31 days)
mercaptopurine	T2	
MESNEX ORAL	T3	
methotrexate sodium (pf) injection solution	T2	PA-BvD
methotrexate sodium injection	T2	PA-BvD
methotrexate sodium oral	T1	PA-BvD
MYCAPSSA	T5	PA; QL (124 EA per 31 days)
mycophenolate mofetil	T2	PA-BvD
mycophenolate sodium	T2	PA-BvD
MYFORTIC ORAL TABLET,DELAYED RELEASE (DR/EC) 180 MG	T3	PA-BvD
MYFORTIC ORAL TABLET,DELAYED RELEASE (DR/EC) 360 MG	T5	PA-BvD
NEORAL	T3	PA-BvD
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
NEXAVAR	T5	PA-NS; QL (124 EA per 31 days)
NILANDRON	T5	
nilutamide	T5	
NINLARO	T5	PA-NS
NUBEQA	T5	PA-NS; QL (124 EA per 31 days)
octreotide acetate injection solution 1,000 mcg/ml, 200 mcg/ml	T3	PA
octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml	T2	PA
octreotide acetate injection solution 500 mcg/ml	T5	PA
ODOMZO	T5	PA-NS; LA
ONUREG	T5	PA-NS; QL (14 EA per 28 days)
ORGOVYX	T5	PA-NS; QL (31 EA per 31 days)
PEMAZYRE	T5	PA-NS; QL (14 EA per 21 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (28 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	T5	PA-NS; QL (56 EA per 28 days)
POMALYST	T5	PA-NS; QL (21 EA per 28 days)
PROGRAF ORAL	T4	PA-BvD
PURIXAN	T4	
QINLOCK	T5	PA-NS; QL (93 EA per 31 days)
RAPAMUNE ORAL SOLUTION	T5	PA-BvD
RAPAMUNE ORAL TABLET 0.5 MG	T4	PA-BvD
RAPAMUNE ORAL TABLET 1 MG, 2 MG	T5	PA-BvD
RETEVMO ORAL CAPSULE 40 MG	T5	PA-NS; QL (186 EA per 31 days)
RETEVMO ORAL CAPSULE 80 MG	T5	PA-NS; QL (124 EA per 31 days)
REVLIMID	T5	PA-NS; QL (21 EA per 28 days)
REZUROCK	T5	PA; QL (62 EA per 31 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)
RUBRACA	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE ORAL	T3	PA-BvD
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML	T4	PA
SIGNIFOR	T5	PA
SIKLOS	T4	
sirolimus	T2	PA-BvD
SOLTAMOX	T4	
SPRYCEL	T5	PA-NS; QL (31 EA per 31 days)
STIVARGA	T5	PA-NS; QL (84 EA per 28 days)
sunitinib	T5	PA-NS
SUTENT	T5	PA-NS
SYNRIBO	T5	
TABLOID	T3	
TABRECTA	T5	PA-NS; QL (124 EA per 31 days)
tacrolimus oral	T2	PA-BvD
TAFINLAR	T5	PA-NS
TAGRISSO	T5	PA-NS; LA; QL (31 EA per 31 days)
TALZENNA ORAL CAPSULE 0.25 MG	T5	PA-NS; QL (93 EA per 31 days)
TALZENNA ORAL CAPSULE 1 MG	T5	PA-NS; QL (31 EA per 31 days)
tamoxifen	T1	

Drug Name	Drug Tier	Requirements/Limits
TARCEVA	T5	PA-NS; QL (31 EA per 31 days)
TARGRETIN	T5	PA-NS
TASIGNA	T5	PA-NS; QL (124 EA per 31 days)
TAZVERIK	T5	PA-NS; QL (248 EA per 31 days)
TEPMETKO	T5	PA-NS; QL (62 EA per 31 days)
THALOMID ORAL CAPSULE 100 MG, 150 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 200 MG	T5	PA-NS; QL (56 EA per 28 days)
TIBSOVO	T5	PA-NS; QL (62 EA per 31 days)
toremifene	T3	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG, 22.5 MG	T3	PA
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG	T5	PA
tretinoin (antineoplastic)	T5	
TREXALL	T3	PA-BvD
TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
TRUSELTIQ ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
TRUSELTIQ ORAL CAPSULE 75 MG/DAY (25 MG X 3)	T5	PA-NS; QL (63 EA 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
UKONIQ	T5	PA-NS; QL (124 EA per 31 days)
VENCLEXTA ORAL TABLET 10 MG	T4	PA-NS
VENCLEXTA ORAL TABLET 100 MG, 50 MG	T5	PA-NS
VENCLEXTA STARTING PACK	T5	PA-NS
VERZENIO	T5	PA-NS; QL (62 EA per 31 days)
VITRAKVI ORAL CAPSULE 100 MG	T5	PA-NS; QL (62 EA per 31 days)
VITRAKVI ORAL CAPSULE 25 MG	T5	PA-NS; QL (186 EA per 31 days)
VITRAKVI ORAL SOLUTION	T5	PA-NS; QL (310 ML per 31 days)
VIZIMPRO	T5	PA-NS; QL (31 EA per 31 days)
VOTRIENT	T5	PA-NS; QL (124 EA per 31 days)
WELIREG	T5	PA-NS; QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
XALKORI	T5	PA-NS; QL (62 EA per 31 days)
XATMEP	T4	PA-BvD
XERMELO	T5	PA; QL (93 EA per 31 days)
XGEVA	T5	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 (40 MG X 1), 60 MG/WEEK (60 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)
XTANDI ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
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)
YONSA	T5	PA-NS; QL (124 EA per 31 days)
ZEJULA	T5	PA-NS; QL (93 EA per 31 days)
ZELBORAF	T5	PA-NS
ZOLINZA	T5	PA-NS
ZORTRESS	T5	PA-BvD
ZYDELIG	T5	PA-NS; QL (62 EA per 31 days)
ZYKADIA ORAL TABLET	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 MAINTENA	T5	QL (1 EA per 28 days)
ABILIFY MYCITE	T5	PA-NS
ABILIFY ORAL TABLET	T5	PA-NS
acetaminophen-caff-dihydrocod	T4	PA; QL (372 EA per 31 days)
acetaminophen-codeine oral solution 120-12 mg/5 ml	T1	PA; QL (5167 ML per 31 days)
acetaminophen-codeine oral tablet	T2	PA; QL (403 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 1,200 MCG	T5	PA; QL (40 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 1,600 MCG	T5	PA; QL (30 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
ACTIQ BUCCAL LOZENGE ON A HANDLE 200 MCG	T5	PA; QL (124 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 400 MCG	T5	PA; QL (119 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 600 MCG	T5	PA; QL (79 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 800 MCG	T5	PA; QL (59 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 ER	T4	ST; QL (450 ML per 30 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)
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	T2	QL (8 EA per 28 days)
almotriptan malate oral tablet 6.25 mg	T2	QL (16 EA per 28 days)
ALPRAZOLAM INTENSOL	T2	PA
alprazolam oral tablet 0.25 mg, 0.5 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet 1 mg, 2 mg	T2	PA; QL (155 EA per 31 days)
alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg	T2	PA; QL (31 EA per 31 days)
alprazolam oral tablet extended release 24 hr 2 mg	T2	PA; QL (155 EA per 31 days)
alprazolam oral tablet extended release 24 hr 3 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet,disintegrating 1 mg, 2 mg	T2	PA; QL (155 EA per 31 days)
AMBIEN	T4	QL (31 EA per 31 days)
AMBIEN CR	T4	QL (31 EA per 31 days)
AMERGE ORAL TABLET 1 MG	T4	QL (20 EA per 28 days)
AMERGE ORAL TABLET 2.5 MG	T4	QL (8 EA per 28 days)
amitriptyline	T2	PA-NS

Drug Name	Drug Tier	Requirements/Limits
amitriptyline-chlordiazepoxide	T2	PA-NS
amoxapine	T1	
amphetamine	T4	ST; QL (450 ML per 30 days)
amphetamine sulfate	T4	PA
AMPYRA	T5	PA; QL (62 EA per 31 days)
AMRIX	T4	PA
ANAFRANIL	T4	PA-NS
APLENZIN	T4	
APOKYN	T5	PA; QL (60 ML per 30 days)
APTENSIO XR	T4	ST; QL (31 EA per 31 days)
APTIOM ORAL TABLET 200 MG, 400 MG	T4	
APTIOM ORAL TABLET 600 MG, 800 MG	T5	
ARICEPT	T4	
aripiprazole oral solution	T3	PA-NS
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 5 mg	T3	PA-NS
aripiprazole oral tablet 20 mg, 30 mg	T4	PA-NS
aripiprazole oral tablet,disintegrating 10 mg	T5	PA-NS
aripiprazole oral tablet,disintegrating 15 mg	T3	PA-NS
ARISTADA INITIO	T5	QL (4.8 ML per 365 days)
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	T4	PA; QL (31 EA per 31 days)
ARTHROTEC 50	T4	
ARTHROTEC 75	T4	
ASCOMP WITH CODEINE	T2	PA; QL (372 EA per 31 days)
asenapine maleate	T4	QL (62 EA per 31 days)
ATIVAN ORAL TABLET 0.5 MG	T4	QL (124 EA per 31 days)
ATIVAN ORAL TABLET 1 MG	T4	QL (186 EA per 31 days)
ATIVAN ORAL TABLET 2 MG	T4	QL (155 EA per 31 days)
atomoxetine oral capsule 10 mg, 25 mg, 40 mg	T4	QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
atomoxetine oral capsule 100 mg, 60 mg, 80 mg	T4	QL (31 EA per 31 days)
atomoxetine oral capsule 18 mg	T4	QL (124 EA 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)
AZILECT	T3	
AZSTARYS	T4	ST
baclofen oral tablet 10 mg	T1	
baclofen oral tablet 20 mg	T2	
baclofen oral tablet 5 mg	T4	
BAFIERTAM	T5	PA; QL (124 EA per 31 days)
BANZEL	T5	PA-NS
BELBUCA	T4	PA; QL (62 EA per 31 days)
BELSOMRA	T4	
benztropine oral	T2	PA
BRISDELLE	T4	
BRIVIACT ORAL	T5	
bromocriptine	T2	
BUPAP	T4	QL (403 EA per 31 days)
buprenorphine	T4	PA; QL (4 EA per 28 days)
buprenorphine hcl sublingual tablet 2 mg	T2	QL (93 EA per 31 days)
buprenorphine hcl sublingual tablet 8 mg	T2	QL (62 EA per 31 days)
buprenorphine-naloxone sublingual film 12-3 mg	T2	QL (62 EA per 31 days)
buprenorphine-naloxone sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg	T2	QL (93 EA per 31 days)
buprenorphine-naloxone sublingual tablet	T4	ST; QL (93 EA per 31 days)
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	
bupropion hcl oral tablet sustained-release 12 hr	T2	QL (62 EA per 31 days)
buspirone	T2	
BUTALBITAL COMPOUND W/CODEINE	T2	PA; QL (372 EA per 31 days)
butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg	T2	PA; QL (403 EA per 31 days)
butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg	T2	PA; QL (372 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
butalbital-acetaminophen oral capsule	T2	QL (403 EA per 31 days)
butalbital-acetaminophen oral tablet 25-325 mg, 50-325 mg	T2	QL (372 EA per 31 days)
butalbital-acetaminophen oral tablet 50-300 mg	T2	QL (403 EA per 31 days)
butalbital-acetaminophen-caff oral capsule 50-300-40 mg	T2	QL (403 EA per 31 days)
butalbital-acetaminophen-caff oral capsule 50-325-40 mg	T2	QL (372 EA per 31 days)
butalbital-acetaminophen-caff oral tablet	T2	QL (372 EA per 31 days)
butalbital-aspirin-caffeine oral capsule	T2	
butorphanol nasal	T2	QL (5 ML per 28 days)
BUTRANS	T4	PA; QL (4 EA per 28 days)
CAFERGOT	T4	
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	T1	
carbamazepine oral tablet	T1	
carbamazepine oral tablet extended release 12 hr	T2	
carbamazepine oral tablet,chewable	T1	
CARBATROL	T4	
carbidopa	T4	
carbidopa-levodopa	T2	
carbidopa-levodopa-entacapone	T2	
carisoprodol	T2	
carisoprodol-aspirin-codeine	T2	PA; QL (2582 EA per 31 days)
CELEBREX	T4	ST; QL (62 EA per 31 days)
celecoxib	T2	ST; QL (62 EA per 31 days)
CELEXA ORAL TABLET	T4	
CELONTIN ORAL CAPSULE 300 MG	T4	
chlordiazepoxide hcl	T2	
chlorpromazine oral	T2	
chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg	T2	PA
citalopram	T1	
clobazam oral suspension	T4	PA-NS; QL (496 ML per 31 days)
clobazam oral tablet	T4	PA-NS; QL (62 EA per 31 days)
clomipramine	T2	PA-NS
clonazepam oral tablet 0.5 mg	T2	QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
clonazepam oral tablet 1 mg	T2	QL (124 EA per 31 days)
clonazepam oral tablet 2 mg	T2	QL (310 EA per 31 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg	T2	QL (93 EA per 31 days)
clonazepam oral tablet,disintegrating 1 mg	T2	QL (124 EA per 31 days)
clonazepam oral tablet,disintegrating 2 mg	T2	QL (310 EA per 31 days)
clonidine hcl oral tablet extended release 12 hr	T2	PA
clorazepate dipotassium oral tablet 15 mg	T2	QL (186 EA per 31 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	T2	QL (93 EA per 31 days)
clozapine oral tablet 100 mg, 25 mg	T2	QL (279 EA per 31 days)
clozapine oral tablet 200 mg	T2	QL (124 EA per 31 days)
clozapine oral tablet 50 mg	T2	QL (93 EA per 31 days)
clozapine oral tablet,disintegrating 100 mg, 25 mg	T2	QL (279 EA per 31 days)
clozapine oral tablet,disintegrating 12.5 mg	T2	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, 25 MG	T4	QL (279 EA per 31 days)
CLOZARIL ORAL TABLET 200 MG	T4	QL (124 EA per 31 days)
CLOZARIL ORAL TABLET 50 MG	T4	QL (93 EA per 31 days)
codeine sulfate	T2	PA; QL (186 EA per 31 days)
COMTAN	T4	
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	ST; QL (31 ML per 31 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	T5	ST; QL (12 ML per 28 days)
COTEMPLA XR-ODT	T4	ST; QL (62 EA per 31 days)
cyclobenzaprine oral capsule,extended release 24hr	T4	PA
cyclobenzaprine oral tablet	T2	PA
CYMBALTA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 MG, 60 MG	T4	QL (62 EA per 31 days)
CYMBALTA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 MG	T4	QL (31 EA per 31 days)
dalfampridine	T5	PA; QL (62 EA per 31 days)
DANTRIUM ORAL CAPSULE 25 MG, 50 MG	T4	

Drug Name	Drug Tier	Requirements/Limits
dantrolene oral	T2	
DAYPRO	T4	
DAYTRANA	T4	PA; QL (30 EA per 30 days)
DAYVIGO	T4	QL (31 EA per 31 days)
DEMEROL (PF) INJECTION SYRINGE 25 MG/ML	T4	PA; QL (824 ML per 31 days)
DEMEROL INJECTION SOLUTION 50 MG/ML	T4	PA; QL (412 ML per 31 days)
DEPAKOTE	T4	
DEPAKOTE ER	T4	
DEPAKOTE SPRINKLES	T4	
desipramine	T2	
DESOXYN	T4	PA
desvenlafaxine	T4	
desvenlafaxine succinate	T4	QL (31 EA per 31 days)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG	T4	ST; QL (155 EA per 31 days)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 15 MG	T4	ST; QL (124 EA per 31 days)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 5 MG	T4	ST; QL (186 EA per 31 days)
dexmethylphenidate oral capsule,er biphasic 50-50	T2	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 oral capsule, extended release 10 mg	T2	QL (155 EA per 31 days)
dextroamphetamine oral capsule, extended release 15 mg	T2	QL (124 EA per 31 days)
dextroamphetamine oral capsule, extended release 5 mg	T2	QL (186 EA per 31 days)
dextroamphetamine oral solution	T3	
dextroamphetamine oral tablet 10 mg	T2	QL (186 EA per 31 days)
dextroamphetamine oral tablet 15 mg, 20 mg, 30 mg	T4	QL (62 EA per 31 days)
dextroamphetamine oral tablet 5 mg	T2	QL (341 EA per 31 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr	T2	QL (31 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 10 mg, 30 mg	T2	QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
dextroamphetamine-amphetamine oral tablet 12.5 mg, 15 mg, 5 mg, 7.5 mg	T1	QL (62 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 20 mg	T2	QL (93 EA per 31 days)
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)
DIASTAT	T4	
DIASTAT ACUDIAL	T4	
diazepam oral concentrate	T2	QL (248 ML per 31 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	T2	QL (1500 ML per 31 days)
diazepam oral tablet	T2	QL (124 EA per 31 days)
diazepam rectal	T4	
diclofenac epolamine	T4	PA; QL (62 EA per 31 days)
diclofenac potassium oral tablet 25 mg	T4	
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 gel 1 %	T3	QL (900 GM per 28 days)
diclofenac-misoprostol	T2	
diflunisal	T2	
dihydroergotamine nasal	T4	PA; QL (8 ML per 31 days)
DILANTIN	T4	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	
DILANTIN-125	T4	
DILAUDID ORAL LIQUID	T4	PA; QL (1550 ML per 31 days)
DILAUDID ORAL TABLET	T4	PA; QL (186 EA per 31 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)	T5	PA; QL (120 EA per 365 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 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	

Drug Name	Drug Tier	Requirements/Limits
divalproex oral tablet,delayed release (dr/ec)	T2	
donepezil	T2	
doxepin oral capsule	T2	PA-NS
doxepin oral concentrate	T2	PA-NS
doxepin oral tablet	T2	PA
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG	T4	PA-NS; QL (93 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 30 MG, 60 MG	T4	PA-NS; QL (62 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	T4	PA-NS; QL (31 EA per 31 days)
DUEXIS	T5	PA; QL (93 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	T4	PA-BvD
DYANAVEL XR	T4	ST; QL (248 ML per 31 days)
EDLUAR	T4	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)
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)	T3	PA; QL (3 ML per 28 days)
EMSAM	T5	QL (30 EA per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	T2	PA; QL (372 EA per 31 days)
entacapone	T2	
EPIDIOLEX	T5	PA-NS
EPITOL	T1	
EQUETRO	T4	

Drug Name	Drug Tier	Requirements/Limits
ergoloid	T2	
ergotamine-caffeine	T2	
escitalopram oxalate oral solution	T4	QL (620 ML per 31 days)
escitalopram oxalate oral tablet 10 mg	T2	QL (45 EA per 30 days)
escitalopram oxalate oral tablet 20 mg, 5 mg	T2	QL (30 EA per 30 days)
ESGIC ORAL TABLET	T4	QL (372 EA per 31 days)
estazolam	T2	
eszopiclone	T2	
ethosuximide oral capsule	T3	
ethosuximide oral solution	T2	
etodolac	T2	
EVEKEO	T4	PA
EVEKEO ODT	T4	ST
EVRYSDI	T5	PA; QL (217 ML per 31 days)
EXELON PATCH	T4	QL (30 EA per 30 days)
FANAPT ORAL TABLET	T4	QL (62 EA per 31 days)
FANAPT ORAL TABLETS,DOSE PACK	T4	QL (16 EA per 365 days)
felbamate	T2	
FELBATOL	T4	
FELDENE	T4	
fenoprofen oral capsule 400 mg	T4	
fenoprofen oral tablet	T2	
fentanyl citrate buccal lozenge on a handle 1,200 mcg	T5	PA; QL (40 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 1,600 mcg	T5	PA; QL (30 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 200 mcg	T5	PA; QL (124 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 400 mcg	T5	PA; QL (119 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 600 mcg	T5	PA; QL (79 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 800 mcg	T5	PA; QL (59 EA per 31 days)
fentanyl citrate buccal tablet, effervescent 100 mcg, 200 mcg	T5	PA; QL (124 EA per 31 days)
fentanyl citrate buccal tablet, effervescent 400 mcg	T5	PA; QL (119 EA per 31 days)
fentanyl citrate buccal tablet, effervescent 600 mcg	T5	PA; QL (79 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
fentanyl citrate buccal tablet, effervescent 800 mcg	T5	PA; QL (59 EA per 31 days)
fentanyl transdermal patch 72 hour 100 mcg/hr	T3	PA; QL (10 EA per 30 days)
fentanyl transdermal patch 72 hour 12 mcg/hr	T3	PA; QL (20 EA per 30 days)
fentanyl transdermal patch 72 hour 25 mcg/hr	T2	PA; QL (20 EA per 30 days)
fentanyl transdermal patch 72 hour 37.5 mcg/hour	T4	PA; QL (20 EA per 30 days)
fentanyl transdermal patch 72 hour 50 mcg/hr	T2	PA; QL (17 EA per 30 days)
fentanyl transdermal patch 72 hour 62.5 mcg/hour	T4	PA; QL (15 EA per 30 days)
fentanyl transdermal patch 72 hour 75 mcg/hr	T3	PA; QL (12 EA per 30 days)
fentanyl transdermal patch 72 hour 87.5 mcg/hour	T4	PA; QL (11 EA per 30 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG	T5	PA; QL (124 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 400 MCG	T5	PA; QL (119 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 600 MCG	T5	PA; QL (79 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 800 MCG	T5	PA; QL (59 EA per 31 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	T4	PA-NS; QL (56 EA per 365 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG	T4	PA-NS; QL (31 EA per 31 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	T4	PA-NS; QL (93 EA per 31 days)
FEXMID	T4	PA
FINTEPLA	T5	PA-NS; QL (360 ML per 30 days)
FIORICET	T4	QL (403 EA per 31 days)
FIORICET WITH CODEINE	T4	PA; QL (403 EA per 31 days)
FIRDAPSE	T5	PA; QL (248 EA per 31 days)
FLECTOR	T4	PA; QL (62 EA per 31 days)
fluoxetine (pmdd)	T1	
fluoxetine oral capsule	T1	
fluoxetine oral capsule,delayed release(dr/ec)	T2	
fluoxetine oral solution	T1	
fluoxetine oral tablet 10 mg, 20 mg	T1	
fluoxetine oral tablet 60 mg	T4	
fluphenazine decanoate	T2	
fluphenazine hcl injection	T2	

Drug Name	Drug Tier	Requirements/Limits
fluphenazine hcl oral concentrate	T2	
fluphenazine hcl oral elixir	T1	
fluphenazine hcl oral tablet	T1	
flurazepam	T2	
flurbiprofen oral tablet 100 mg	T2	
fluvoxamine	T2	
FOCALIN ORAL TABLET 10 MG	T4	ST; QL (62 EA per 31 days)
FOCALIN ORAL TABLET 2.5 MG, 5 MG	T4	ST; QL (93 EA per 31 days)
FOCALIN XR	T4	ST; QL (31 EA per 31 days)
FORFIVO XL	T4	
FROVA	T4	QL (12 EA per 28 days)
frovatriptan	T3	QL (12 EA per 28 days)
FYCOMPA	T5	
gabapentin oral capsule 100 mg, 400 mg	T2	PA-NS; QL (270 EA per 30 days)
gabapentin oral capsule 300 mg	T2	PA-NS; QL (360 EA per 30 days)
gabapentin oral solution 250 mg/5 ml	T2	PA-NS; QL (2160 ML per 30 days)
gabapentin oral tablet 600 mg	T2	PA-NS; QL (180 EA per 30 days)
gabapentin oral tablet 800 mg	T2	PA-NS; QL (120 EA per 30 days)
GABITRIL ORAL TABLET 12 MG, 16 MG, 2 MG	T4	
GABITRIL ORAL TABLET 4 MG	T5	
galantamine	T2	
GEODON INTRAMUSCULAR	T4	
GEODON ORAL	T4	QL (62 EA per 31 days)
GILENYA ORAL CAPSULE 0.5 MG	T5	PA; QL (31 EA per 31 days)
glatiramer subcutaneous syringe 20 mg/ml	T5	QL (31 ML per 31 days)
glatiramer subcutaneous syringe 40 mg/ml	T5	QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	T5	QL (31 ML per 31 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	T5	QL (12 ML per 28 days)
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG	T4	PA; QL (62 EA per 31 days)
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 68.5 MG	T4	PA; QL (124 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T3	PA; QL (155 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T3	PA; QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
guanfacine oral tablet extended release 24 hr	T2	PA
HALCION ORAL TABLET 0.25 MG	T4	PA
HALDOL DECANOATE	T4	
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 ORAL TABLET EXTENDED RELEASE 300 MG	T4	PA; QL (90 EA per 30 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG	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	T4	PA; QL (31 EA per 31 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	T2	PA; QL (5723 ML per 31 days)
hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	T2	PA; QL (403 EA per 31 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
hydrocodone-ibuprofen	T2	PA; QL (155 EA per 31 days)
hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml	T2	PA; QL (124 ML per 31 days)
hydromorphone oral liquid	T2	PA; QL (1550 ML per 31 days)
hydromorphone oral tablet	T2	PA; QL (186 EA per 31 days)
hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 8 mg	T2	PA; QL (62 EA per 31 days)
hydromorphone oral tablet extended release 24 hr 32 mg	T2	PA; QL (48 EA per 31 days)
HYSINGLA ER	T4	PA; QL (31 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	
ibuprofen oral suspension	T1	
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	T2	PA-NS
IMITREX NASAL SPRAY,NON-AEROSOL 20 MG/ACTUATION	T4	QL (8 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
IMITREX NASAL SPRAY,NON-AEROSOL 5 MG/ACTUATION	T4	QL (32 EA per 28 days)
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	T4	QL (4 ML per 28 days)
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	T5	PA; QL (300 EA per 30 days)
INDOCIN	T4	
indomethacin oral	T1	
INGREZZA INITIATION PACK	T5	PA; QL (56 EA per 365 days)
INGREZZA ORAL CAPSULE 40 MG	T5	PA; QL (62 EA per 31 days)
INGREZZA ORAL CAPSULE 60 MG, 80 MG	T5	PA; QL (31 EA per 31 days)
INTUNIV ER	T4	PA
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 3 MG	T4	QL (31 EA per 31 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG	T4	QL (62 EA per 31 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 9 MG	T5	QL (31 EA per 31 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	T5	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	T5	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	T5	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T4	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	T5	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.875 ML	T5	QL (0.875 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.315 ML	T5	QL (1.315 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	T5	QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.625 ML	T5	QL (2.625 ML per 84 days)

Drug Name	Drug Tier	Requirements/Limits
JORNAY PM	T4	ST; QL (31 EA per 31 days)
KAPVAY	T4	PA
KEPPRA ORAL SOLUTION	T5	
KEPPRA ORAL TABLET 1,000 MG	T5	
KEPPRA ORAL TABLET 250 MG, 500 MG, 750 MG	T4	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR 500 MG	T4	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR 750 MG	T5	
KESIMPTA PEN	T5	PA; QL (0.4 ML per 28 days)
ketoprofen oral capsule	T2	
ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg	T2	
ketorolac nasal	T4	QL (5 EA per 31 days)
ketorolac oral	T2	
KEVEYIS	T4	PA; QL (124 EA per 31 days)
KLONOPIN ORAL TABLET 0.5 MG	T4	QL (93 EA per 31 days)
KLONOPIN ORAL TABLET 1 MG	T4	QL (124 EA per 31 days)
KLONOPIN ORAL TABLET 2 MG	T4	QL (310 EA per 31 days)
KLOXXADO	T3	
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	T5	PA; QL (155 EA per 31 days)
LAMICTAL ODT	T4	
LAMICTAL ORAL TABLET	T4	
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	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 25 mg(14)-50 mg (14)-100 mg (7)	T2	
lamotrigine oral tablet extended release 24hr	T2	
lamotrigine oral tablet, chewable dispersible	T2	
lamotrigine oral tablet,disintegrating	T2	

Drug Name	Drug Tier	Requirements/Limits
lamotrigine oral tablets,dose pack	T2	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	T5	PA-NS; QL (31 EA per 31 days)
LATUDA ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY	T5	PA; QL (31 EA per 31 days)
LAZANDA NASAL SPRAY,NON-AEROSOL 400 MCG/SPRAY	T5	PA; QL (12 EA per 31 days)
levetiracetam oral solution 100 mg/ml	T2	
levetiracetam oral tablet	T2	
levetiracetam oral tablet extended release 24 hr	T2	
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)
lithium carbonate	T1	
LITHOBID	T4	
LODINE ORAL TABLET	T4	
LODOSYN	T4	
LORAZEPAM INTENSOL	T2	QL (155 ML per 31 days)
lorazepam oral tablet 0.5 mg	T2	QL (124 EA per 31 days)
lorazepam oral tablet 1 mg	T2	QL (186 EA per 31 days)
lorazepam oral tablet 2 mg	T2	QL (155 EA per 31 days)
LORZONE	T4	
loxapine succinate	T2	
LUCEMYRA	T5	
LUNESTA	T4	
LYRICA CR	T4	PA; QL (31 EA per 31 days)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	T4	PA-NS; QL (93 EA per 31 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	T4	PA-NS; QL (62 EA per 31 days)
LYRICA ORAL SOLUTION	T4	PA-NS; QL (930 ML per 31 days)
MARPLAN	T3	
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)

Drug Name	Drug Tier	Requirements/Limits
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 2 MG	T5	PA; QL (31 EA per 31 days)
MAYZENT STARTER PACK	T5	PA; QL (24 EA per 365 days)
meclofenamate	T2	
mefenamic acid	T4	
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	T3	
memantine oral tablets,dose pack	T4	
meperidine (pf) injection solution 100 mg/ml	T2	PA; QL (200 ML per 31 days)
meperidine (pf) injection solution 25 mg/ml	T2	PA; QL (800 ML per 31 days)
meperidine (pf) injection solution 50 mg/ml	T2	PA; QL (400 ML per 31 days)
meperidine oral solution	T2	PA; QL (6200 ML per 31 days)
meperidine oral tablet 100 mg	T2	PA; QL (620 EA per 31 days)
meperidine oral tablet 50 mg	T2	PA; QL (1240 EA per 31 days)
meprobamate	T2	
MESTINON ORAL	T5	
MESTINON TIMESPAN	T5	
metaxalone	T2	PA
methadone oral solution 10 mg/5 ml	T2	PA; QL (1033 ML per 31 days)
methadone oral solution 5 mg/5 ml	T2	PA; QL (2066 ML per 31 days)
methadone oral tablet 10 mg	T2	PA; QL (206 EA per 31 days)
methadone oral tablet 5 mg	T2	PA; QL (248 EA per 31 days)
methamphetamine	T5	PA
methocarbamol oral	T2	
METHYLIN ORAL SOLUTION	T4	ST
methylphenidate hcl oral cap,er sprinkle,biphasic 40-60	T4	QL (31 EA per 31 days)
methylphenidate hcl oral capsule, er biphasic 30-70	T2	QL (31 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 10 mg	T2	QL (186 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
methylphenidate hcl oral capsule,er biphasic 50-50 20 mg	T2	QL (93 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 40 mg	T2	QL (62 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 60 mg	T2	QL (31 EA per 31 days)
methylphenidate hcl oral solution	T2	
methylphenidate hcl oral tablet	T2	QL (93 EA per 31 days)
methylphenidate hcl oral tablet extended release 10 mg	T2	QL (31 EA per 31 days)
methylphenidate hcl oral tablet extended release 20 mg	T2	QL (93 EA per 31 days)
methylphenidate hcl oral tablet extended release 24hr 18 mg, 18 mg (bx rating), 27 mg, 27 mg (bx rating), 36 mg, 36 mg (bx rating), 54 mg, 54 mg (bx rating)	T2	QL (31 EA per 31 days)
methylphenidate hcl oral tablet extended release 24hr 72 mg	T4	ST; QL (31 EA per 31 days)
methylphenidate hcl oral tablet,chewable 10 mg	T2	QL (186 EA per 31 days)
methylphenidate hcl oral tablet,chewable 2.5 mg, 5 mg	T2	QL (93 EA per 31 days)
MIGERGOT	T5	
MIGRANAL	T4	PA; QL (8 ML per 31 days)
MIRAPEX ER	T4	
mirtazapine	T2	
MOBIC ORAL TABLET	T4	
modafinil	T2	PA; QL (31 EA per 31 days)
molindone	T4	
morphine concentrate oral solution	T2	PA; QL (310 ML per 31 days)
morphine oral capsule, er multiphase 24 hr 120 mg	T2	PA; QL (51 EA per 31 days)
morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	T2	PA; QL (62 EA per 31 days)
morphine oral capsule,extend.release pellets	T2	PA; QL (62 EA per 31 days)
morphine oral solution 10 mg/5 ml	T2	PA; QL (2800 ML per 31 days)
morphine oral solution 20 mg/5 ml (4 mg/ml)	T2	PA; QL (1400 ML per 31 days)
morphine oral tablet	T2	PA; QL (186 EA per 31 days)
morphine oral tablet extended release 100 mg	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	T2	PA; QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG	T4	PA; 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)
MS CONTIN ORAL TABLET EXTENDED RELEASE 200 MG	T4	PA; QL (31 EA per 31 days)
MYDAYIS	T4	ST; QL (31 EA per 31 days)
MYSOLINE	T5	
nabumetone	T1	
NALFON ORAL CAPSULE 400 MG	T4	
NALFON ORAL TABLET	T4	
naloxone injection solution	T2	
naloxone injection syringe	T2	
naltrexone	T2	
NAMENDA ORAL TABLET	T4	PA
NAMENDA TITRATION PAK	T4	PA
NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR	T4	PA
NAMZARIC	T4	PA
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 375 MG, 500 MG	T4	
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 750 MG	T5	
naproxen oral suspension	T1	
naproxen oral tablet	T1	
naproxen oral tablet,delayed release (dr/ec)	T2	
naproxen sodium oral tablet 275 mg, 550 mg	T1	
naproxen sodium oral tablet, er multiphase 24 hr 375 mg, 500 mg	T4	
naproxen-esomeprazole	T5	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 (8 EA per 28 days)
NARCAN	T3	
NARDIL	T4	
NAYZILAM	T4	PA-NS; QL (10 EA per 30 days)
nefazodone	T2	
NEUPRO	T4	
NEURONTIN ORAL CAPSULE 100 MG, 400 MG	T4	PA-NS; QL (270 EA per 30 days)
NEURONTIN ORAL CAPSULE 300 MG	T4	PA-NS; QL (360 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
NEURONTIN ORAL SOLUTION	T4	PA-NS; QL (2160 ML per 30 days)
NEURONTIN ORAL TABLET 600 MG	T4	PA-NS; QL (180 EA per 30 days)
NEURONTIN ORAL TABLET 800 MG	T4	PA-NS; QL (120 EA per 30 days)
NORGESIC FORTE	T4	
NORPRAMIN ORAL TABLET 10 MG, 25 MG	T4	
nortriptyline	T2	
NOURIANZ	T5	PA; QL (31 EA per 31 days)
NUCYNTA	T4	PA; QL (186 EA per 31 days)
NUCYNTA ER	T4	PA; QL (62 EA per 31 days)
NUEDEXTA	T3	PA; QL (62 EA per 31 days)
NUPLAZID ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
NUPLAZID ORAL TABLET 10 MG	T5	PA-NS; QL (31 EA per 31 days)
NURTEC ODT	T4	QL (18 EA per 28 days)
NUVIGIL	T4	PA; QL (31 EA per 31 days)
olanzapine intramuscular	T2	
olanzapine oral	T2	QL (31 EA per 31 days)
olanzapine-fluoxetine	T2	
ONFI ORAL SUSPENSION	T4	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)
ONZETRA XSAIL	T4	QL (16 EA per 28 days)
orphenadrine citrate oral	T2	
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG, 193 MG	T4	PA; QL (31 EA per 31 days)
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 322 MG/DAY(129 MG X1-193MG X1)	T4	PA; QL (60 EA per 30 days)
oxaprozin	T2	
oxazepam	T2	
oxcarbazepine	T2	
OXTELLAR XR	T4	
oxycodone oral capsule	T2	PA; QL (186 EA per 31 days)
oxycodone oral concentrate	T2	PA; QL (180 ML per 31 days)
oxycodone oral solution	T2	PA; QL (4133 ML per 31 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg	T2	PA; QL (186 EA per 31 days)
oxycodone oral tablet 30 mg	T3	PA; QL (138 EA per 31 days)
oxycodone oral tablet,oral only,ext.rel.12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg	T4	PA; QL (100 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
oxycodone oral tablet,oral only,ext.rel.12 hr 60 mg	T4	PA; QL (69 EA per 31 days)
oxycodone oral tablet,oral only,ext.rel.12 hr 80 mg	T4	PA; QL (62 EA per 31 days)
oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg	T4	PA; QL (403 EA per 31 days)
oxycodone-acetaminophen oral tablet 10-325 mg	T3	PA; QL (372 EA per 31 days)
oxycodone-acetaminophen oral tablet 2.5-325 mg, 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, 40 MG	T4	PA; QL (100 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG	T4	PA; QL (69 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	T4	PA; QL (62 EA per 31 days)
oxymorphone oral tablet	T2	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	T2	PA; QL (100 EA per 31 days)
oxymorphone oral tablet extended release 12 hr 30 mg	T2	PA; QL (69 EA per 31 days)
oxymorphone oral tablet extended release 12 hr 40 mg	T2	PA; QL (51 EA per 31 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	T4	QL (31 EA per 31 days)
paliperidone oral tablet extended release 24hr 6 mg	T4	QL (62 EA per 31 days)
PAMELOR	T4	
PARLODEL	T4	
PARNATE	T4	
paroxetine hcl oral tablet	T1	
paroxetine hcl oral tablet extended release 24 hr	T2	
paroxetine mesylate(menop.sym)	T4	
PAXIL	T4	
PAXIL CR	T4	
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP	T4	QL (224 GM per 28 days)
pentazocine-naloxone	T2	QL (335 EA per 31 days)
PERCOCET	T4	PA; QL (372 EA per 31 days)
perphenazine	T2	
perphenazine-amitriptyline	T2	PA-NS
PERSERIS	T5	QL (1 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
PEXEVA	T4	
phenelzine	T2	
phenobarbital	T2	PA-NS
PHENYTEK	T4	
phenytoin oral suspension 125 mg/5 ml	T2	
phenytoin oral tablet,chewable	T2	
phenytoin sodium extended	T2	
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	T2	
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	T2	
PRISTIQ	T4	QL (31 EA per 31 days)
PROCENTRA	T3	
PROLATE ORAL TABLET	T4	PA; QL (403 EA per 31 days)
protriptyline	T2	
PROVIGIL ORAL TABLET 100 MG	T4	PA; QL (31 EA per 31 days)
PROVIGIL ORAL TABLET 200 MG	T5	PA; QL (31 EA per 31 days)
PROZAC ORAL CAPSULE	T4	
pyridostigmine bromide oral syrup	T2	
pyridostigmine bromide oral tablet 30 mg	T3	
pyridostigmine bromide oral tablet 60 mg	T2	
pyridostigmine bromide oral tablet extended release	T2	
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG	T4	PA; QL (93 EA per 31 days)
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 200 MG	T4	PA; QL (62 EA per 31 days)
QUDEXY XR	T4	
quetiapine oral tablet 100 mg, 200 mg, 300 mg, 400 mg, 50 mg	T2	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)

Drug Name	Drug Tier	Requirements/Limits
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 20 MG, 40 MG	T4	ST; QL (31 EA per 31 days)
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)
ramelteon	T4	QL (31 EA per 31 days)
rasagiline	T3	
RAZADYNE ER	T4	
RELAFEN DS	T4	
RELEXXII	T4	ST; QL (31 EA per 31 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	QL (31 EA per 31 days)
REXULTI	T5	PA-NS; QL (31 EA per 31 days)
REYVOW ORAL TABLET 100 MG	T4	QL (8 EA per 28 days)
REYVOW ORAL TABLET 50 MG	T4	QL (4 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	T4	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 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 oral solution	T1	QL (496 ML per 31 days)
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	T2	QL (31 EA per 31 days)
risperidone oral tablet,disintegrating 0.5 mg, 1 mg, 2 mg	T1	QL (31 EA per 31 days)
risperidone oral tablet,disintegrating 3 mg	T1	QL (93 EA per 31 days)
risperidone oral tablet,disintegrating 4 mg	T1	QL (124 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
RITALIN	T4	ST; QL (93 EA per 31 days)
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG	T4	ST; QL (186 EA per 31 days)
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 20 MG, 40 MG	T4	ST; QL (31 EA per 31 days)
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 30 MG	T4	ST; QL (62 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 ORAL TABLET 500 MG	T2	
ROXICODONE ORAL TABLET 15 MG, 5 MG	T4	PA; QL (186 EA per 31 days)
ROXICODONE ORAL TABLET 30 MG	T4	PA; QL (138 EA per 31 days)
ROZEREM	T4	QL (31 EA per 31 days)
rufinamide	T5	PA-NS
RUZURGI	T5	PA; QL (310 EA per 31 days)
RYTARY	T3	ST
SABRIL	T5	PA-NS
SAPHRIS	T4	QL (62 EA per 31 days)
SECUADO	T5	QL (31 EA per 31 days)
selegiline hcl	T2	
SEROQUEL	T4	QL (62 EA per 31 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR	T4	QL (62 EA per 31 days)
sertraline oral concentrate	T1	
sertraline oral tablet	T1	
SILENOR	T4	PA
SINEMET ORAL TABLET 10-100 MG, 25-100 MG	T4	
SKELAXIN	T4	
SOMA	T4	
SPRITAM	T4	
SPRIX	T4	QL (5 EA per 31 days)
STALEVO 100	T4	
STALEVO 125	T4	

Drug Name	Drug Tier	Requirements/Limits
STALEVO 150	T4	
STALEVO 200	T4	
STALEVO 50	T4	
STALEVO 75	T4	
STRATTERA ORAL CAPSULE 10 MG, 25 MG, 40 MG	T4	ST; QL (62 EA per 31 days)
STRATTERA ORAL CAPSULE 100 MG, 60 MG, 80 MG	T4	ST; QL (31 EA per 31 days)
STRATTERA ORAL CAPSULE 18 MG	T4	ST; QL (124 EA per 31 days)
SUBOXONE SUBLINGUAL FILM 12-3 MG	T4	ST; QL (62 EA per 31 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG, 8-2 MG	T4	ST; QL (93 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 1,200 MCG (600 MCG/SPRAY X 2)	T5	PA; QL (29 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 1,600 MCG (800 MCG/SPRAY X 2)	T5	PA; QL (22 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY	T5	PA; QL (124 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 400 MCG/SPRAY	T5	PA; QL (86 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 600 MCG/SPRAY	T5	PA; QL (57 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 800 MCG/SPRAY	T5	PA; QL (43 EA per 31 days)
sulindac	T2	
sumatriptan nasal spray,non-aerosol 20 mg/actuation	T2	QL (8 EA per 28 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	T2	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 cartridge 4 mg/0.5 ml	T2	QL (6 ML per 28 days)
sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml	T2	QL (4 ML per 28 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml	T2	QL (6 ML per 28 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	T2	QL (4 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
sumatriptan succinate subcutaneous solution	T2	QL (4 ML per 28 days)
sumatriptan-naproxen	T4	QL (9 EA per 28 days)
SUNOSI	T4	PA; QL (31 EA per 31 days)
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG	T4	
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)
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	
TEGSEDI	T5	PA; QL (6 ML per 28 days)
temazepam	T2	QL (31 EA per 31 days)
TENCON	T2	QL (372 EA per 31 days)
tetrabenazine oral tablet 12.5 mg	T5	PA; QL (93 EA per 31 days)
tetrabenazine oral tablet 25 mg	T5	PA; QL (124 EA per 31 days)
thioridazine	T2	
thiothixene	T1	
tiagabine	T2	
tizanidine	T2	
tolcapone	T5	
TOPAMAX	T4	
topiramate oral capsule, sprinkle	T2	
topiramate oral capsule,sprinkle,er 24hr	T4	
topiramate oral tablet	T2	
TOSYMRA	T4	QL (12 EA per 28 days)
tramadol oral capsule,er biphase 24 hr 17-83	T4	PA; QL (31 EA per 31 days)
tramadol oral capsule,er biphase 24 hr 25-75 100 mg, 200 mg	T4	PA; QL (31 EA per 31 days)
tramadol oral tablet 100 mg	T4	PA; QL (124 EA per 31 days)
tramadol oral tablet 50 mg	T1	PA; QL (240 EA per 30 days)
tramadol oral tablet extended release 24 hr	T2	PA; QL (30 EA per 30 days)
tramadol oral tablet, er multiphase 24 hr	T2	PA; QL (30 EA per 30 days)
tramadol-acetaminophen	T2	PA; QL (372 EA per 31 days)
TRANXENE T-TAB	T4	QL (372 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
tranylcypromine	T2	
trazodone oral tablet 100 mg, 150 mg, 50 mg	T1	
trazodone oral tablet 300 mg	T2	
TREXIMET ORAL TABLET 85-500 MG	T4	QL (9 EA per 28 days)
TREZIX	T4	PA; QL (372 EA per 31 days)
triazolam	T2	PA
trifluoperazine	T2	
trihexyphenidyl	T2	
TRILEPTAL	T4	
trimipramine	T3	PA-NS
TRINTELLIX	T3	PA-NS
TROKENDI XR	T4	
UBRELVY ORAL TABLET 100 MG	T4	QL (17 EA per 28 days)
UBRELVY ORAL TABLET 50 MG	T4	QL (34 EA per 28 days)
ULTRACET	T4	PA; QL (372 EA per 31 days)
ULTRAM	T4	PA; QL (240 EA per 30 days)
VALIUM	T4	QL (124 EA per 31 days)
valproic acid	T2	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	T2	
VALTOCO	T4	PA-NS; QL (10 EA per 30 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 150 mg, 37.5 mg, 75 mg	T2	QL (31 EA per 31 days)
venlafaxine oral tablet extended release 24hr 225 mg	T4	QL (31 EA per 31 days)
VERSACLOZ	T4	QL (558 ML per 31 days)
vigabatrin	T5	PA-NS
VIGADRONE	T5	PA-NS
VIIBRYD ORAL TABLET	T3	PA-NS; QL (31 EA per 31 days)
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)	T3	PA-NS; QL (60 EA per 365 days)
VIMOVO	T5	PA; QL (62 EA per 31 days)
VIMPAT ORAL SOLUTION	T4	
VIMPAT ORAL TABLET	T4	
VIVITROL	T5	

Drug Name	Drug Tier	Requirements/Limits
VIVLODEX	T4	PA; QL (31 EA per 31 days)
VRAYLAR ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
VRAYLAR ORAL CAPSULE,DOSE PACK	T4	PA-NS; QL (14 EA per 365 days)
VTOL LQ	T2	QL (5723 ML per 31 days)
VUMERITY	T5	PA; QL (124 EA per 31 days)
VYVANSE	T4	ST; QL (31 EA per 31 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	T4	QL (93 EA per 31 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T4	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 0.5 MG, 1 MG	T4	PA; QL (31 EA per 31 days)
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 2 MG	T4	PA; QL (155 EA per 31 days)
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 3 MG	T4	PA; QL (93 EA per 31 days)
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)	T5	PA-NS
XCOPRI ORAL TABLET 100 MG, 150 MG, 50 MG	T4	PA-NS
XCOPRI ORAL TABLET 200 MG	T5	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	T4	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	T5	PA-NS
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)
XTAMPZA ER	T4	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	QL (62 EA per 31 days)
zaleplon oral capsule 5 mg	T2	QL (93 EA per 31 days)
ZANAFLEX	T4	
ZARONTIN	T4	

Drug Name	Drug Tier	Requirements/Limits
ZEBUTAL	T2	QL (372 EA per 31 days)
ZELAPAR	T5	
ZEMBRACE SYMTOUCH	T4	QL (8 ML per 28 days)
ZENZEDI ORAL TABLET 10 MG, 5 MG	T2	QL (62 EA per 31 days)
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	T4	QL (62 EA per 31 days)
ZEPOSIA	T5	PA; QL (31 EA per 31 days)
ZEPOSIA STARTER KIT	T5	PA; QL (74 EA per 365 days)
ZEPOSIA STARTER PACK	T5	PA; QL (14 EA per 365 days)
ziprasidone hcl	T2	QL (62 EA per 31 days)
ziprasidone mesylate	T2	
ZIPSOR	T4	
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	T2	QL (31 EA per 31 days)
zolpidem sublingual	T3	QL (31 EA per 31 days)
ZOLPIMIST	T4	QL (7.7 ML per 30 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	
zonisamide	T2	
ZORVOLEX	T4	
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 2.9-0.71 MG	T3	QL (93 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 8.6-2.1 MG	T3	QL (62 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 5.7-1.4 MG	T3	QL (31 EA per 31 days)
ZYPREXA INTRAMUSCULAR	T4	
ZYPREXA ORAL	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	T4	QL (2 EA per 28 days)
ZYPREXA ZYDIS	T4	QL (31 EA per 31 days)
Cardiovascular, Hypertension / Lipids		
ACCUPRIL	T4	
ACCURETIC	T4	
acebutolol	T1	
ALDACTAZIDE	T4	
ALDACTONE	T4	
aliskiren	T4	
ALTACE ORAL CAPSULE 1.25 MG	T4	QL (62 EA per 31 days)
ALTACE ORAL CAPSULE 10 MG	T4	QL (93 EA per 31 days)
ALTACE ORAL CAPSULE 2.5 MG, 5 MG	T4	
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR 20 MG, 60 MG	T4	
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR 40 MG	T5	
amiloride	T1	
amiloride-hydrochlorothiazide	T1	
amiodarone oral	T2	
amlodipine	T1	
amlodipine-atorvastatin	T2	
amlodipine-benazepril	T1	
amlodipine-olmesartan	T3	QL (31 EA per 31 days)
amlodipine-valsartan	T2	
amlodipine-valsartan-hcthiazid	T2	
ANTARA ORAL CAPSULE 30 MG, 90 MG	T4	
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	
atorvastatin	T1	
AVALIDE	T4	QL (31 EA per 31 days)
AVAPRO	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
AZOR	T4	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	
betaxolol oral	T1	
BIDIL	T4	
bisoprolol fumarate	T1	
bisoprolol-hydrochlorothiazide	T1	
BRILINTA	T3	
bumetanide	T1	
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	
CALAN SR	T4	
candesartan	T1	
candesartan-hydrochlorothiazid	T1	
captopril	T1	
CARDIZEM CD	T4	
CARDIZEM LA	T4	
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	T4	
CARDURA	T4	
CARDURA XL	T4	
CAROSPIR	T4	
CARTIA XT	T1	
carvedilol	T1	
carvedilol phosphate	T4	
CATAPRES-TTS-1	T4	
CATAPRES-TTS-2	T4	
CATAPRES-TTS-3	T4	
chlorthalidone oral tablet 25 mg, 50 mg	T1	
cholestyramine (with sugar) oral powder in packet	T2	

Drug Name	Drug Tier	Requirements/Limits
CHOLESTYRAMINE LIGHT ORAL POWDER	T2	
cilostazol	T2	
clonidine	T2	
clonidine hcl oral tablet	T1	
clopidogrel oral tablet 75 mg	T1	
colesevelam	T3	
COLESTID ORAL PACKET	T4	
COLESTID ORAL TABLET	T4	
colestipol oral packet	T2	
colestipol oral tablet	T2	
COREG	T4	
COREG CR	T4	
CORGARD	T4	
CORLANOR ORAL SOLUTION	T4	PA; QL (420 ML per 28 days)
CORLANOR ORAL TABLET 5 MG	T4	PA; QL (93 EA per 31 days)
CORLANOR ORAL TABLET 7.5 MG	T4	PA; QL (62 EA per 31 days)
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	
DEMSER	T4	
DIBENZYLINE	T5	PA
DIGITEK ORAL TABLET 125 MCG (0.125 MG)	T1	QL (62 EA per 31 days)
DIGITEK ORAL TABLET 250 MCG (0.25 MG)	T2	QL (31 EA per 31 days)
DIGOX ORAL TABLET 125 MCG (0.125 MG)	T1	QL (62 EA per 31 days)
DIGOX ORAL TABLET 250 MCG (0.25 MG)	T2	QL (31 EA per 31 days)
digoxin oral solution	T2	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)
diltiazem hcl oral capsule,extended release 12 hr	T1	
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	T1	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	T1	
diltiazem hcl oral tablet	T1	

Drug Name	Drug Tier	Requirements/Limits
diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg	T1	
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	T2	
DIURIL	T4	
dofetilide	T3	
DOPTELET (10 TAB PACK)	T5	PA
DOPTELET (15 TAB PACK)	T5	PA
DOPTELET (30 TAB PACK)	T5	PA
doxazosin	T1	
DYRENIUM	T4	
EDARBI	T4	
EDARBYCLOR	T4	
EDECRIN	T3	
EFFIENT	T4	
ELIQUIS DVT-PE TREAT 30D START	T3	QL (74 EA per 31 days)
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 31 days)
enalapril maleate oral solution	T2	
enalapril maleate oral tablet	T1	
enalapril-hydrochlorothiazide	T1	
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	T3	QL (186 EA per 31 days)
ENTRESTO ORAL TABLET 49-51 MG	T3	QL (93 EA per 31 days)
ENTRESTO ORAL TABLET 97-103 MG	T3	QL (62 EA per 31 days)
eplerenone	T2	
ethacrynic acid	T2	
EXFORGE	T4	
EXFORGE HCT	T4	
EZALLOR SPRINKLE	T4	
ezetimibe	T2	

Drug Name	Drug Tier	Requirements/Limits
ezetimibe-simvastatin	T3	
felodipine	T2	
fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg	T2	
fenofibrate nanocrystallized oral tablet 145 mg, 48 mg	T2	
fenofibrate oral capsule	T4	
fenofibrate oral tablet 120 mg, 40 mg	T4	
fenofibrate oral tablet 160 mg, 54 mg	T2	
fenofibric acid (choline)	T3	
FENOGLIDE	T4	
flecainide	T2	
FLOLIPID	T4	
fluvastatin oral capsule	T1	
fluvastatin oral tablet extended release 24 hr	T3	
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	T5	
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	T2	
fosinopril	T1	
fosinopril-hydrochlorothiazide	T1	
FRAGMIN SUBCUTANEOUS SOLUTION	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 18,000 ANTI-XA UNIT/0.72 ML, 7,500 ANTI-XA UNIT/0.3 ML	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 15,000 ANTI-XA UNIT/0.6 ML, 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML	T3	
furosemide injection	T2	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	T2	
furosemide oral tablet	T1	
gemfibrozil	T1	
GONITRO	T4	
guanfacine oral tablet	T2	
heparin (porcine) injection solution	T2	
hydralazine oral	T1	
hydrochlorothiazide	T1	
HYZAAR	T4	
icosapent ethyl	T4	

Drug Name	Drug Tier	Requirements/Limits
indapamide	T1	
INDERAL LA	T4	
INNOPRAN XL	T4	
INSPRA	T4	
irbesartan	T1	QL (31 EA per 31 days)
irbesartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
ISORDIL	T4	
ISORDIL TITRADOSE ORAL TABLET 5 MG	T4	
isosorbide dinitrate oral tablet	T2	
isosorbide mononitrate	T1	
isradipine	T2	
JANTOVEN	T1	
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG	T5	PA
KATERZIA	T4	
labetalol oral	T1	
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	T4	
LESCOL XL	T4	
LIPITOR	T4	
LIPOFEN	T4	
lisinopril	T1	
lisinopril-hydrochlorothiazide	T1	
LIVALO	T4	
LOPID	T4	
LOPRESSOR ORAL	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	
LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG	T4	

Drug Name	Drug Tier	Requirements/Limits
lovastatin	T1	
LOVAZA	T3	
LOVENOX SUBCUTANEOUS SYRINGE 100 MG/ML	T5	
LOVENOX SUBCUTANEOUS SYRINGE 120 MG/0.8 ML, 150 MG/ML, 30 MG/0.3 ML, 40 MG/0.4 ML, 60 MG/0.6 ML, 80 MG/0.8 ML	T4	
MATZIM LA	T1	
MAXZIDE	T4	
MAXZIDE-25MG	T4	
methyldopa	T2	
metolazone	T2	
metoprolol succinate	T1	
metoprolol ta-hydrochlorothiaz	T1	
metoprolol tartrate oral	T1	
metyrosine	T3	
mexiletine	T2	
MICARDIS	T4	
MICARDIS HCT	T4	
MINIPRESS	T4	
minoxidil oral	T2	
moexipril	T1	
MULPLETA	T5	PA
MULTAQ	T4	
nadolol	T1	
nebivolol oral tablet 10 mg, 2.5 mg	T4	QL (93 EA per 31 days)
nebivolol oral tablet 20 mg	T4	QL (62 EA per 31 days)
nebivolol oral tablet 5 mg	T4	QL (217 EA per 31 days)
NEXLETOL	T4	PA; QL (31 EA per 31 days)
NEXLIZET	T4	PA; QL (31 EA per 31 days)
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	
NIASPAN EXTENDED-RELEASE ORAL TABLET EXTENDED RELEASE 24 HR 1,000 MG, 750 MG	T4	
NIASPAN EXTENDED-RELEASE ORAL TABLET EXTENDED RELEASE 24 HR 500 MG	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
nicardipine oral	T2	
nifedipine	T2	
nimodipine	T2	
nisoldipine	T2	
NITRO-BID	T2	
NITRO-DUR	T3	
nitroglycerin sublingual	T2	
nitroglycerin transdermal patch 24 hour	T2	
nitroglycerin translingual	T2	
NITROLINGUAL	T4	
NITROSTAT	T4	
NORPACE	T4	
NORPACE CR	T4	
NORVASC	T4	
NYMALIZE ORAL SYRINGE 60 MG/10 ML	T4	
olmesartan oral tablet 20 mg, 40 mg	T2	QL (31 EA per 31 days)
olmesartan oral tablet 5 mg	T2	QL (93 EA per 31 days)
olmesartan-amlodipin-hcthiazid	T3	
olmesartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
omega-3 acid ethyl esters	T3	
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	T4	PA; QL (93 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG	T5	PA; QL (186 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG	T5	PA; QL (521 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG	T5	PA; QL (261 EA per 31 days)
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	T2	
pentoxifylline	T2	
perindopril erbumine	T1	
phenoxybenzamine	T5	PA
pindolol	T1	
PLAVIX ORAL TABLET 75 MG	T4	
PRADAXA	T4	QL (124 EA per 31 days)
PRALUENT PEN	T4	PA; QL (2 ML per 28 days)
prasugrel	T3	
pravastatin	T1	

Drug Name	Drug Tier	Requirements/Limits
prazosin	T1	
PREVALITE ORAL POWDER IN PACKET	T2	
PRINIVIL ORAL TABLET 20 MG	T4	
PROCARDIA XL	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	
propranolol oral tablet	T1	
QBRELIS	T4	
QUESTRAN LIGHT	T4	
QUESTRAN ORAL POWDER IN PACKET	T4	
quinapril	T1	
quinapril-hydrochlorothiazide	T1	
quinidine gluconate oral	T2	
quinidine sulfate oral tablet	T2	
ramipril	T1	
RANEXA	T4	QL (62 EA per 31 days)
ranolazine	T3	QL (62 EA per 31 days)
REPATHA PUSHTRONEX	T3	PA; QL (7 ML per 28 days)
REPATHA SURECLICK	T3	PA; QL (3 ML per 28 days)
REPATHA SYRINGE	T3	PA; QL (3 ML per 28 days)
rosuvastatin	T2	
ROSZET	T4	ST; QL (31 EA per 31 days)
RYTHMOL SR	T4	
SAVAYSA	T4	QL (31 EA per 31 days)
simvastatin oral tablet	T1	
SORINE	T1	
SOTALOL AF	T1	
sotalol oral	T1	
SOTYLIZE	T4	
spironolactone	T1	
spironolacton-hydrochlorothiaz	T1	

Drug Name	Drug Tier	Requirements/Limits
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	T4	
TAVALISSE	T5	PA; QL (62 EA per 31 days)
TAZTIA XT	T1	
TEKTURNA	T4	
TEKTURNA HCT	T4	
telmisartan	T1	
telmisartan-amlodipine	T1	
telmisartan-hydrochlorothiazid	T1	
TENORETIC 100	T4	
TENORETIC 50	T4	
TENORMIN	T4	
terazosin	T1	
THALITONE	T4	
TIADYLT ER	T1	
TIAZAC	T4	
TIKOSYN	T3	
timolol maleate oral	T1	
TOPROL XL	T4	
torsemide oral	T1	
trandolapril	T1	
trandolapril-verapamil	T2	
triamterene	T4	
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg	T1	
triamterene-hydrochlorothiazid oral tablet	T1	
TRIBENZOR	T4	
TRICOR	T4	
TRILIPIX	T4	
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 tablet 160 mg, 40 mg, 80 mg	T1	QL (62 EA per 31 days)
valsartan oral tablet 320 mg	T2	QL (31 EA per 31 days)
valsartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
VASCEPA	T4	
VASERETIC	T4	

Drug Name	Drug Tier	Requirements/Limits
VASOTEC	T4	
VECAMYL	T4	
verapamil oral	T2	
VERELAN	T4	
VERELAN PM	T4	
VERQUVO	T4	PA; QL (31 EA per 31 days)
VYNDAMAX	T5	PA; QL (31 EA per 31 days)
VYNDAQEL	T5	PA; QL (124 EA per 31 days)
VYTORIN 10-10	T4	
VYTORIN 10-20	T4	
VYTORIN 10-40	T4	
VYTORIN 10-80	T4	
warfarin	T1	
WELCHOL	T4	
XARELTO DVT-PE TREAT 30D START	T3	QL (51 EA per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG	T3	QL (31 EA per 31 days)
XARELTO ORAL TABLET 15 MG	T3	QL (52 EA per 31 days)
XARELTO ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
ZESTORETIC	T4	
ZESTRIL	T4	
ZETIA	T4	
ZIAC	T4	
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG, 80 MG	T4	
ZONTIVITY	T4	
ZYPITAMAG ORAL TABLET 2 MG, 4 MG	T4	
Dermatologicals/Topical Therapy		
ABSORICA	T4	
ABSORICA LD	T4	
ACANYA TOPICAL GEL WITH PUMP	T4	
ACCUTANE ORAL CAPSULE 20 MG, 30 MG, 40 MG	T2	
acitretin	T4	PA
acyclovir topical cream	T3	
acyclovir topical ointment	T1	QL (30 GM per 30 days)
ACZONE	T4	
adapalene topical cream	T2	PA
adapalene topical gel	T2	PA
adapalene topical solution	T2	PA

Drug Name	Drug Tier	Requirements/Limits
adapalene topical swab	T2	PA
adapalene-benzoyl peroxide	T4	
AKLIEF	T4	PA
ALA-CORT TOPICAL CREAM	T1	
ALA-SCALP	T4	
alclometasone	T1	
ALDARA	T4	
ALTABAX	T4	
ALTRENO	T4	PA
amcinonide	T2	
ammonium lactate	T2	
AMNESTEEM	T2	
AMZEEQ	T4	
APEXICON E	T2	
ARAZLO	T4	
ATRALIN	T4	PA
AVITA	T4	PA
azelaic acid	T4	
AZELEX	T4	
BENZACLIN PUMP	T4	
BENZAMYCIN	T4	
BESER	T2	
betamethasone dipropionate	T1	
betamethasone valerate	T1	
betamethasone, augmented	T2	
BRYHALI	T4	
calcipotriene scalp	T2	QL (60 ML per 28 days)
calcipotriene topical cream	T2	QL (60 GM per 28 days)
calcipotriene topical foam	T4	
calcipotriene topical ointment	T2	QL (60 GM per 28 days)
calcipotriene-betamethasone	T5	
calcitriol topical	T2	
CAPEX	T4	
CARAC	T5	PA
ciclopirox topical cream	T2	QL (90 GM per 28 days)
ciclopirox topical gel	T2	QL (45 GM per 28 days)
ciclopirox topical shampoo	T2	
ciclopirox topical solution	T2	

Drug Name	Drug Tier	Requirements/Limits
ciclopirox topical suspension	T2	QL (60 ML per 28 days)
CLARAVIS	T2	
CLEOCIN T TOPICAL LOTION	T4	
CLINDACIN P	T4	
CLINDAGEL	T4	
clindamycin phosphate topical foam	T2	
clindamycin phosphate topical gel	T2	
clindamycin phosphate topical lotion	T2	
clindamycin phosphate topical solution	T2	
clindamycin phosphate topical swab	T2	
clindamycin-benzoyl peroxide topical gel	T2	
clindamycin-benzoyl peroxide topical gel with pump 1.2-2.5 %	T2	
clindamycin-tretinoin	T2	
clobetasol scalp	T2	
clobetasol topical cream	T3	
clobetasol topical foam	T2	
clobetasol topical gel	T2	
clobetasol topical lotion	T2	
clobetasol topical ointment	T3	
clobetasol topical shampoo	T2	
clobetasol topical spray,non-aerosol	T2	
clobetasol-emollient	T3	
CLOBEX	T4	
clocortolone pivalate	T4	
CLODAN	T2	
CLODERM	T4	
clotrimazole topical	T2	
clotrimazole-betamethasone topical cream	T2	QL (45 GM per 28 days)
clotrimazole-betamethasone topical lotion	T2	QL (60 ML per 28 days)
CONDYLOX TOPICAL GEL	T3	
CORDRAN TAPE LARGE ROLL	T3	
CORDRAN TOPICAL CREAM	T3	
CORDRAN TOPICAL LOTION	T3	
CORDRAN TOPICAL OINTMENT	T3	
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)

Drug Name	Drug Tier	Requirements/Limits
CUTIVATE TOPICAL LOTION	T4	
dapsone topical	T4	
DENAVIR	T3	
DERMA-SMOOTHE/FS SCALP OIL	T4	
DESONATE	T4	
desonide	T2	
DESOWEN TOPICAL CREAM	T4	
desoximetasone	T2	
diclofenac sodium topical gel 3 %	T4	PA; QL (100 GM per 28 days)
DIFFERIN TOPICAL CREAM	T4	PA
DIFFERIN TOPICAL GEL WITH PUMP	T4	PA
DIFFERIN TOPICAL LOTION	T4	PA
diflorasone	T2	
DIPROLENE (AUGMENTED) TOPICAL OINTMENT	T4	
DOVONEX TOPICAL	T4	QL (60 GM per 28 days)
doxepin topical	T4	PA; QL (45 GM per 28 days)
DUOBRII	T5	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 (4 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 (4 ML per 28 days)
econazole	T2	
EFUDEX TOPICAL CREAM	T4	
ELIDEL	T4	QL (100 GM per 28 days)
ENSTILAR	T4	QL (60 GM per 28 days)
EPIDUO FORTE	T4	
EPIDUO TOPICAL GEL WITH PUMP	T4	
ERTACZO	T4	ST
ERY PADS	T2	
ERYGEL	T3	
erythromycin with ethanol topical gel	T2	
erythromycin with ethanol topical solution	T2	
erythromycin-benzoyl peroxide	T2	
EUCRISA	T4	PA; QL (60 GM per 30 days)

Drug Name	Drug Tier	Requirements/Limits
EVOCLIN	T4	
EXTINA	T4	ST
FABIOR	T4	
FINACEA	T4	
fluocinolone and shower cap	T2	
fluocinolone topical cream	T2	
fluocinolone topical ointment	T2	
fluocinolone topical solution	T2	
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-E	T2	QL (60 GM per 28 days)
FLUOROPLEX	T4	
fluorouracil topical cream 0.5 %	T5	
fluorouracil topical cream 5 %	T2	
fluorouracil topical solution	T2	
flurandrenolide	T3	
fluticasone propionate topical	T2	
gentamicin topical	T1	
halcinonide	T4	
halobetasol propionate topical cream	T2	
halobetasol propionate topical ointment	T2	
HALOG	T4	
hydrocortisone butyrate	T2	
hydrocortisone topical cream 1 %, 2.5 %	T1	
hydrocortisone topical lotion 2.5 %	T1	
hydrocortisone topical ointment 1 %, 2.5 %	T1	
hydrocortisone valerate	T2	
ILUMYA	T5	PA; QL (1 ML per 84 days)
imiquimod topical cream in packet 3.75 %	T5	
imiquimod topical cream in packet 5 %	T2	
IMPEKLO	T4	
isotretinoin	T2	
ivermectin topical cream	T4	
ivermectin topical lotion	T2	
JUBLIA	T4	

Drug Name	Drug Tier	Requirements/Limits
KENALOG TOPICAL	T3	
KERYDIN	T4	
ketoconazole topical cream	T2	
ketoconazole topical foam	T4	
ketoconazole topical shampoo	T2	
KETODAN	T2	ST
KLARON	T4	
LEXETTE	T4	
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 VISCOUS	T2	
lidocaine-prilocaine topical cream	T2	PA; QL (30 GM per 28 days)
LIDODERM	T4	PA; QL (93 EA per 31 days)
lindane topical shampoo	T2	
LOCOID LIPOCREAM	T4	
LOCOID TOPICAL LOTION	T4	
LOPROX (AS OLAMINE) TOPICAL CREAM	T4	QL (90 GM per 28 days)
LOPROX TOPICAL SHAMPOO	T4	
luliconazole	T4	
LUXIQ	T4	
LUZU	T4	
mafenide acetate	T4	
malathion	T2	
MENTAX	T4	
methoxsalen	T2	
METROCREAM	T4	
METROGEL TOPICAL GEL 1 %	T4	
METROLOTION	T4	
metronidazole topical cream	T2	
metronidazole topical gel 0.75 %	T2	
metronidazole topical gel 1 %	T1	
metronidazole topical lotion	T2	
MIRVASO TOPICAL GEL WITH PUMP	T4	
mometasone topical	T2	
mupirocin	T2	
mupirocin calcium	T4	ST

Drug Name	Drug Tier	Requirements/Limits
MYORISAN	T2	
naftifine topical cream	T4	ST
NAFTIN TOPICAL GEL	T4	ST
NATROBA	T4	
NEO-SYNALAR	T4	
NEUAC	T2	
NOLIX	T3	
NORITATE	T5	
NYAMYC	T2	
nystatin topical	T2	
nystatin-triamcinolone	T3	
NYSTOP	T2	
OLUX	T4	
OLUX-E	T4	
ONEXTON TOPICAL GEL WITH PUMP	T4	
OVIDE	T4	
oxiconazole	T4	ST
OXISTAT	T4	ST
PANDEL	T4	
PANRETIN	T5	PA-NS
permethrin	T2	
pimecrolimus	T3	
PLIAGLIS	T4	
podofilox	T2	
prednicarbate topical ointment	T2	
PROTOPIC	T4	
PRUDOXIN	T4	PA; QL (45 GM per 28 days)
PSORCON	T4	
QBREXZA	T4	
REGRANEX	T5	PA
RETIN-A	T4	PA
RETIN-A MICRO	T4	PA
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %	T4	PA
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.08 %	T5	PA
RHOFADE	T4	
SANTYL	T3	QL (180 GM per 30 days)
selenium sulfide topical lotion	T1	

Drug Name	Drug Tier	Requirements/Limits
SILIQ	T5	PA; QL (6 ML per 28 days)
SILVADENE	T4	
silver sulfadiazine	T1	
SKYRIZI SUBCUTANEOUS PEN INJECTOR	T5	PA; QL (1 ML per 28 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (1 ML per 28 days)
SKYRIZI SUBCUTANEOUS SYRINGE KIT	T5	PA; QL (1 EA per 28 days)
SOOLANTRA	T4	
SORIATANE ORAL CAPSULE 10 MG, 25 MG	T5	PA
SORILUX	T4	
spinosad	T4	
SSD	T4	
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)
sulfacetamide sodium (acne)	T1	
SULFAMYLON TOPICAL CREAM	T3	
SULFAMYLON TOPICAL PACKET	T4	
SYNALAR TOPICAL CREAM	T4	
TACLONEX TOPICAL OINTMENT	T5	
TACLONEX TOPICAL SUSPENSION	T4	
tacrolimus topical	T2	
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE	T5	PA; QL (1 ML per 28 days)
tavaborole	T4	
tazarotene topical cream	T4	PA
tazarotene topical foam	T4	
TAZORAC	T4	PA
TEMOVATE TOPICAL CREAM	T4	
TEXACORT	T4	
TOPICORT	T4	
TOVET EMOLLIENT	T3	
TREMFYA	T5	PA; QL (1 ML per 56 days)
tretinoin	T2	PA
tretinoin microspheres topical gel	T2	PA

Drug Name	Drug Tier	Requirements/Limits
triamcinolone acetonide topical aerosol	T2	
triamcinolone acetonide topical cream	T1	
triamcinolone acetonide topical lotion	T1	
triamcinolone acetonide topical ointment	T1	
TRIANEX	T2	
TRIDERM TOPICAL CREAM	T1	
ULTRAVATE TOPICAL LOTION	T4	
VALCHLOR	T5	PA-NS
VANOS	T4	
VECTICAL	T4	
VELTIN	T4	
VERDESO	T4	
VEREGEN	T4	
XEPI	T4	
XERESE	T4	
XOLEGEL	T4	ST
ZENATANE	T2	
ZIANA	T4	
ZILXI	T4	
ZONALON	T4	PA; QL (30 GM per 28 days)
ZOVIRAX TOPICAL CREAM	T4	
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	T5	
Diagnostics / Miscellaneous Agents		
acamprosate	T2	
AGRYLIN	T4	
anagrelide	T2	
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
AURYXIA	T4	PA; QL (372 EA per 31 days)
BUPHENYL	T5	PA
bupropion hcl (smoking deter)	T2	QL (62 EA per 31 days)
CARBAGLU	T5	PA
CARNITOR ORAL	T4	PA-BvD
cevimeline	T2	
CHANTIX	T4	QL (60 EA per 30 days)
CHANTIX CONTINUING MONTH BOX	T4	QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
CHANTIX STARTING MONTH BOX	T4	QL (106 EA per 365 days)
CHEMET	T3	
CLINIMIX 4.25%/D5W SULFIT FREE	T4	PA-BvD
CLINIMIX E 2.75%/D5W SULF FREE	T4	PA-BvD
d10 %-0.45 % sodium chloride	T2	
d2.5 %-0.45 % sodium chloride	T2	
d5 % and 0.9 % sodium chloride	T2	
d5 %-0.45 % sodium chloride	T2	
deferasirox oral granules in packet	T4	PA
deferasirox oral tablet	T4	PA
deferasirox oral tablet, dispersible	T5	PA
deferiprone	T5	PA
dextrose 10 % and 0.2 % nacl	T2	
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	T5	PA
ENDARI	T4	PA; QL (180 EA per 30 days)
EVOXAC	T4	
EXJADE	T5	PA
EXSERVAN	T5	PA; QL (62 EA per 31 days)
FERRIPROX	T5	PA
FOSRENOL ORAL POWDER IN PACKET	T5	
FOSRENOL ORAL TABLET,CHEWABLE 1,000 MG, 750 MG	T5	
FOSRENOL ORAL TABLET,CHEWABLE 500 MG	T4	
GLASSIA	T5	PA
INCRELEX	T5	PA
JADENU	T4	PA
JADENU SPRINKLE	T4	PA
lanthanum	T4	
levocarnitine (with sugar)	T2	PA-BvD
levocarnitine oral tablet	T2	PA-BvD
LITHOSTAT	T4	
LOKELMA	T3	PA; QL (93 EA per 31 days)
midodrine	T2	

Drug Name	Drug Tier	Requirements/Limits
NICOTROL	T3	
NICOTROL NS	T4	
nitisinone	T5	
NITYR	T5	
NORTHERA	T5	PA
ORFADIN	T5	
OXBRYTA	T5	PA; QL (155 EA per 31 days)
pilocarpine hcl oral	T2	
PROLASTIN-C INTRAVENOUS RECON SOLN	T5	PA
RAVICTI	T5	PA
RENAGEL ORAL TABLET 800 MG	T4	
RENVELA ORAL POWDER IN PACKET	T3	
RENVELA ORAL TABLET	T4	
RILUTEK	T5	
riluzole	T4	
risedronate oral tablet 30 mg	T2	
SALAGEN (PILOCARPINE)	T4	
sevelamer carbonate	T3	
sevelamer hcl	T3	
sodium chloride 0.9 % intravenous parenteral solution	T2	
sodium chloride irrigation	T2	
sodium phenylbutyrate	T5	
sodium polystyrene sulfonate oral powder	T2	
SPS (WITH SORBITOL) ORAL	T2	
SYPRINE	T3	QL (248 EA per 31 days)
THIOLA	T5	PA
THIOLA EC	T5	PA
TIGLUTIK	T5	PA
tiopronin	T5	PA
trientine	T3	QL (248 EA per 31 days)
varenicline	T4	QL (62 EA per 31 days)
VELPHORO	T5	
VELTASSA	T3	PA; QL (30 EA per 30 days)
XURIDEN	T5	PA
ZEMAIRA	T5	PA
Ear, Nose / Throat Medications		
acetic acid otic (ear)	T2	

Drug Name	Drug Tier	Requirements/Limits
azelastine nasal	T2	QL (30 ML per 25 days)
CETRAXAL	T4	
chlorhexidine gluconate mucous membrane	T1	
CIPRO HC	T4	
CIPRODEX	T3	
ciprofloxacin hcl otic (ear)	T1	
ciprofloxacin-dexamethasone	T3	
ciprofloxacin-fluocinolone	T4	
DERMOTIC OIL	T4	
FLAC OTIC OIL	T2	
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)
neomycin-polymyxin-hc otic (ear)	T2	
ofloxacin otic (ear)	T2	
olopatadine nasal	T2	QL (30.5 GM per 30 days)
OTOVEL	T4	
PATANASE	T4	QL (30.5 GM per 30 days)
PERIOGARD	T1	
triamcinolone acetonide dental	T2	
Endocrine/Diabetes		
acarbose	T1	QL (93 EA per 31 days)
ACTHAR	T5	PA
ACTOPLUS MET	T4	QL (93 EA per 31 days)
ACTOS	T4	QL (31 EA per 31 days)
ADLYXIN	T4	QL (6 ML per 28 days)
ADMELOG SOLOSTAR U-100 INSULIN	T4	
ADMELOG U-100 INSULIN LISPRO	T4	
AFREZZA	T4	
ALCOHOL PADS	T2	
ALKINDI SPRINKLE	T5	PA
alogliptin	T4	QL (31 EA per 31 days)
alogliptin-metformin	T4	QL (62 EA per 31 days)
alogliptin-pioglitazone	T4	QL (31 EA per 31 days)
AMARYL	T4	
ANDRODERM	T3	PA

Drug Name	Drug Tier	Requirements/Limits
ANDROGEL	T3	PA
APIDRA SOLOSTAR U-100 INSULIN	T4	
APIDRA U-100 INSULIN	T4	
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	
AVEED	T4	PA
BAQSIMI	T3	
BASAGLAR KWIKPEN U-100 INSULIN	T3	
BYDUREON BCISE	T4	QL (3.4 ML per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	T4	QL (2.4 ML per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	T4	QL (1.2 ML per 30 days)
cabergoline	T2	
calcitonin (salmon) nasal	T2	PA-BvD
calcitriol oral	T2	PA-BvD
CERDELGA	T5	PA; QL (62 EA per 31 days)
cinacalcet oral tablet 30 mg	T3	PA-BvD; QL (62 EA per 31 days)
cinacalcet oral tablet 60 mg	T5	PA-BvD; QL (62 EA per 31 days)
cinacalcet oral tablet 90 mg	T5	PA-BvD; QL (124 EA per 31 days)
CORTEF	T4	
CYCLOSET	T4	
CYTOMEL	T4	
danazol	T2	
DDAVP ORAL	T4	
DEPO-TESTOSTERONE	T4	PA
desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)	T4	
desmopressin oral	T2	
DEXABLISS	T2	
dexamethasone oral elixir	T1	
dexamethasone oral tablet	T1	
dexamethasone oral tablets,dose pack	T2	
diazoxide	T3	
doxercalciferol oral capsule 0.5 mcg, 2.5 mcg	T2	PA-BvD
doxercalciferol oral capsule 1 mcg	T4	PA-BvD
DUETACT	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
EMFLAZA	T5	PA
EUTHYROX	T4	
FARXIGA	T4	
FIASP FLEXTOUCH U-100 INSULIN	T3	
FIASP PENFILL U-100 INSULIN	T3	
FIASP U-100 INSULIN	T3	
fludrocortisone	T2	
FORTAMET ORAL TABLET EXTENDED RELEASE 24HR 1,000 MG	T4	ST; QL (62 EA per 31 days)
FORTESTA	T4	PA
GALAFOLD	T5	PA; QL (14 EA per 28 days)
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T2	
glimepiride	T1	PA
glipizide	T1	
glipizide-metformin	T1	
GLUCAGEN HYPOKIT	T3	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
GLUCOTROL XL	T4	
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 1,000 MG	T4	ST; QL (62 EA per 31 days)
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 500 MG	T4	ST; QL (31 EA per 31 days)
glyburide	T2	PA
glyburide micronized	T2	PA
glyburide-metformin	T2	PA
GLYNASE	T4	PA
GLYXAMBI	T3	QL (31 EA per 31 days)
GVOKE HYPOPEN 2-PACK	T3	
GVOKE PFS 2-PACK SYRINGE	T3	
HEMADY	T4	PA-NS
HUMALOG JUNIOR KWIKPEN U-100	T3	
HUMALOG KWIKPEN INSULIN	T3	
HUMALOG MIX 50-50 INSULN U-100	T3	
HUMALOG MIX 50-50 KWIKPEN	T3	
HUMALOG MIX 75-25 KWIKPEN	T3	
HUMALOG MIX 75-25(U-100)INSULN	T3	
HUMALOG U-100 INSULIN	T3	
HUMULIN 70/30 U-100 INSULIN	T3	
HUMULIN 70/30 U-100 KWIKPEN	T3	

Drug Name	Drug Tier	Requirements/Limits
HUMULIN N NPH INSULIN KWIKPEN	T3	
HUMULIN N NPH U-100 INSULIN	T3	
HUMULIN R REGULAR U-100 INSULN	T3	
HUMULIN R U-500 (CONC) INSULIN	T3	
HUMULIN R U-500 (CONC) KWIKPEN	T3	
hydrocortisone oral	T1	
insulin asp prt-insulin aspart	T3	
insulin aspart u-100	T3	
insulin lispro	T3	
insulin lispro protamin-lispro	T3	
insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge	T3	
INVOKAMET	T3	QL (62 EA per 31 days)
INVOKAMET XR	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 100 MG	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 300 MG	T3	QL (31 EA per 31 days)
ISTURISA	T5	PA
JANUMET	T3	QL (62 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	T3	QL (31 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	T3	QL (62 EA per 31 days)
JANUVIA ORAL TABLET 100 MG, 50 MG	T3	QL (31 EA per 31 days)
JANUVIA ORAL TABLET 25 MG	T3	QL (93 EA per 31 days)
JARDIANCE	T3	
JATENZO ORAL CAPSULE 158 MG, 237 MG	T4	PA; QL (62 EA per 31 days)
JATENZO ORAL CAPSULE 198 MG	T4	PA; QL (124 EA per 31 days)
JENTADUETO	T3	QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	T3	QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	T3	QL (31 EA per 31 days)
JYNARQUE	T5	PA
KAZANO	T4	QL (62 EA per 31 days)
KOMBIGLYZE XR	T4	
KORLYM	T5	PA; QL (124 EA per 31 days)
KUVAN ORAL POWDER IN PACKET	T4	PA
KUVAN ORAL TABLET,SOLUBLE	T5	PA

Drug Name	Drug Tier	Requirements/Limits
LANTUS SOLOSTAR U-100 INSULIN	T3	
LANTUS U-100 INSULIN	T3	
LEVEMIR FLEXTOUCH U-100 INSULN	T3	
LEVEMIR U-100 INSULIN	T3	
LEVO-T	T4	
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	
liothyronine oral	T2	
LYUMJEV KWIKPEN U-100 INSULIN	T4	
LYUMJEV KWIKPEN U-200 INSULIN	T4	
LYUMJEV U-100 INSULIN	T4	
MEDROL	T4	
MEDROL (PAK)	T4	
metformin oral solution	T4	ST; QL (791 ML per 31 days)
metformin oral tablet	T1	
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	T2	
METHITEST	T5	PA
methylprednisolone	T2	
methyltestosterone oral capsule	T5	PA
miglitol	T2	
miglustat	T5	PA; QL (93 EA per 31 days)
MILLIPRED ORAL TABLET	T2	
MYALEPT	T5	PA
nateglinide	T1	QL (93 EA per 31 days)
NATESTO	T4	PA
NATPARA	T5	PA; QL (31 EA per 31 days)
NESINA	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
NOCDURNA (MEN)	T4	QL (31 EA per 31 days)
NOCDURNA (WOMEN)	T4	QL (31 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 U-100 INSULN	T3	
NOVOLOG FLEXPEN U-100 INSULIN	T3	
NOVOLOG MIX 70-30 U-100 INSULN	T3	
NOVOLOG MIX 70-30FLEXPEN U-100	T3	
NOVOLOG PENFILL U-100 INSULIN	T3	
NOVOLOG U-100 INSULIN ASPART	T3	
ONGLYZA	T4	QL (31 EA per 31 days)
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)
OSENI	T4	QL (31 EA per 31 days)
oxandrolone oral tablet 10 mg	T5	PA
oxandrolone oral tablet 2.5 mg	T2	PA
OZEMPIC	T3	QL (3 ML per 28 days)
PALYNZIQ	T5	PA
paricalcitol oral	T2	PA-BvD
pen needle, diabetic needle 29 gauge x 1/2"	T4	
pioglitazone	T1	QL (31 EA per 31 days)
pioglitazone-glimepiride	T1	QL (31 EA per 31 days)
pioglitazone-metformin	T1	QL (93 EA per 31 days)
prednisolone oral solution	T2	
prednisolone sodium phosphate oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	T2	
prednisolone sodium phosphate oral tablet,disintegrating	T2	
PREDNISONE INTENSOL	T4	
prednisone oral solution	T2	
prednisone oral tablet	T1	
prednisone oral tablets,dose pack	T2	
PROGLYCEM	T4	
propylthiouracil	T2	

Drug Name	Drug Tier	Requirements/Limits
QTERN	T4	QL (31 EA per 31 days)
RAYALDEE	T4	QL (62 EA per 31 days)
RAYOS	T4	
repaglinide oral tablet 0.5 mg	T1	QL (124 EA per 31 days)
repaglinide oral tablet 1 mg	T2	QL (124 EA per 31 days)
repaglinide oral tablet 2 mg	T2	QL (248 EA per 31 days)
RIOMET	T4	ST; QL (791 ML per 31 days)
ROCALTROL	T4	PA-BvD
RYBELSUS	T3	QL (31 EA per 31 days)
SAMSCA	T5	PA
sapropterin oral powder in packet	T4	PA
sapropterin oral tablet,soluble	T5	PA
SEGLUROMET	T4	QL (62 EA per 31 days)
SEMGLEE PEN U-100 INSULIN	T4	
SEMGLEE U-100 INSULIN	T4	
SENSIPAR ORAL TABLET 30 MG, 60 MG	T5	PA-BvD; QL (62 EA per 31 days)
SENSIPAR ORAL TABLET 90 MG	T5	PA-BvD; QL (124 EA per 31 days)
SOLIQUA 100/33	T4	QL (18 ML per 30 days)
SOMAVERT	T5	PA
STEGLATRO	T4	QL (31 EA per 31 days)
STEGLUJAN	T4	QL (31 EA per 31 days)
SYMLINPEN 120	T3	QL (10.8 ML per 28 days)
SYMLINPEN 60	T3	QL (6 ML per 28 days)
SYNAREL	T5	
SYNJARDY	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	T3	QL (31 EA per 31 days)
SYNTHROID	T3	
TAPERDEX	T4	
TESTIM	T4	PA
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	T2	PA
testosterone enanthate	T2	PA
testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 12.5 mg/ 1.25 gram (1 %)	T4	PA

Drug Name	Drug Tier	Requirements/Limits
testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)	T3	PA
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)	T4	PA
testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)	T3	PA
testosterone transdermal solution in metered pump w/app	T4	PA
THYQUIDITY	T4	
TIROSINT	T4	
TIROSINT-SOL	T4	
tolvaptan	T5	PA
TOUJEO MAX U-300 SOLOSTAR	T3	
TOUJEO SOLOSTAR U-300 INSULIN	T3	
TRADJENTA	T3	QL (31 EA per 31 days)
TRESIBA FLEXTOUCH U-100	T3	
TRESIBA FLEXTOUCH U-200	T3	
TRESIBA U-100 INSULIN	T3	
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	QL (2 ML per 28 days)
UNITHROID	T3	
VICTOZA 3-PAK	T3	QL (9 ML per 30 days)
VOGELXO TRANSDERMAL GEL	T4	PA
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	T4	PA
XIGDUO XR	T4	
XULTOPHY 100/3.6	T3	
XYOSTED	T4	PA
ZAVESCA	T5	PA; QL (93 EA per 31 days)
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	T4	PA-BvD
Gastroenterology		
ACIPHEX	T4	QL (62 EA per 31 days)
alosetron	T5	PA
AMITIZA	T3	QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
amoxicil-clarithromy-lansopraz	T2	
ANTIVERT ORAL TABLET 50 MG	T4	
ANUSOL-HC TOPICAL	T4	
aprepitant	T4	PA-BvD
APRISO	T4	
ASACOL HD	T3	
AZULFIDINE	T4	
AZULFIDINE EN-TABS	T4	
balsalazide	T2	
BONJESTA	T4	PA; QL (62 EA per 31 days)
budesonide oral	T4	
CANASA	T4	
CARAFATE ORAL SUSPENSION	T3	
CARAFATE ORAL TABLET	T4	
CHENODAL	T5	PA
chlordiazepoxide-clidinium	T2	
CHOLBAM	T5	PA
cimetidine	T2	
cimetidine hcl oral	T2	
CIMZIA	T5	PA; QL (2 EA per 28 days)
CIMZIA POWDER FOR RECONST	T5	PA; QL (2 EA per 28 days)
CLENPIQ	T4	
COLAZAL	T4	
COMPRO	T2	
CONSTULOSE	T2	
CREON	T3	
cromolyn oral	T4	
CUVPOSA	T4	
CYSTADANE	T3	
CYTOTEC	T4	
DELZICOL	T4	
DEXILANT	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	T2	
DIPENTUM	T4	
diphenoxylate-atropine	T2	

Drug Name	Drug Tier	Requirements/Limits
doxylamine-pyridoxine (vit b6)	T4	PA; QL (124 EA per 31 days)
dronabinol oral capsule 10 mg	T4	PA-BvD
dronabinol oral capsule 2.5 mg, 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
ENTOCORT EC	T4	
ENULOSE	T2	
esomeprazole magnesium oral capsule,delayed release(dr/ec)	T2	QL (31 EA per 31 days)
esomeprazole magnesium oral granules dr for susp in packet	T2	
famotidine oral suspension	T1	
famotidine oral tablet 20 mg, 40 mg	T1	
GASTROCROM	T4	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T2	
GAVILYTE-G	T2	
GAVILYTE-N	T2	
GENERLAC	T2	
GIMOTI	T4	PA; QL (9.8 ML per 28 days)
glycopyrrolate oral tablet 1 mg, 2 mg	T2	
GOLYTELY ORAL RECON SOLN	T4	
granisetron hcl oral	T2	PA-BvD
HELIDAC	T4	
hydrocortisone rectal	T1	
hydrocortisone-pramoxine rectal cream 1-1 %	T4	
KRISTALOSE	T4	
lactulose oral packet	T4	
lactulose oral solution 10 gram/15 ml	T1	
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	T3	QL (31 EA per 31 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	T3	QL (62 EA per 31 days)
lansoprazole oral tablet,disintegrat, delay rel 15 mg	T3	QL (31 EA per 31 days)
lansoprazole oral tablet,disintegrat, delay rel 30 mg	T3	QL (62 EA per 31 days)
LIALDA	T4	

Drug Name	Drug Tier	Requirements/Limits
LIBRAX (WITH CLIDINIUM)	T4	
LINZESS	T3	QL (31 EA per 31 days)
LOMOTIL	T4	
loperamide oral capsule	T2	
LOTRONEX	T5	PA
lubiprostone	T4	ST; QL (62 EA per 31 days)
MARINOL	T4	PA-BvD
meclizine oral tablet 12.5 mg, 25 mg	T2	
mesalamine oral capsule (with del rel tablets)	T3	
mesalamine oral capsule,extended release 24hr	T4	
mesalamine oral tablet,delayed release (dr/ec) 1.2 gram	T3	
mesalamine oral tablet,delayed release (dr/ec) 800 mg	T4	
mesalamine rectal enema	T2	
mesalamine rectal suppository	T4	
methscopolamine	T2	
metoclopramide hcl oral	T2	
misoprostol	T2	
MOTEGRITY	T4	PA; QL (31 EA per 31 days)
MOVANTIK	T3	QL (31 EA per 31 days)
MOVIPREP	T4	
MYTESI	T4	QL (62 EA per 31 days)
NEXIUM	T4	QL (31 EA per 31 days)
NEXIUM PACKET	T3	
nizatidine	T2	
NULYTELY LEMON-LIME	T4	
OCALIVA	T5	PA; QL (31 EA per 31 days)
OMECLAMOX-PAK	T4	
omeprazole oral capsule,delayed release(dr/ec)	T1	
omeprazole-sodium bicarbonate oral capsule	T2	
omeprazole-sodium bicarbonate oral packet	T4	
ondansetron	T2	PA-BvD
ondansetron hcl oral	T2	PA-BvD
ORTIKOS	T4	
OSMOPREP	T4	

Drug Name	Drug Tier	Requirements/Limits
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, 21,000-54,700- 83,900 UNIT, 37,000-97,300- 149,900 UNIT, 4,200-14,200- 24,600 UNIT	T4	
pantoprazole oral granules dr for susp in packet	T4	
pantoprazole oral tablet,delayed release (dr/ec)	T1	
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram	T2	
peg3350-sod sul-nacl-kcl-asb-c	T4	
peg-electrolyte soln	T2	
PENTASA	T3	
PEPCID ORAL TABLET	T4	
PERTZYE	T4	
PLENVU	T4	
PREVACID ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 MG	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	T4	
prochlorperazine	T2	
prochlorperazine maleate	T2	
PROCTO-MED HC	T2	
PROCTO-PAK	T2	
PROCTOZONE-HC	T2	
PROTONIX ORAL	T4	
PYLERA	T4	
rabeprazole oral tablet,delayed release (dr/ec)	T2	QL (62 EA per 31 days)
RECTIV	T4	
REGLAN ORAL	T4	
RELISTOR ORAL	T5	PA; QL (93 EA per 31 days)
RELISTOR SUBCUTANEOUS SOLUTION	T4	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)

Drug Name	Drug Tier	Requirements/Limits
RELTONE	T4	
ROWASA RECTAL ENEMA KIT	T4	
SANCUSO	T4	
scopolamine base	T3	QL (10 EA per 30 days)
SUCRAID	T5	
sucralfate	T2	
sulfasalazine	T2	
SUPREP BOWEL PREP KIT	T3	
SUTAB	T4	
SYMPROIC	T4	PA; QL (31 EA per 31 days)
SYNDROS	T5	PA
TALICIA	T4	
TRANSDERM-SCOP	T3	QL (10 EA per 30 days)
trimethobenzamide oral	T2	PA
TRULANCE	T4	QL (31 EA per 31 days)
UCERIS	T4	
URSO 250	T4	
URSO FORTE	T4	
ursodiol oral capsule 300 mg	T3	
ursodiol oral tablet	T3	
VARUBI ORAL	T4	PA-BvD
VIBERZI	T5	PA; QL (62 EA per 31 days)
VIOKACE	T4	
ZEGERID	T4	
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 3,000-10,000 -14,000- UNIT, 5,000-17,000- 24,000 UNIT	T3	
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 25,000-79,000- 105,000 UNIT, 40,000-126,000- 168,000 UNIT	T5	
Immunology, Vaccines / Biotechnology		
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 300 MCG/ML	T5	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	T4	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML, 60 MCG/0.3 ML	T4	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML	T5	PA-BvD
ARCALYST	T5	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	QL (4 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	QL (4 EA per 28 days)
bcg vaccine, live (pf)	T4	
BETASERON SUBCUTANEOUS KIT	T5	QL (14 EA per 28 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T3	
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
EGRIFTA SV	T5	PA
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
ENGERIX-B PEDIATRIC (PF)	T3	PA-BvD
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T4	PA-BvD
EXTAVIA SUBCUTANEOUS KIT	T5	QL (15 EA per 30 days)
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	T5	PA
FULPHILA	T5	
GAMMAGARD LIQUID	T5	PA
GAMMAGARD S-D (IGA < 1 MCG/ML)	T5	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T4	PA
GAMMAPLEX	T5	PA
GAMMAPLEX (WITH SORBITOL)	T5	PA
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T3	PA
GARDASIL 9 (PF)	T3	

Drug Name	Drug Tier	Requirements/Limits
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	T4	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML	T5	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG/ML (36 UNIT/ML)	T5	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 5 MG/ML (15 UNIT/ML)	T4	PA
GRANIX	T5	
GRASTEK	T4	PA
HAVRIX (PF) INTRAMUSCULAR SYRINGE	T3	
HIBERIX (PF)	T3	
HUMATROPE INJECTION CARTRIDGE	T5	PA
IMOVAX RABIES VACCINE (PF)	T3	PA-BvD
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	T3	
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)	T4	PA-NS
INTRON A INJECTION RECON SOLN 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML)	T5	PA-NS
INTRON A INJECTION SOLUTION	T5	PA-NS
IPOL	T3	
IXIARO (PF)	T3	
KINRIX (PF) INTRAMUSCULAR SYRINGE	T3	
LEUKINE INJECTION RECON SOLN	T5	PA
MENACTRA (PF) INTRAMUSCULAR SOLUTION	T3	
MENQUADFI (PF)	T4	
MENVEO A-C-Y-W-135-DIP (PF)	T3	
M-M-R II (PF)	T3	
NEULASTA	T5	
NEUPOGEN INJECTION SOLUTION 300 MCG/ML	T4	
NEUPOGEN INJECTION SOLUTION 480 MCG/1.6 ML	T5	

Drug Name	Drug Tier	Requirements/Limits
NEUPOGEN INJECTION SYRINGE	T5	
NIVESTYM	T5	
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML)	T5	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
NUTROPIN AQ NUSPIN	T5	PA
NYVEPRIA	T5	
OCTAGAM	T5	PA
ODACTRA	T4	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	T4	PA
PANZYGA	T5	PA
PEDIARIX (PF)	T3	PA-BvD
PEDVAX HIB (PF)	T3	
PEGASYS	T5	PA
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	T5	QL (1 ML per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	T5	QL (1 ML per 28 days)
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 40,000 UNIT/ML	T5	PA-BvD
PROQUAD (PF)	T3	
QUADRACEL (PF)	T3	
RABAVERT (PF)	T3	PA-BvD
REBIF (WITH ALBUMIN)	T5	QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	T5	QL (6 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	T5	QL (4.2 ML per 365 days)
REBIF TITRATION PACK	T5	QL (8.4 ML per 365 days)
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	T3	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
RETACRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	T5	PA-BvD
ROTARIX	T3	
ROTATEQ VACCINE	T3	
SAIZEN	T5	PA
SAIZEN SAIZENPREP	T5	PA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	T5	PA
SHINGRIX (PF)	T3	
TDVAX	T3	
TENIVAC (PF) INTRAMUSCULAR SYRINGE	T3	
tetanus,diphtheria tox ped(pf)	T4	
TRUMENBA	T3	
TWINRIX (PF)	T3	
TYPHIM VI	T3	
UDENYCA	T5	
VAQTA (PF)	T3	
VARIVAX (PF)	T3	
VARIZIG	T4	
YF-VAX (PF)	T3	
ZARXIO	T5	
ZIEXTENZO	T5	
ZOMACTON	T4	PA
ZORBTIVE	T5	PA
Musculoskeletal / Rheumatology		
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	

Drug Name	Drug Tier	Requirements/Limits
alendronate oral solution	T1	
alendronate oral tablet 10 mg, 35 mg, 70 mg	T1	
allopurinol	T1	
ARAVA	T5	
ATELVIA	T4	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
BINOSTO	T4	
BONIVA ORAL	T4	
colchicine	T4	QL (62 EA per 31 days)
COLCRYS	T4	QL (124 EA per 31 days)
CUPRIMINE	T5	
DEPEN TITRATABS	T5	
ENBREL MINI	T5	PA; QL (7.84 ML per 28 days)
ENBREL SUBCUTANEOUS RECON SOLN	T5	PA; QL (8 EA per 28 days)
ENBREL SUBCUTANEOUS 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 (7.84 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (7.84 ML per 28 days)
EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	T5	PA; QL (2.34 ML per 28 days)
EVISTA	T3	
febuxostat	T4	PA
FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (600MCG/2.4ML)	T5	PA; QL (2.4 ML per 28 days)
FOSAMAX ORAL TABLET 70 MG	T4	
FOSAMAX PLUS D	T4	
GLOPERBA	T4	QL (310 ML per 31 days)
HUMIRA PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA PEN CROHNS-UC-HS START	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN PSOR-UVEITS-ADOL HS	T5	PA; QL (4 EA per 28 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF)	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	T5	PA; QL (3 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEN PEDIATRIC UC	T5	PA; QL (4 EA per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA; QL (3 EA per 28 days)
ibandronate oral	T2	
KEVZARA	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
leflunomide	T2	
MITIGARE	T3	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)
OTEZLA	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (55 EA per 28 days)
OTREXUP (PF)	T4	PA
penicillamine	T5	
probenecid	T2	
probenecid-colchicine	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)
raloxifene	T3	
RASUVO (PF)	T4	PA
REDITREX (PF)	T4	PA
RIDAURA	T3	
RINVOQ	T5	PA; QL (31 EA per 31 days)
risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg	T2	
risedronate oral tablet,delayed release (dr/ec)	T2	
SAVELLA	T4	PA
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
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)
teriparatide	T5	PA; QL (2.48 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)
ZYLOPRIM	T4	
Obstetrics / Gynecology		
ACTIVELLA ORAL TABLET 1-0.5 MG	T4	
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
AMABELZ	T2	
AMETHIA	T2	
ANGELIQ	T4	
ANNOVERA	T4	
APRI	T2	
ARANELLE (28)	T2	
ASHLYNA	T2	
AUBRA EQ	T2	
AVIANE	T2	
AYGESTIN	T4	
BALCOLTRA	T4	
BALZIVA (28)	T2	
BEYAZ	T4	
BIJUVA	T4	
BLISOVI 24 FE	T2	
BLISOVI FE 1.5/30 (28)	T2	
BRIELLYN	T2	
CAMILA	T2	
CAMRESE LO	T2	
CAZIANT (28)	T2	
CLEOCIN VAGINAL	T4	
CLIMARA	T4	

Drug Name	Drug Tier	Requirements/Limits
CLIMARA PRO	T4	
clindamycin phosphate vaginal	T2	
CLINDESSE	T4	
COMBIPATCH	T4	
CRINONE	T4	PA
CRYSELLE (28)	T2	
CYCLAFEM 1/35 (28)	T2	
CYCLAFEM 7/7/7 (28)	T2	
CYRED EQ	T2	
DEBLITANE	T2	
DELESTROGEN	T4	
DEPO-ESTRADIOL	T4	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	T4	
DEPO-SUBQ PROVERA 104	T4	
desog-e.estradiol/e.estradiol	T2	
desogestrel-ethinyl estradiol	T2	
DIVIGEL TRANSDERMAL GEL IN PACKET 1 MG/GRAM (0.1 %)	T4	
DOLISHALE	T2	
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	
EMOQUETTE	T2	
ENPRESSE	T2	
ENSKYCE	T2	
ERRIN	T2	
ESTARYLLA	T2	
ESTRACE	T4	
estradiol oral	T1	
estradiol transdermal	T2	
estradiol vaginal	T4	
estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml	T2	
estradiol-norethindrone acet	T2	

Drug Name	Drug Tier	Requirements/Limits
ESTRING	T4	
ESTROGEL	T4	
ethynodiol diac-eth estradiol	T2	
etonogestrel-ethinyl estradiol	T3	
EVAMIST	T4	
FALMINA (28)	T2	
FEMHRT LOW DOSE	T4	
FEMRING	T4	
FEMYNOR	T2	
FYAVOLV	T2	
GEMMILY	T4	
GENERESS FE	T4	
GYNAZOLE-1	T3	
HAILEY 24 FE	T2	
ICLEVIA	T2	
IMVEXXY MAINTENANCE PACK	T4	
IMVEXXY STARTER PACK	T4	
INCASSIA	T2	
INTRAROSA	T4	PA; QL (28 EA per 28 days)
INTROVALE	T2	
ISIBLOOM	T2	
JASMIEL (28)	T2	
JINTELI	T2	
JULEBER	T2	
JUNEL 1.5/30 (21)	T2	
JUNEL 1/20 (21)	T2	
JUNEL FE 1.5/30 (28)	T2	
JUNEL FE 1/20 (28)	T2	
JUNEL FE 24	T2	
KAITLIB FE	T2	
KARIVA (28)	T2	
KELNOR 1/35 (28)	T2	
KELNOR 1-50 (28)	T2	
KURVELO (28)	T2	
l norgest/e.estradiol-e.estrad	T2	
LARIN 1.5/30 (21)	T2	
LARIN 1/20 (21)	T2	
LARIN FE 1.5/30 (28)	T2	

Drug Name	Drug Tier	Requirements/Limits
LARIN FE 1/20 (28)	T2	
LARISSIA	T2	
LAYOLIS FE	T4	
LEENA 28	T2	
LESSINA	T2	
LEVONEST (28)	T2	
levonorgestrel-ethinyl estrad	T2	
levonorg-eth estrad triphasic	T2	
LEVORA-28	T2	
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	
LORYNA (28)	T2	
LOSEASONIQUE	T4	
LOW-OGESTREL (28)	T2	
LUPANETA PACK (1 MONTH)	T5	
LUPANETA PACK (3 MONTH)	T5	
LUTERA (28)	T2	
LYLEQ	T2	
LYLLANA	T2	
LYSTEDA	T4	
LYZA	T2	
MARLISSA (28)	T2	
medroxyprogesterone	T2	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	T4	
MENOSTAR	T4	
MERZEE	T4	
metronidazole vaginal	T2	
MIBELAS 24 FE	T2	
MICONAZOLE-3 VAGINAL SUPPOSITORY	T2	
MICROGESTIN 1.5/30 (21)	T2	
MICROGESTIN 1/20 (21)	T2	
MICROGESTIN FE 1.5/30 (28)	T2	
MICROGESTIN FE 1/20 (28)	T2	
MILI	T2	

Drug Name	Drug Tier	Requirements/Limits
MIMVEY	T2	
MINASTRIN 24 FE	T4	
MINIVELLE	T4	
MYFEMBREE	T5	PA; QL (31 EA per 31 days)
NATAZIA	T4	
NECON 0.5/35 (28)	T2	
NEXTSTELLIS	T4	
NIKKI (28)	T2	
NORA-BE	T2	
noreth-ethinyl estradiol-iron	T2	
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 tablet 1 mg-20 mcg (21)/75 mg (7)	T2	
norethindrone-e.estradiol-iron oral tablet,chewable	T2	
norgestimate-ethinyl estradiol	T2	
NORTREL 0.5/35 (28)	T2	
NORTREL 1/35 (21)	T2	
NORTREL 1/35 (28)	T2	
NORTREL 7/7/7 (28)	T2	
NUVARING	T4	
NYLIA 7/7/7 (28)	T2	
NYMYO	T2	
OCELLA	T2	
ORIAHNN	T5	PA; QL (56 EA per 28 days)
ORSYTHIA	T2	
OSPHENA	T4	PA; QL (31 EA per 31 days)
PIMTREA (28)	T2	
PIRMELLA ORAL TABLET 1-35 MG-MCG	T2	
PORTIA 28	T2	
PREFEST	T4	
PREMARIN ORAL	T4	
PREMARIN VAGINAL	T3	
PREMPHASE	T4	
PREMPRO	T4	
PREVIFEM	T2	

Drug Name	Drug Tier	Requirements/Limits
progesterone micronized	T2	
PROMETRIUM	T4	
PROVERA	T4	
QUARTETTE	T4	
RECLIPSEN (28)	T2	
RIVELSA	T4	
SAFYRAL	T4	
SEASONIQUE	T4	
SETLAKIN	T2	
SHAROBEL	T2	
SLYND	T4	
SPRINTEC (28)	T2	
SRONYX	T2	
SYEDA	T2	
TARINA 24 FE	T2	
TARINA FE 1-20 EQ (28)	T2	
terconazole	T2	
TILIA FE	T2	
tranexamic acid oral	T2	
TRI-ESTARYLLA	T2	
TRI-LEGEST FE	T2	
TRI-LO-ESTARYLLA	T2	
TRI-LO-SPRINTEC	T2	
TRI-MILI	T2	
TRI-NYMYO	T2	
TRI-PREVIFEM (28)	T2	
TRI-SPRINTEC (28)	T2	
TRIVORA (28)	T2	
TRI-VYLIBRA	T2	
TRI-VYLIBRA LO	T2	
TYDEMY	T2	
VAGIFEM	T4	
VANDAZOLE	T3	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VESTURA (28)	T2	
VIENVA	T2	
VIVELLE-DOT	T4	
VYFEMLA (28)	T2	

Drug Name	Drug Tier	Requirements/Limits
VYLIBRA	T2	
WYMZYA FE	T2	
XULANE	T2	
YASMIN (28)	T4	
YAZ (28)	T4	
YUVAFEM	T4	
ZAFEMY	T2	
ZARAH	T2	
ZOVIA 1/35E (28)	T2	
Ophthalmology		
acetazolamide	T2	
ACULAR	T4	
ACULAR LS	T4	
ACUVAIL (PF)	T4	
ALOCRIL	T4	
ALOMIDE	T3	
ALPHAGAN P	T3	
ALREX	T4	
apraclonidine	T2	
atropine ophthalmic (eye) drops	T2	
AZASITE	T4	
azelastine ophthalmic (eye)	T2	
AZOPT	T4	
bacitracin ophthalmic (eye)	T2	
bacitracin-polymyxin b ophthalmic (eye)	T2	
bepotastine besilate	T4	
BEPREVE	T4	
BESIVANCE	T4	
betaxolol ophthalmic (eye)	T2	
BETIMOL	T4	
BETOPTIC S	T4	
bimatoprost ophthalmic (eye)	T2	
BLEPH-10	T4	
BLEPHAMIDE	T3	
BLEPHAMIDE S.O.P.	T3	
brimonidine	T2	
brinzolamide	T4	
bromfenac	T2	

Drug Name	Drug Tier	Requirements/Limits
BROMSITE	T4	
carteolol	T2	
CEQUA	T4	QL (60 EA per 30 days)
CILOXAN OPHTHALMIC (EYE) DROPS	T4	
CILOXAN OPHTHALMIC (EYE) OINTMENT	T3	
ciprofloxacin hcl ophthalmic (eye)	T1	
COMBIGAN	T3	
COSOPT	T4	
COSOPT (PF)	T4	
cromolyn ophthalmic (eye)	T2	
CYSTADROPS	T5	QL (20 ML per 28 days)
CYSTARAN	T5	
dexamethasone sodium phosphate ophthalmic (eye)	T2	
diclofenac sodium ophthalmic (eye)	T1	
difluprednate	T3	
dorzolamide	T2	
dorzolamide-timolol	T2	
dorzolamide-timolol (pf) ophthalmic (eye) dropperette	T4	
DUREZOL	T3	
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	
FML S.O.P.	T4	
gatifloxacin	T3	
GENTAK OPHTHALMIC (EYE) OINTMENT	T2	
gentamicin ophthalmic (eye) drops	T1	
ILEVRO	T3	
INVELTYS	T4	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	T3	

Drug Name	Drug Tier	Requirements/Limits
ISOPTO CARPINE	T4	
ISTALOL	T4	
ketorolac ophthalmic (eye)	T2	
LACRISERT	T3	
LASTACAFT	T4	
latanoprost	T1	
levobunolol ophthalmic (eye) drops 0.5 %	T1	
levofloxacin ophthalmic (eye)	T2	
LOTEMAX	T4	
LOTEMAX SM	T4	
loteprednol etabonate	T4	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
MAXIDEX	T4	
MAXITROL	T4	
methazolamide	T2	
MOXEZA	T4	
moxifloxacin ophthalmic (eye) drops	T3	
NATACYN	T3	
neomycin-bacitracin-poly-hc	T2	
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	
olopatadine ophthalmic (eye)	T3	
OXERVATE	T5	PA; QL (112 ML per 56 days)
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	T2	
polymyxin b sulf-trimethoprim	T1	
POLYTRIM	T4	
PRED FORTE	T4	
PRED MILD	T4	
PRED-G	T4	
PRED-G S.O.P.	T4	
prednisolone acetate	T1	
prednisolone sodium phosphate ophthalmic (eye)	T2	

Drug Name	Drug Tier	Requirements/Limits
PROLENSA	T4	
RESTASIS	T3	QL (60 EA per 30 days)
RHOPRESSA	T4	
ROCKLATAN	T4	
SIMBRINZA	T4	
sulfacetamide sodium ophthalmic (eye) drops	T2	
sulfacetamide sodium ophthalmic (eye) ointment	T1	
sulfacetamide-prednisolone	T2	
timolol maleate (pf)	T4	
timolol maleate ophthalmic (eye) drops	T1	
timolol maleate ophthalmic (eye) drops, once daily	T2	
timolol maleate ophthalmic (eye) gel forming solution	T2	
TIMOPTIC OCUDOSE (PF)	T4	
TIMOPTIC-XE	T4	
TOBRADEX OPHTHALMIC (EYE) DROPS,SUSPENSION	T4	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
TOBRADEX ST	T3	
tobramycin ophthalmic (eye)	T1	
tobramycin-dexamethasone	T2	
TOBREX OPHTHALMIC (EYE) DROPS	T4	
TOBREX OPHTHALMIC (EYE) OINTMENT	T3	
TRAVATAN Z	T4	
travoprost	T3	
trifluridine	T2	
TRUSOPT	T4	
VIGAMOX	T4	
VYZULTA	T4	ST; QL (5 ML per 31 days)
XALATAN	T4	
XELPROS	T4	
XIIDRA	T4	QL (60 EA per 30 days)
ZERVIATE	T4	
ZIOPTAN (PF)	T4	
ZIRGAN	T4	ST
ZYLET	T4	

Drug Name	Drug Tier	Requirements/Limits
ZYMAXID	T3	
Respiratory And Allergy		
ACCOLATE	T4	
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	QL (60 EA per 30 days)
ADVAIR HFA	T4	QL (12 GM per 30 days)
AIRDUO DIGIHALER	T4	PA; QL (2 EA per 365 days)
AIRDUO RESPICLICK	T4	QL (1 EA 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	T1	
ALVESCO	T4	QL (12.2 GM per 30 days)
ALYQ	T5	PA; QL (62 EA per 31 days)
ambrisentan	T5	PA; QL (31 EA per 31 days)
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
arformoterol	T4	PA-BvD
ARMONAIR DIGIHALER	T4	PA; QL (2 EA per 365 days)
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	T3	QL (25.8 GM per 30 days)
AUVI-Q INJECTION AUTO-INJECTOR 0.1 MG/0.1 ML, 0.15 MG/0.15 ML	T4	ST
AUVI-Q INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML	T5	ST
azelastine-fluticasone	T4	
BECONASE AQ	T4	

Drug Name	Drug Tier	Requirements/Limits
BERINERT INTRAVENOUS KIT	T5	PA
BEVESPI AEROSPHERE	T4	QL (10.7 GM per 30 days)
bosentan	T5	PA; QL (62 EA per 31 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BREZTRI AEROSPHERE	T4	QL (10.7 GM per 30 days)
BRONCHITOL	T5	PA; QL (560 EA per 28 days)
BROVANA	T4	PA-BvD
budesonide inhalation	T2	PA-BvD
budesonide-formoterol	T4	QL (10.2 GM per 30 days)
carbinoxamine maleate oral liquid	T4	PA
carbinoxamine maleate oral tablet 4 mg	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	
clemastine oral syrup	T2	
clemastine oral tablet 2.68 mg	T2	
COMBIVENT RESPIMAT	T3	QL (4 GM per 30 days)
cromolyn inhalation	T2	PA-BvD
cyproheptadine	T2	PA
DALIRESP ORAL TABLET 250 MCG	T4	QL (31 EA per 31 days)
DALIRESP ORAL TABLET 500 MCG	T3	QL (31 EA per 31 days)
desloratadine	T2	QL (31 EA per 31 days)
dexchlorpheniramine maleate oral solution	T2	
DUAKLIR PRESSAIR	T4	QL (1 EA per 30 days)
DULERA	T4	QL (13 GM per 30 days)
DYMISTA	T4	ST
epinephrine injection auto-injector	T3	
EPIPEN 2-PAK	T4	
EPIPEN JR 2-PAK	T4	
ESBRIET ORAL CAPSULE	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 267 MG	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 801 MG	T5	PA; QL (93 EA per 31 days)
FASENRA	T5	PA; QL (1 ML per 56 days)
FASENRA PEN	T5	PA; QL (1 ML per 56 days)
FIRAZYR	T5	PA; QL (18 ML per 30 days)
FLOVENT DISKUS	T3	QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION, 220 MCG/ACTUATION	T3	QL (24 GM per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	T3	QL (12 GM per 30 days)
flunisolide	T2	QL (50 ML per 25 days)
fluticasone propionate nasal	T2	QL (16 GM per 30 days)
fluticasone propion-salmeterol inhalation aerosol powdr breath activated	T3	QL (1 EA per 30 days)
fluticasone propion-salmeterol inhalation blister with device	T3	QL (60 EA per 30 days)
formoterol fumarate	T4	PA-BvD
HAEGARDA	T5	PA
hydroxyzine hcl oral	T2	PA
hydroxyzine pamoate	T2	PA
icatibant	T5	PA; QL (18 ML per 30 days)
INCRUSE ELLIPTA	T3	QL (30 EA per 30 days)
ipratropium bromide inhalation	T1	PA-BvD
ipratropium-albuterol	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET 25 MG	T5	PA; QL (62 EA per 31 days)
KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
LETAIRIS	T5	PA; QL (31 EA per 31 days)
levalbuterol hcl	T2	PA-BvD
levalbuterol tartrate	T3	QL (30 GM per 30 days)
levocetirizine oral solution	T2	QL (310 ML per 31 days)
levocetirizine oral tablet	T1	QL (31 EA per 31 days)
LONHALA MAGNAIR REFILL	T4	
mometasone nasal	T3	QL (34 GM per 30 days)
montelukast	T2	QL (31 EA per 31 days)
NASONEX	T4	QL (34 GM per 30 days)
NUCALA	T5	PA; QL (3 EA per 28 days)
OFEV	T5	PA; QL (62 EA per 31 days)
OMNARIS	T4	
OPSUMIT	T5	PA; QL (31 EA per 31 days)
ORKAMBI ORAL GRANULES IN PACKET	T5	PA; QL (62 EA per 31 days)
ORKAMBI ORAL TABLET	T5	PA; QL (124 EA per 31 days)
ORLADEYO	T5	PA; QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
PERFOROMIST	T4	PA-BvD
PROAIR DIGIHALER	T4	PA; QL (2 EA per 365 days)
PROAIR HFA	T4	ST; QL (17 GM per 30 days)
PROAIR RESPICLICK	T4	ST; QL (2 EA per 30 days)
promethazine oral	T2	PA
promethazine rectal suppository 12.5 mg, 25 mg	T2	
PROMETHEGAN RECTAL SUPPOSITORY 25 MG, 50 MG	T2	
PROVENTIL HFA	T4	ST; QL (13.4 GM per 30 days)
PULMICORT	T4	PA-BvD
PULMICORT FLEXHALER	T4	QL (1 EA per 30 days)
PULMOZYME	T5	PA
QNASL	T4	
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	T3	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	T3	QL (21.2 GM per 30 days)
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	T5	PA; QL (224 ML per 31 days)
REVATIO ORAL TABLET	T5	PA; QL (93 EA per 31 days)
RUCONEST	T5	PA
RYCLORA	T4	
RYVENT	T4	PA
SEREVENT DISKUS	T3	QL (60 EA per 30 days)
sildenafil (pulm.hypertension) oral suspension for reconstitution	T5	PA; QL (224 ML per 31 days)
sildenafil (pulm.hypertension) oral tablet	T3	PA; QL (93 EA per 31 days)
SINGULAIR	T4	QL (31 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER	T3	QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T4	QL (4 GM per 30 days)
SYMBICORT	T3	QL (10.2 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
SYMJEPI	T4	
tadalafil (pulm. hypertension)	T5	PA; QL (62 EA per 31 days)
TAKHZYRO	T5	PA; QL (4 ML per 28 days)
terbutaline oral	T2	

Drug Name	Drug Tier	Requirements/Limits
THEO-24	T4	
theophylline oral solution	T2	
theophylline oral tablet extended release 12 hr 300 mg, 450 mg	T2	
theophylline oral tablet extended release 24 hr	T2	
TRACLEER ORAL TABLET	T5	PA; QL (62 EA per 31 days)
TRACLEER ORAL TABLET FOR SUSPENSION	T5	PA; QL (124 EA per 31 days)
TRELEGY ELLIPTA	T3	QL (60 EA per 30 days)
TRIKAFTA	T5	PA; QL (84 EA per 28 days)
TUDORZA PRESSAIR	T4	QL (1 EA per 30 days)
VENTAVIS	T5	PA
VENTOLIN HFA	T3	QL (36 GM per 30 days)
VISTARIL	T4	PA
WIXELA INHUB	T3	QL (60 EA per 30 days)
XHANCE	T4	QL (32 ML per 30 days)
XOLAIR	T5	PA
XOPENEX	T4	PA-BvD
XOPENEX CONCENTRATE	T4	PA-BvD
XOPENEX HFA	T4	ST; QL (30 GM per 30 days)
YUPELRI	T4	PA-BvD
zafirlukast	T2	
ZETONNA	T4	
zileuton	T5	PA
ZYFLO	T4	PA
Urologicals		
alfuzosin	T2	QL (31 EA per 31 days)
AVODART	T4	QL (31 EA per 31 days)
bethanechol chloride	T2	
CIALIS ORAL TABLET 2.5 MG	T4	PA; QL (62 EA per 31 days)
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T3	
darifenacin	T3	QL (31 EA per 31 days)
DETROL	T4	QL (62 EA per 31 days)
DETROL LA	T4	QL (31 EA per 31 days)
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG	T4	QL (93 EA per 31 days)
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24HR 5 MG	T4	QL (155 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
dutasteride	T2	QL (31 EA per 31 days)
dutasteride-tamsulosin	T3	QL (31 EA per 31 days)
ELMIRON	T5	
finasteride oral tablet 5 mg	T2	
flavoxate	T2	
FLOMAX	T4	
GELNIQUE TRANSDERMAL GEL IN PACKET	T4	QL (30 GM per 30 days)
GEMTESA	T4	QL (31 EA per 31 days)
JALYN	T4	QL (31 EA per 31 days)
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON	T3	QL (310 ML per 31 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	T2	
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET	T5	PA
PROSCAR	T4	
RAPAFLO	T4	
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)
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	T3	QL (31 EA per 31 days)
trospium oral capsule,extended release 24hr	T2	QL (31 EA per 31 days)
trospium oral tablet	T2	QL (93 EA per 31 days)
UROCIT-K 10	T4	
UROCIT-K 15	T4	
UROCIT-K 5	T4	
UROXATRAL	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
VESICARE	T4	QL (31 EA per 31 days)
VESICARE LS	T4	QL (310 ML per 31 days)
Vitamins, Hematinics / Electrolytes		
AMINOSYN II 15 %	T3	PA-BvD
AMINOSYN-PF 7 % (SULFITE-FREE)	T4	PA-BvD
calcium acetate(phosphat bind)	T2	
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
DOJOLVI	T5	PA
fluoride (sodium) oral tablet	T2	
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	T4	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T3	PA-BvD
ISOLYTE-S	T3	PA-BvD
KLOR-CON	T3	
KLOR-CON 10	T3	
KLOR-CON 8	T3	
KLOR-CON M10	T1	
KLOR-CON M15	T1	
KLOR-CON M20	T1	
K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ, 20 MEQ	T4	
K-TAB ORAL TABLET EXTENDED RELEASE 8 MEQ	T3	
magnesium sulfate injection	T2	
NUTRILIPID	T4	PA-BvD
PHOSLYRA	T4	
PLASMA-LYTE 148	T4	PA-BvD
PLASMA-LYTE A	T4	PA-BvD
PLENAMINE	T3	PA-BvD
potassium chlorid-d5-0.45%nacl	T2	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	T2	

Drug Name	Drug Tier	Requirements/Limits
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l	T2	
potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	T2	
potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml	T2	
potassium chloride intravenous	T2	
potassium chloride oral capsule, extended release	T1	
potassium chloride oral liquid	T2	
potassium chloride oral tablet extended release	T1	
potassium chloride oral tablet,er particles/crystals	T1	
potassium chloride-0.45 % nacl	T2	
potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l	T2	
potassium chloride-d5-0.9%nacl	T2	
PREMASOL 10 %	T4	PA-BvD
PRENATAL VITAMIN PLUS LOW IRON	T2	PA
PROCALAMINE 3%	T4	PA-BvD
PROSOL 20 %	T4	PA-BvD
sodium chloride 0.45 % intravenous parenteral solution	T2	
sodium chloride 3 %	T2	
sodium chloride 5 %	T2	
TPN ELECTROLYTES	T4	
TRAVASOL 10 %	T3	PA-BvD
TROPHAMINE 10 %	T4	PA-BvD

Index of Drugs

acitretin

Products Affected

- *acitretin*
- **SORIATANE ORAL CAPSULE 10 MG, 25 MG**

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	

actemra

Products Affected

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

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

acthar h.p.

Products Affected

- **ACTHAR**

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

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

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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

ADHD Drugs

Products Affected

- *clonidine hcl oral tablet extended release 12 hr*
- *guanfacine oral tablet extended release 24 hr*
- **INTUNIV ER**
- **KAPVAY**

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	

afinitor

Products Affected

- **AFINITOR** *mg, 5 mg, 7.5 mg*
- **AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG**
- *everolimus (antineoplastic) oral tablet 2.5*

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

aimovig

Products Affected

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

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

airduo digihaler

Products Affected

- **AIRDUO DIGIHALER**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of asthma -AND- Inadequate response to non-digitized LABA/ICS inhaler-AND- Attestation that a digital inhaler is required.
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ajovy

Products Affected

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

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

alecensa

Products Affected

- **ALECENSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

alkindi

Products Affected

- **ALKINDI SPRINKLE**

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

ALPHA1-PROTEINASE INHIBITORS

Products Affected

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

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

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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

ampyra

Products Affected

- **AMPYRA**
- *dalfampridine*

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

anabolic steroids

Products Affected

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

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

apokyn

Products Affected

- **APOKYN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease -AND- for use in acute, intermittent treatment of hypomobility off-episodes -AND- documentation of concurrent medication for the treatment of Parkinson's disease (e.g. carbidopa/levodopa, pramipexole, ropinerole) -AND- Therapeutic failure, intolerance, or contraindication to a generic pramipexole containing product and a generic ropinirole containing product
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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 a macrolide -AND- Arikayce will be used in conjunction with a background multidrug regimen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	18 months
Other Criteria	For reauthorization, attestation of positive sputum cultures -OR- negative sputum cultures for insufficient period of time (e.g. less than 12 months).
Indications	All FDA-approved Indications.
Off Label Uses	

armonair digihaler

Products Affected

- **ARMONAIR DIGIHALER**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of asthma -AND- Inadequate response to non-digitized ICS inhaler-AND- Attestation that a digital inhaler is required.
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

attr-cm drugs

Products Affected

- **VYNDAMAX**
- **VYNDAQEL**

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

atypical antipsychotics

Products Affected

- **ABILIFY MYCITE**
- **ABILIFY ORAL TABLET**
- *aripiprazole*
- **REXULTI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. If medication is being used for major depressive disorder, documentation of adjunctive therapy and an adequate trial of 1 alternative antidepressant is required (e.g. SSRI, SNRI, NDRIs, TCA, MAOI). For Rexulti, trial, intolerance, or contraindication to one other formulary generic atypical antipsychotic (e.g. quetiapine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

aubagio

Products Affected

- **AUBAGIO**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Aubagio and other disease modifying agents such as fingolimod, interferons, Copaxone, Tysabri
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	Doses greater than 14 mg per day will not be approved
Indications	All FDA-approved Indications.
Off Label Uses	

auryxia

Products Affected

- **AURYXIA**

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

austedo

Products Affected

- **AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 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	For members who are not poor CYP2D6 metabolizers, doses above plan quantity limit will be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

ayvakit

Products Affected

- **AYVAKIT**

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

bafiertam

Products Affected

- **BAFIERTAM**

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

balversa

Products Affected

- **BALVERSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic urothelial carcinoma - AND- FGFR3 or FGFR2 mutation positive as detected by FDA approved test -AND- Disease progression during or following at least one prior platinum containing chemotherapy including within 12 months of neoadjuvant or adjuvant platinum containing chemotherapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

banzel

Products Affected

- **BANZEL**
- *rufinamide*

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- an adequate trial or intolerance of a previous antiepileptic therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses greater than 3200mg per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

belbuca

Products Affected

- **BELBUCA**

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

PA Criteria	Criteria Details
Other Criteria	Belbuca should not be used concomitantly with substance abuse therapies.
Indications	All FDA-approved Indications.
Off Label Uses	

benlysta

Products Affected

- **BENLYSTA SUBCUTANEOUS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of active systemic lupus erythematosus (SLE) -AND- documentation of positive anti-nuclear antibody (ANA) titer (greater than or equal to 1:80) or anti-double-stranded DNA antibody (anti-dsDNA) greater than or equal to 30IU/mL -AND- trial, intolerance, or inadequate response to at least 2 of the following standard of care drug classes: 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate) -AND- member will continue to receive concomitant standard of care treatment with use of at least one of the following (alone or in combination): 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate) -OR- Documentation of active lupus nephritis -AND- documentation of positive ANA titer (greater than or equal to 1:80) or anti-dsDNA greater than or equal to 30 IU/mL -AND- trial, intolerance, or inadequate response to at least 2 of the following standard of care drug classes: 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate) -AND- member will continue to receive concomitant standard of care treatment which includes corticosteroids (e.g. prednisone) with at least one of the following: 1.) mycophenolate for induction followed by mycophenolate for maintenance 2.) cyclophosphamide for induction followed by azathioprine for maintenance
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months

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

benznidazole

Products Affected

- *benznidazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	Deny if less than 2 or greater than 12 years of age.
Prescriber Restrictions	
Coverage Duration	2 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

berinert

Products Affected

- **BERINERT INTRAVENOUS KIT**

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

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	

bosulif

Products Affected

- **BOSULIF**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Ph+ chronic myelogenous leukemia (CML) of any phase and lack of response or intolerance to prior therapy (e.g. imatinib, dasatinib, nilotinib) -OR- documentation of newly-diagnosed chronic phase Ph+ CML
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

braftovi

Products Affected

- **BRAFTOVI ORAL CAPSULE 75 MG**

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

bronchitol

Products Affected

- **BRONCHITOL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis -AND- Passed a Bronchitol Tolerance Test -AND- Used in conjunction with standard therapies for the management of cystic fibrosis to improve pulmonary function (e.g. bronchodilators, antibiotics, anti-inflammatory therapy).
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	

brukinsa

Products Affected

- **BRUKINSA**

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

buphenyl

Products Affected

- **BUPHENYL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic management of a 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	

butrans

Products Affected

- *buprenorphine*
- **BUTRANS**

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

PA Criteria	Criteria Details
Other Criteria	Buprenorphine topical patch should not be used concomitantly with substance abuse therapies.
Indications	All FDA-approved Indications.
Off Label Uses	

cablivi

Products Affected

- **CABLIVI INJECTION KIT**

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

cabometyx

Products Affected

- **CABOMETYX**

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

calquence

Products Affected

- **CALQUENCE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Mantle Cell Lymphoma, Chronic Lymphocytic Leukemia or Small Lymphocytic Leukemia. For Mantle Cell Lymphoma, the member has received at least one prior therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

caplyta

Products Affected

- **CAPLYTA**

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

caprelsa

Products Affected

- **CAPRELSA**

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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

carac

Products Affected

- **CARAC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure of 1 generic fluorouracil topical product (with shared indication) is required.
Indications	All FDA-approved Indications.
Off Label Uses	

carbaglu

Products Affected

- **CARBAGLU**

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	
Indications	All FDA-approved Indications.
Off Label Uses	

carbinoxamine

Products Affected

- *carbinoxamine maleate oral liquid*
- *carbinoxamine maleate oral tablet 4 mg*
- **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	

CERDELGA

Products Affected

- **CERDELGA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of mild to moderate type 1 Gaucher disease confirmed by the following A. or B. A) With one of the following symptoms (1, 2, 3, 4, or, 5): 1)Hepatomegaly. 2)Splenomegaly. 3)Bone disease (i.e. osteonecrosis, osteopenia, secondary pathologic fractures, bone infarct). 4)Bone marrow complications as defined by anemia with hemoglobin less than or equal to 11.5 g/dL for females or 12.5 g/dL for males. 5)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). -OR- B) Glucocerebrosidase activity in peripheral leukocytes is less than or equal to 15 percent of normal activity or genetic testing confirms mutant alleles -AND- Documentation of CYP2D6 metabolizer status (e.g. intermediate metabolizer).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CF drugs

Products Affected

- **BETHKIS**
- **PULMOZYME**
- **TOBI**
- **TOBI PODHALER INHALATION**

CAPSULE, W/INHALATION DEVICE

- *tobramycin in 0.225 % nacl*
- *tobramycin inhalation*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis. For Bethkis: failure on, intolerance to, or contraindication to generic tobramycin inhalation solution
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Inhalation solutions covered under Part B when administered in the home setting using a covered nebulizer (i.e. DME).
Indications	All FDA-approved Indications.
Off Label Uses	

chenodal

Products Affected

- **CHENODAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of radiolucent gallstones AND an inadequate response to ursodiol therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months for initial approval with an additional 12 months upon renewal
Other Criteria	Safety of use beyond 24 months is not established
Indications	All FDA-approved Indications.
Off Label Uses	

chloroquine

Products Affected

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

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

cholbam

Products Affected

- **CHOLBAM**

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

cialis

Products Affected

- **CIALIS ORAL TABLET 2.5 MG, 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 at least two alternative medications in the following classes (alpha-1 adrenergic blockers and/or 5-alpha reductase inhibitors)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Cialis, trial and failure of generic tadalafil is required.
Indications	All FDA-approved Indications.
Off Label Uses	

cimzia

Products Affected

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

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

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

cinryze

Products Affected

- **CINRYZE**

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

PA Criteria	Criteria Details
Off Label Uses	

cometriq

Products Affected

- **COMETRIQ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of progressive, metastatic medullary thyroid cancer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

copiktra

Products Affected

- **COPIKTRA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL) in patients who are no longer responding or intolerant to 2 prior therapies - OR- Documentation of Follicular Lymphoma (FL) in patients who are no longer responding or intolerant to 2 prior systemic therapies.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

corlanor

Products Affected

- **CORLANOR ORAL SOLUTION**
- **CORLANOR 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) Left ventricular ejection fraction less than or equal to 35 percent, when applicable. 4) In adult patients (greater than or equal to 18 years), trial/failure of maximum tolerated dose of one beta-blocker used for treatment of heart failure (e.g., bisoprolol, carvedilol, metoprolol succinate) OR contraindication to beta-blocker use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For oral solution, attestation of inability to swallow tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	

Cosentyx

Products Affected

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

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, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs.
Age Restrictions	Deny if less than 6 years of age
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	

cotellic

Products Affected

- **COTELLIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of unresectable or metastatic melanoma in patients with a BRAF V600E or V600K mutation AND used in combination with vemurafenib
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

crinone

Products Affected

- **CRINONE**

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	

daraprim

Products Affected

- **DARAPRIM**
- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For primary prophylaxis of toxoplasmosis gondii infection and treatment of cystoisosporiasis: failure, intolerance or contraindication to trimethoprim-sulfamethoxazole. For secondary prophylaxis of toxoplasmosis gondii infection, CD4 count less than 200 cells/mm*3. For 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, trial and failure of generic pyrimethamine is required.
Indications	All FDA-approved Indications.
Off Label Uses	

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

daytrana

Products Affected

- **DAYTRANA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
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	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	

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. For Chronic Iron Overload in Non-Transfusion-Dependent Thalassemia (NTDT) Syndrome, liver iron concentration of at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw) -AND- serum ferritin greater than 300 mcg/L.
Age Restrictions	Deny if less than 2 years of age for chronic iron overload or less than 10 years of age chronic iron overload in NTDT
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Jadenu and brand Exjade, trial and failure of deferasirox (generic Exjade) is required. For reauthorization of chronic iron overload due to blood transfusion, attestation of positive clinical response -AND- required regular blood transfusions -AND- serum ferritin level greater than or equal to 500mcg/L. For reauthorization of chronic iron overload in NTDT syndrome, attestation of positive clinical response -AND- liver iron concentration greater than or equal to 3mg Fe/g dw.
Indications	All FDA-approved Indications.
Off Label Uses	

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	
Required Medical Information	Documentation of Dravets syndrome - AND- Used in combination with clobazam
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications. For reauthorization, attestation supporting reduction in seizure frequency
Indications	All FDA-approved Indications.
Off Label Uses	

dihydroergotamine

Products Affected

- *dihydroergotamine nasal*
- **MIGRANAL**

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	

dojolvi

Products Affected

- **DOJOLVI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of molecularly confirmed long-chain fatty acid oxidation disorders
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive clinical response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	

doptelet

Products Affected

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

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

doxepin cream

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial, intolerance, or contraindication to at least 2 generic formulary topical corticosteroids -AND- course of therapy will not exceed 8 days
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	

drizalma

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- inability to swallow capsules
Age Restrictions	Deny if less than 18 years of age in the treatment of fibromyalgia, major depressive disorder, diabetic peripheral neuropathy and chronic musculoskeletal pain -OR- if less than 7 years of age in generalized anxiety disorder
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

duexis

Products Affected

- **DUEXIS**
- *ibuprofen-famotidine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Both of the following. 1) Trial/failure of ibuprofen used in combination with famotidine. 2) Trial/failure of one additional generic formulary NSAID (other than ibuprofen) used in combination with one additional generic formulary H2-receptor blocker (other than famotidine).
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	

duobrii

Products Affected

- **DUOBRII**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of plaque psoriasis -AND- therapeutic failure or intolerance to generic tazarotene cream -AND- therapeutic failure or intolerance to 1 high-potency topical corticosteroid (e.g. betamethasone diproprionate 0.05%, halobetasol propionate 0.05%)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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	
Required Medical Information	Documentation of all of the following (1-3): 1) moderate to severe atopic dermatitis 2) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- atopic dermatitis of the face or anogenital involvement 3) trial & failure, intolerance, or contraindication to tacrolimus ointment or pimecrolimus cream -OR- Documentation of the following (4-7): 4) moderate-to-severe asthma 5) documented FEV less than 80 percent predicted 6) Blood eosinophils greater than or equal to 150 cells/uL -OR- patient is currently taking daily or alternate-day oral corticosteroids 7) using a medium- or high-dose inhaled corticosteroid and a long acting beta agonist -OR- Documentation of the following (8-9): 8) chronic rhinosinusitis with nasal polyposis 9) trial & failure, intolerance or contraindication to intra-nasal corticosteroid and 14 day course of oral corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. Reauthorization or continuation of therapy will be approved when documentation of improvement or response to therapy is provided.
Indications	All FDA-approved Indications.
Off Label Uses	

egfr tyrosine kinase inhibitors

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Gilotrif: tumors with resistant EGFR mutations. Tarceva: 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 diagnosis -AND- all of the following, if applicable to diagnosis 1) Epidermal growth factor receptor (EGFR) mutations, including exon 19 deletions or exon 21 (L858R) substitution mutations 2) Alternatives tried/failed 3) Concomitant therapy 4) Line of therapy in which medication will be used
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

egrifta

Products Affected

- **EGRIFTA SV**

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	
Indications	All FDA-approved Indications.
Off Label Uses	

emflaza

Products Affected

- **EMFLAZA**

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

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	
Required Medical Information	Documentation of diagnosis. For Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, the following criteria will apply (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes. For episodic cluster headaches, characterized by severe or very severe unilateral orbital, supraorbital, and/or temporal pain lasting 15 to 180 minutes when left untreated -AND- Attack frequency of at least one attack every other day during the cluster period.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For reauthorization, attestation of reduction in average monthly migraine days or number of migraine episodes is required -OR- attestation of reduction in the number of mean weekly cluster headaches from baseline is required.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

enbrel

Products Affected

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

endari

Products Affected

- **ENDARI**

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

enspryng

Products Affected

- **ENSPRYNG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of neuromyelitis optica spectrum disorder (NMSOD) -AND- Attestation of anti-aquaporin-4 (AQP4) antibody positive -AND- Not used in combination with another monoclonal antibody used for the treatment of NMSOD.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of decrease in number of NMSOD 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	

epclusa

Products Affected

- **EPCLUSA ORAL TABLET**
- *sofosbuvir-velpatasvir*

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	Doses greater than one tablet per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

epidiolex

Products Affected

- **EPIDIOLEX**

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

erivedge

Products Affected

- **ERIVEDGE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced basal cell carcinoma (BCC), which includes metastatic -OR- locally advanced basal cell carcinoma, for whom surgery is inappropriate or in whom recurrence after surgery is documented -AND- is not a candidate for radiation
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications. Doses greater than 150mg/day will not be approved
Indications	All FDA-approved Indications.
Off Label Uses	

erleada

Products Affected

- **ERLEADA**

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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

eucrisa

Products Affected

- **EUCRISA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1 and 2): 1) mild to moderate atopic dermatitis 2) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- documentation of facial or anogenital involvement
Age Restrictions	Deny if less than 3 months of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	If 2 years of age or older, therapeutic failure of one of the following is required: topical tacrolimus -OR- topical pimecrolimus. 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	

evekeo

Products Affected

- *amphetamine sulfate*
- **EVEKEO**

PA Criteria	Criteria Details
Exclusion Criteria	Obesity
Required Medical Information	Documentation of diagnosis. For narcolepsy the following are required: Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B)Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP.
Age Restrictions	Deny if less than 6 years of age for narcolepsy or 3 years of age for ADHD
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For narcolepsy, trial and failure, intolerance to 2 of the following generic alternatives is required: immediate release amphetamine/dextroamphetamine, dextroamphetamine, and methylphenidate. For ADHD, trial/failure or intolerance to 2 unique generic stimulants (e.g. methylphenidate) is required.
Indications	All FDA-approved Indications.
Off Label Uses	

evenity

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- at high risk for fracture, meeting one of the following (1. thru 4.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) Age 50 years or older with T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 50 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of trial/failure, intolerance, or contraindication to at least one oral bisphosphonate. Covered under Part B when furnished incident to physician services. A cumulative lifetime approval of romosozumab will be limited to a coverage duration of 12 months.
Indications	All FDA-approved Indications.
Off Label Uses	

evrysdi

Products Affected

- **EVRYSDI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of spinal muscular atrophy -AND- Baseline motor function test results (e.g. MFM, CHOP, HINE, RULM, HFMSE, 6MWT) -AND- Not using concomitantly with Spinraza -AND- Molecular genetic testing of 5q SMA showing Homozygous gene deletion, Homozygous conversion mutation or Compound heterozygote
Age Restrictions	Deny if less than 2 months of age
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For reauthorization, attestation of stable or clinically significant improvement in Spinal Muscular Atrophy associated symptoms (e.g. stabilization or decreased decline in motor function compared to the predicted natural history trajectory of disease) -OR- Stable or improved motor function results compared to baseline (e.g. MFM, CHOP, HINE, RULM, HFMSE, 6MWT).
Indications	All FDA-approved Indications.
Off Label Uses	

Exservan

Products Affected

- **EXSERVAN**

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	For reauthorization, attestation of stability or improvement in symptoms of ALS.
Indications	All FDA-approved Indications.
Off Label Uses	

farydak

Products Affected

- **FARYDAK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of use in combination with bortezomib and dexamethasone for patients with multiple myeloma who have received at least 2 prior regimens, including bortezomib and an immunomodulatory agent (e.g. Thalomid, Revlimid, Pomalyst)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

fasenra

Products Affected

- **FASENRA**
- **FASENRA PEN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of severe asthma -and- history of at least one asthma exacerbations requiring oral or systemic corticosteroid treatment in the past 12 months -and- documented reduced lung function [prebronchodilator FEV1 below 80% in adults, and below 90% in adolescents] despite regular treatment with (a. or b.): a) high dose inhaled corticosteroid and additional asthma controller medication or b.) a medium or high dose inhaled corticosteroid plus a long-acting beta agonist with or without oral corticosteroids and additional asthma controller medication
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Blood eosinophil count (in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection) greater than or equal to 150 cells/microliter within 6 weeks of initiation of therapy. For 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	

ferriprox

Products Affected

- *deferiprone*
- **FERRIPROX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of transfusional iron overload due to thalassemia syndromes, sickle cell disease, or 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 a liver iron concentration (LIC) of greater than or equal to 7 mg Fe/g dw
Age Restrictions	Deny if less than 8 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure of deferasirox (generic Exjade) is required. For reauthorization, attestation of positive clinical response -AND- required regular blood transfusions -AND- serum ferritin level greater than or equal to 500mcg/L or an LIC of greater than or equal to 3 mg Fe/g dw.
Indications	All FDA-approved Indications.
Off Label Uses	

fetzima

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder and trial and failure of two other antidepressants.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

fintepla

Products Affected

- **FINTEPLA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Therapeutic failure, contraindication or intolerance to 2 of the following: 1) clobazam 2) topiramate 3) divalproex sodium or valproic acid.
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications. For reauthorization, attestation of reduction in seizure frequency
Indications	All FDA-approved Indications.
Off Label Uses	

firazyr

Products Affected

- **FIRAZYR**
- *icatibant*

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

PA Criteria	Criteria Details
Off Label Uses	

firdapse

Products Affected

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

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 of positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	

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	

forteo

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of underlying hypercalcemic disorder such as hypercalcemia, hyperparathyroidism or hypoparathyroidism, or high risk for osteosarcoma (Paget's disease, prior radiation therapy, bone metastases, open epiphyses, etc.). Treatment duration greater than 24 months.
Required Medical Information	Documentation of diagnosis -AND- at high risk for fracture, meeting one of the following (1. thru 4.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) Age 50 years or older with T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 50 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Documentation of trial/failure, intolerance, or contraindication to at least one oral bisphosphonate. Additional documentation of trial/failure, intolerance or contraindication to preferred parathyroid hormone analog Tymlos is required for applicable indication. Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Tymlos or teriparatide will be limited to a coverage duration of 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	

Fotivda

Products Affected

- **FOTIVDA**

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

gabapentin

Products Affected

- *gabapentin oral capsule 100 mg, 300 mg, 400 mg*
- *gabapentin oral solution 250 mg/5 ml*
- *gabapentin oral tablet 600 mg, 800 mg*
- **NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG**
- **NEURONTIN ORAL SOLUTION**
- **NEURONTIN ORAL TABLET 600 MG, 800 MG**

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

galafold

Products Affected

- **GALAFOLD**

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

gattex

Products Affected

- **GATTEX 30-VIAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of short bowel syndrome (SBS) AND dependence on parenteral nutrition or intravenous nutritional support for at least 12 months AND requiring parenteral nutrition at least 3 times per week -OR- Documentation of SBS AND age 1 to 17 years of age AND Dependence on parenteral nutrition
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

gavreto

Products Affected

- **GAVRETO**

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

gilenya

Products Affected

- **GILENYA ORAL CAPSULE 0.5 MG**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Gilenya and other disease modifying agents such as interferons, Copaxone, Tysabri
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- new starts to therapy have the following baseline information documented within 6 months of initiating therapy: ophthalmologic evaluation, liver transaminase and bilirubin, complete blood count, and electrocardiogram if using an antiarrhythmic agent or have second degree or greater AV block -AND- new starts to therapy do not have any of the following comorbid conditions or concomitant therapies: bradycardia, congestive heart failure, sick sinus syndrome, prolonged QT interval, ischemic cardiac disease, irregular heartbeat, current neutropenia, current chronic or acute infections, use of antineoplastics, immunosuppressive or immune modulating therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	Doses greater than 0.5mg/day will not be approved
Indications	All FDA-approved Indications.
Off Label Uses	

gimoti

Products Affected

- **GIMOTI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute or recurrent diabetic gastroparesis -AND- Attestastion of no signs or symptoms of tardive dyskinesia -AND- Therapeutic failure or intolerance to generic metoclopramide tablets or generic metoclopramide solution -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	Deny if less than 18 years of age
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 adminstration -AND- Attestastion 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	

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 diagnosis and all of the following, if applicable to diagnosis 1) Alternatives tried 2) Concomitant therapy 3) mutation status, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

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	

Gralise

Products Affected

- **GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 600 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of postherpetic neuralgia (PHN) -AND- Trial and failure or intolerance to generic gabapentin. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

grastek

Products Affected

- **GRASTEK**

PA Criteria	Criteria Details
Exclusion Criteria	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy
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	

growth hormone

Products Affected

- **GENOTROPIN**
- **GENOTROPIN MINIQUICK**
- **HUMATROPE INJECTION CARTRIDGE**
- **NORDITROPIN FLEXPRO**
- **NUTROPIN AQ NUSPIN**
- **OMNITROPE**
- **SAIZEN**
- **SAIZEN SAIZENPREP**
- **SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG**
- **ZOMACTON**
- **ZORBTIVE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis, growth chart, bone age, growth velocity, and response to stimulation test, when applicable to meet standard diagnostic criteria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

haegarda

Products Affected

- **HAEGARDA**

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

PA Criteria	Criteria Details
Off Label Uses	

HARVONI

Products Affected

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

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	Doses greater than one tablet per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

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- therapeutic failure or intolerance to generic dexamethasone.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

HETLIOZ

Products Affected

- **HETLIOZ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Non-24 Sleep-Wake disorder -AND- patient is totally blind -OR- Documented diagnosis of Smith-Magenis Syndrome as confirmed by chromosome analysis -AND- patient is experiencing nighttime sleep disturbances (e.g. difficulty falling asleep, shortened sleep cycles, inability to enter REM sleep, or frequent awaking during the night and early in the morning)
Age Restrictions	Deny if less than 16 years of age for nighttime sleep disturbances in Smith-Magenis Syndrome
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of increased total nighttime sleep or decreased daytime nap duration for Non-24 Sleep-Wake disorder -OR- attestation of positive clinical response to therapy with minimal side effects for Smith-Magenis Syndrome
Indications	All FDA-approved Indications.
Off Label Uses	

Hetlioz LQ

Products Affected

- **HETLIOZ LQ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Smith-Magenis Syndrome as confirmed by chromosome analysis -AND- patient is experiencing nighttime sleep disturbances (e.g. difficulty falling asleep, shortened sleep cycles, inability to enter REM sleep, or frequent awaking during the night and early in the morning)
Age Restrictions	Deny if less than 3 or greater than 15 years of age.
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
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	

high-risk meds

Products Affected

- *amitriptyline*
- *amitriptyline-chlordiazepoxide*
- **AMRIX**
- **ANAFRANIL**
- *benztropine oral*
- *carisoprodol-aspirin-codeine*
- *chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg*
- *clomipramine*
- *cyclobenzaprine*
- *cyproheptadine*
- *doxepin oral capsule*
- *doxepin oral concentrate*
- *doxepin oral tablet*
- **FEXMID**
- *glimepiride*
- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*
- **GLYNASE**
- *hydroxyzine hcl oral*
- *hydroxyzine pamoate*
- *imipramine hcl*
- *imipramine pamoate*
- *metaxalone*
- *perphenazine-amitriptyline*
- *promethazine oral*
- **SILENOR**
- *trimipramine*
- **VISTARIL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all medications subject to this PA group, the following information (1 through 3) is required: 1. Documentation of diagnosis 2. Explanation of risk-benefit profile favoring use of the high-risk medication 3. Attestation of an intent to monitor and address treatment-related adverse events. For the target high-risk medications glyburide, glimepiride, and TCAs: in addition to criteria 1 through 3 above, trial and failure or documentation of intolerance or contraindication to at least 2 non-high risk alternative drugs for the same indication, if available, is required. Non-high risk alternative medications for those target high-risk medications include the following: 1. Glyburide and Glimepiride (non-high risk alternative include glipizide) 2. TCAs (non-high risk alternatives include SSRIs and SNRIs). If using one of the above 2 high-risk medications for a medically-accepted indication not shared by the safer alternatives listed, then no trial of alternatives is required for that target high-risk medication.
Age Restrictions	Automatic approval if less than 65 years of age
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications. Doxepin doses less than or equal to 6 mg per day will receive automatic approval.
Indications	All Medically-accepted Indications.
Off Label Uses	

high-risk meds phenobarbital

Products Affected

- *phenobarbital*

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

homozygous fh

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic testing showing functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality -OR- untreated LDL-C concentrations greater than 500 mg/dL or treated LDL-C concentrations greater than or equal to 300 mg/dL -AND- the presence of Xanthomas in the first decade of life -OR- documentation of HeFH in both parents -AND- will not be used concomitantly with a PCSK9 inhibitor [e.g. alirocumab (Praluent), evolocumab (Repatha)].
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Patients must have an adequate trial/failure or contraindication to the preferred product Repatha. For reauthorization, documentation showing an LDL-C reduction on Juxtapid therapy from baseline must be provided.
Indications	All FDA-approved Indications.
Off Label Uses	

horizant

Products Affected

- **HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG, 600 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of moderate to severe active primary restless leg syndrome and trial and failure of two accepted medications for the treatment of this condition one of which must include pramipexole or ropinirole -OR- documentation of post herpetic neuralgia and trial and failure of generic gabapentin. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

humira

Products Affected

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

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

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

Ibrance

Products Affected

- **IBRANCE**

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

iclusig

Products Affected

- **ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG**

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of newly-diagnosed chronic phase CML
Required Medical Information	Documentation of accelerated phase or blast phase CML in patients for whom no other tyrosine kinase inhibitor therapy is indicated -OR- Documentation of Ph+ ALL in patients for whom no other tyrosine kinase inhibitor is indicated -OR- Documentation of T315I positive chronic phase, accelerated phase, or blast phase CML -OR- Documented T315I positive Ph+ ALL -OR- Documentation of chronic phase CML in patients with resistance or intolerance to two prior tyrosine kinase inhibitors.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

idhifa

Products Affected

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

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

ig

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For select diagnoses the following apply- 1) For Myasthenia Gravis Syndrome, documentation that the patient is refractory to other standard therapies (e.g., cholinesterase inhibitors, corticosteroids, azathioprine) given in therapeutic doses over at least 3 months OR is intolerant of/has a contraindication to those standard therapies. 2) For Multiple Sclerosis, patient is refractory to other standard therapies (e.g., interferons) given in therapeutic doses over at least 3 months, OR is intolerant of/has a contraindication to those standard therapies. 3) For Inflammatory Myopathies, the patient is refractory to corticosteroids given in therapeutic doses over at least 4 months, OR is intolerant of/has a contraindication to corticosteroids or immunosuppressants. 4) For CLL, IgG level less than 600mg/dL or evidence of a specific antibody deficiency or recurrent bacterial infections. 5) For Bone Marrow Transplant, the member is 20 years of age or older and within the first 100 days after transplantation. 6) For Dermatomyositis/Polymyositis, trial and failure, intolerance, or contraindication to standard fist line therapy (i.e. corticosteroids or immunosuppressants). 7) For Pediatric HIV, the patient is less than 13 y.o. who have entry CD4 lymphocyte count greater than or equal to 200/mm3, who are clinically symptomatic or asymptomatic but are immunologically abnormal. 8) For Guillain-Barre syndrome, impaired function by objective assessment and/or objective findings on physical exam at the time of initial therapy and IVIG therapy must be initiated within 2 weeks of symptom onset. 9) For Autoimmune Mucocutaneous Blistering Diseases (e.g. Stevens-Johnson Syndrome), trial and failure, intolerance, or contraindication to conventional therapy (e.g. corticosteroids) or the patient has rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents.

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

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, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For psoriasis, patients must have an adequate trial or intolerance to 2 of the preferred products Cosentyx, Humira, Otezla, Stelara, Enbrel and Skyrizi. For psoriasis 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	

imbruvica

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) 17p deletion status 2) Alternatives tried/failed 3) concomitant therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

inbrija

Products Affected

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

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

increlex

Products Affected

- **INCRELEX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis, growth chart, stimulation test results, growth velocity, and IGF-1 level, when applicable to meet standard diagnostic criteria.
Age Restrictions	Deny if greater than 18 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ingrezza

Products Affected

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

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

inlyta

Products Affected

- **INLYTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For advanced renal cell carcinoma (RCC), trial and failure of one prior systemic therapy -OR- As first-line treatment in combination with avelumab or pembrolizumab
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

inqovi

Products Affected

- **INQOVI**

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

inrebic

Products Affected

- **INREBIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate-2 or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis -AND- risk stratification per International Prognostic Scoring System (IPSS) -AND- If a new start, baseline platelet count of greater than 50x10*9/L
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

interferon alfa

Products Affected

- **INTRON A INJECTION**
- **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	

interleukin-1b blockers

Products Affected

- **ARCALYST**

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

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	

IPF AGENTS

Products Affected

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

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

PA Criteria	Criteria Details
Off Label Uses	

iressa

Products Affected

- **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 metastatic non-small cell lung cancer (NSCLC) in patients whose tumors express EGFR exon 19 deletion mutations or exon 21 (L858R) mutations as detected by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

isturisa

Products Affected

- **ISTURISA**

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

itraconazole

Products Affected

- *itraconazole*
- **SPORANOX**

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: 3 months initial, 12 months reauth
Other Criteria	Documentation of trial/failure or intolerance of amphotericin b must be provided for approval in patients with aspergillosis.
Indications	All FDA-approved Indications.
Off Label Uses	

jakafi

Products Affected

- **JAKAFI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis -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	Applies to new starts only for protected indications. Platelet count to be provided.
Indications	All FDA-approved Indications.
Off Label Uses	

jynarque

Products Affected

- **JYNARQUE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of rapidly progressing autosomal dominant polycystic kidney disease defined by one of the following: 1.) Historical decline in eGFR greater than or equal to 5mL/min/1.73 m*2 within a 12 month period. 2.) Decline in eGFR of greater than or equal to 2.5mL/min/1.73m*2 over a period of 5 years. 3.) 5% increase in total kidney volume per year by 3 repeat CT or MRI. 4.) Average kidney length greater than 16.5cm. 5.) Family history of end-stage renal disease before age 58. 6.) Mayo imaging classification of 1C, 1D, or 1E. 7.) Kidney bleeds.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, prescriber attestation of improved kidney function or slowed decline of kidney function
Indications	All FDA-approved Indications.
Off Label Uses	

kalydeco

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Homozygous for the F508del mutation in the CFTR gene
Required Medical Information	Documentation of cystic fibrosis (CF) in patients who have one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to ivacaftor based on clinical and or in vitro assay (e.g. G551D, G1244E, G1349D)
Age Restrictions	Granules- Deny if less than 4 months or greater than 5 years of age. Tablets- Deny if less than 6 years of age.
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	Doses greater than 300mg/day will not be approved. For reauthorization, documentation supporting improvement or stabilization of FEV1 compared to baseline FEV1 -or- increase in body mass index -or- decreased pulmonary exacerbations -or- improved quality of life as demonstrated by CF Questionnaire is required.
Indications	All FDA-approved Indications.
Off Label Uses	

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	

keveyis

Products Affected

- **KEVEYIS**

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	2 months initial authorization, 12 months reauthorization
Other Criteria	Doses exceeding 200 mg per day will not be approved. For reauthorization, attestation the number of muscle weakness attacks per week has decreased from baseline
Indications	All FDA-approved Indications.
Off Label Uses	

kevzara

Products Affected

- **KEVZARA**

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

kineret

Products Affected

- **KINERET**

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

kisqali

Products Affected

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

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

klisyri

Products Affected

- **KLISYRI**

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

korlym

Products Affected

- **KORLYM**

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

koselugo

Products Affected

- **KOSELUGO ORAL CAPSULE 10 MG, 25 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	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

kuvan

Products Affected

- **KUVAN**
- *sapropterin*

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

kynmobi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease -AND- for use in acute, intermittent treatment of hypomobility off-episodes -AND- documentation of concurrent medication for the treatment of Parkinson's disease (e.g. carbidopa/levodopa, pramipexole, ropinerole) -AND- Therapeutic failure, intolerance, or contraindication to a generic pramipexole containing product and a generic ropinirole containing product
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

lampit

Products Affected

- **LAMPIT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Weight of at least 2.5 kg
Age Restrictions	Deny if greater than 18 years old
Prescriber Restrictions	
Coverage Duration	2 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

latuda

Products Affected

- **LATUDA 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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

lenvima

Products Affected

- **LENVIMA**

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

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	

leukotriene modifiers

Products Affected

- *zileuton*
- **ZYFLO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of asthma -AND- trial/failure of generic montelukast
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

lidoderm

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*
- **LIDODERM**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of postherpetic neuralgia (PHN) -AND- trial and failure of 1 other agent used to treat PHN (e.g. gabapentin), inability to swallow oral medication or unable to take an oral medication due to potential adverse events (e.g. sedation) -OR- documentation of diabetic peripheral neuropathy (DPN) -AND- trial and failure of one other agent used to treat DPN (e.g. duloxetine), inability to swallow oral medication or unable to take an oral medication due to potential adverse events (e.g. sedation)
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

lokelma

Products Affected

- **LOKELMA**

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

lonsurf

Products Affected

- **LONSURF**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic colorectal cancer in patients who have previously been treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy -OR- documentation of metastatic gastric or gastroesophageal junction adenocarcinoma 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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

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)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

lotronex

Products Affected

- *alosetron*
- **LOTRONEX**

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 & failure, intolerance, or contraindication to a generic anti-diarrheal agent (e.g. loperamide)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Initial: 12 weeks. Reauth: 6 months
Other Criteria	For reauthorization, attestation that symptoms of IBS continue to persist AND positive clinical response.
Indications	All FDA-approved Indications.
Off Label Uses	

Lumakras

Products Affected

- **LUMAKRAS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic non-small cell lung cancer (NSCLC) -AND- KRAS G12C mutation as detected by an FDA-approved test -AND- have received at least 1 prior systemic therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	

lupkynis

Products Affected

- **LUPKYNIS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of active lupus nephritis -AND- Concurrent systemic lupus erythematous documented by positive ANA titer (greater than or equal to 1:80) or anti-dsDNA greater than or equal to 30 IU/mL -AND- Trial, intolerance, or inadequate response to at least 2 of the following standard of care drug classes: 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate) -AND- Member will continue to receive concomitant standard of care treatment with corticosteroids (e.g. prednisone) and mycophenolate mofetil.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	24 weeks initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of disease stability or disease improvement
Indications	All FDA-approved Indications.
Off Label Uses	

lynparza

Products Affected

- **LYNPARZA**

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

lyrica

Products Affected

- **LYRICA CR**
- **LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG**
- **LYRICA ORAL SOLUTION**
- *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg*
- *pregabalin oral solution*
- *pregabalin oral tablet extended release 24 hr*

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

mavenclad

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Mavenclad and other disease modifying agents such as interferons, Copaxone, Tysabri. Treatment duration greater than 24 months. Documentation of pregnancy, malignancy, HIV infection, active chronic infection, hypersensitivity to cladribine, breastfeeding or reproductive age not planning to use effective contraception
Required Medical Information	Documentation of diagnosis of relapse-remitting multiples sclerosis or active secondary progressive disease -AND- therapeutic failure or intolerance to one other disease modifying therapy (e.g. Avonex, Gilenya, Copaxone) -AND- new starts to therapy have the following baseline information documented within 6 months of initiating therapy: cancer screening, infection screening, liver function tests, and complete blood count.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Coverage beyond 24 months will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

mavyret

Products Affected

- **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	Doses greater than three tablets per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

mayzent

Products Affected

- **MAYZENT ORAL TABLET 0.25 MG, 2 MG**
- **MAYZENT STARTER PACK**

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

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	For tablets, Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

mekinist

Products Affected

- **MEKINIST**

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

mektovi

Products Affected

- **MEKTOVI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of unresectable or metastatic melanoma in patients with a BRAF V600E or V600K mutation -AND- used in combination with encorafenib
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

methamphetamine

Products Affected

- **DESOXYN**
- *methamphetamine*

PA Criteria	Criteria Details
Exclusion Criteria	Obesity
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	

motegrity

Products Affected

- **MOTEGRITY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic idiopathic constipation -AND- Failure or intolerance to Linzess and Amitiza.
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	

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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

myalept

Products Affected

- **MYALEPT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of congenital or acquired generalized lipodystrophy with absence or loss of subcutaneous body fat -AND- Leptin levels less than 8 ng/mL for males or less than 12 ng/mL for females -AND- the member has a diagnosis of diabetes or fasting insulin levels greater than 30uU/mL or fasting hypertriglyceridemia greater than 200mg/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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	Deny if less than 18 years of age
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	

namenda

Products Affected

- **NAMENDA ORAL TABLET**
- **NAMENDA TITRATION PAK**
- **NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR**

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

namzaric

Products Affected

- **NAMZARIC**

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

natpara

Products Affected

- **NATPARA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of use as an adjunct to control hypocalcemia in patients with hypoparathyroidism
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

nayzilam

Products Affected

- **NAYZILAM**

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

nerlynx

Products Affected

- **NERLYNX**

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

nexavar

Products Affected

- **NEXAVAR**

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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

nexletol

Products Affected

- **NEXLETOL**
- **NEXLIZET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FH (e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than 100 mg/dL despite use of maximally tolerated statin or statin intolerance AND therapeutic failure, intolerance or contraindication to ezetimibe AND must be used with maximally tolerated statin dose or documentation of statin intolerance. 2. Hypercholesterolemia ASCVD AND LDL-C greater than 70 mg/dL despite use of maximally tolerated statin or statin intolerance AND therapeutic failure, intolerance or contraindication to ezetimibe AND must be used with maximally tolerated statin dose or documentation of statin intolerance.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, documentation showing an LDL-C reduction from baseline AND attestation of continued use of Nexletol or Nexlizet with a maximally tolerated statin, unless statin intolerant. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin or documentation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

NORTHERA

Products Affected

- *droxidopa*
- **NORTHERA**

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

nourianz

Products Affected

- **NOURIANZ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease experiencing off episodes -AND- trial/failure, contraindication or intolerance to selegiline and entacapone -AND- Used as adjunct to levodopa/carbidopa.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

nubeqa

Products Affected

- **NUBEQA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of non-metastatic castration-resistant prostate cancer - AND- the member meets one of the following (1 or 2) 1. Documentation of use in combination with a GnRH analog -OR- 2. The member has had a bilateral orchiectomy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

nucala

Products Affected

- **NUCALA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of severe asthma evidenced by pretreatment forced expiratory volume in 1 second (FEV1) less than 80% predicted and FEV1 reversibility of at least 12% after albuterol administration -AND- 1.) A history of 2 or more exacerbations in the previous year or inadequate symptom control with inhaled corticosteroid in combination with 3 months of controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline), unless intolerant of or contraindication to all agents.-AND- 2 or 3. 2) Greater than or equal to 150 cells/uL screening within 6 weeks of dosing. 3) Greater than or equal to 300 cells/uL within 12 months of screening. -OR- Documentation of eosinophilic granulomatosis with polyangitis (EGPA) in patients who have a history of relapsing or refractory disease and will be receiving concomitant glucocorticoid treatment with or without immunosuppressive therapy -OR- Documentation of hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause for greater than or equal to 6 months -AND- At least 2 HES flares (HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy) within the past 12 months -AND- Stable on HES therapy for at least 4 weeks (chronic or episodic oral corticosteroids, immunosuppressive or cytotoxic therapy) -OR- Documentation of chronic rhinosinusitis with nasal polyps (CRSwNP) and trial/failure, contraindication, or intolerance to an intranasal corticosteroid.
Age Restrictions	Deny if less than 6 years old for asthma -OR- less than 12 years old for hypereosiniphilic syndrome -OR- less than 18 years old for CRSwNP
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

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	

nuplazid

Products Affected

- **NUPLAZID ORAL CAPSULE**
- **NUPLAZID ORAL TABLET 10 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hallucinations and delusions associated with Parkinson's disease psychosis
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

nuvigil

Products Affected

- *armodafinil*
- **NUVIGIL**

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

ocaliva

Products Affected

- **OCALIVA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of primary biliary cholangitis -AND- trial and failure, contraindication, or intolerance to ursodiol monotherapy -AND- will use concomitantly with ursodiol unless contraindicated or intolerant.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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	
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	

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 18 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	

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

olumiant

Products Affected

- **OLUMIANT**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orencia, Stelara, Actemra, azathioprine, cyclosporine
Required Medical Information	Documentation of diagnosis. For rheumatoid arthritis an inadequate response or intolerance to at least one non-biologic DMARD (e.g., methotrexate, leflunomide).
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra, Rinvoq and Xeljanz/Xeljanz XR.
Indications	All FDA-approved Indications.
Off Label Uses	

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- adequate trial or intolerance of a previous antiepileptic therapy
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

ongentys

Products Affected

- **ONGENTYS**

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

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

oralair

Products Affected

- **ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY**

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 Sweet Vernal, Orchard, Perennial Rye, Timothy or Kentucky Blue Grass pollens -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
Age Restrictions	Deny if less than 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	

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

orgovyx

Products Affected

- **ORGOVYX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced prostate cancer -AND- the member is appropriate to receive androgen deprivation therapy by meeting one of the following (1, 2, or 3) 1. Biochemical (prostate specific antigen) or clinical relapse following local primary intervention 2. Newly diagnosed castration-sensitive metastatic disease 3. Advanced local disease
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications. 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	

oriahnn

Products Affected

- **MYFEMBREE**
- **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- Combined treatment duration with Oriahnn and Myfembree 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- Combined treatment duration with Oriahnn and Myfembree does not exceed 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	

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

orkambi

Products Affected

- **ORKAMBI ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis and homozygous F508del mutation
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation supporting improvement or stabilization of FEV1 compared to baseline FEV1 -or- increase in body mass index -or- decreased pulmonary exacerbations -or- improved quality of life as demonstrated by CF Questionnaire is required.
Indications	All FDA-approved Indications.
Off Label Uses	

orkambi granules

Products Affected

- **ORKAMBI ORAL GRANULES IN PACKET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis and homozygous F508del mutation
Age Restrictions	Deny if less than 2 or greater than 5 years of age.
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation supporting improvement or stabilization of FEV1 compared to baseline FEV1 -or- increase in body mass index -or- decreased pulmonary exacerbations -or- improved quality of life as demonstrated by CF Questionnaire is required.
Indications	All FDA-approved Indications.
Off Label Uses	

orladeyo

Products Affected

- **ORLADEYO**

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

PA Criteria	Criteria Details
Off Label Uses	

osmolex

Products Affected

- **OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG, 193 MG, 322 MG/DAY(129 MG X1-193MG X1)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease or drug-induced extrapyramidal symptoms -AND- trial and failure, contraindication, or intolerance to immediate-release amantadine
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	

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	

OTEZLA

Products Affected

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

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, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For oral ulcers associated with Behcet's Disease, inadequate response or intolerance to topical triamcinolone for acute flare-up of oral ulcers -AND- inadequate response or intolerance to colchicine for prevention of recurrent oral ulcers
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	

otrexup

Products Affected

- **OTREXUP (PF)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to oral generic methotrexate tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

oxbryta

Products Affected

- **OXBRYTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of sickle cell disease.
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

oxervate

Products Affected

- **OXERVATE**

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

palynziq

Products Affected

- **PALYNZIQ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of phenylketonuria. Member meets the following criteria 1.) Baseline Phe level greater than 600 micrometers/L -AND- 2.) Failure or intolerance to existing management (i.e. Kuvan therapy) -AND- 3.) Has a prescription for epinephrine agent unless contraindicated.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in baseline pretreatment Phe levels -OR- blood Phe levels are within recommended target range -OR- attestation that additional therapy with Palynziq is needed to allow adequate trial of maximum tolerated dose for 16 weeks
Indications	All FDA-approved Indications.
Off Label Uses	

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Under CMS Review
Indications	All FDA-approved Indications.
Off Label Uses	

pemazyre

Products Affected

- **PEMAZYRE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) FGFR2 fusion or other rearrangement as detected by an FDA-approved test, if applicable to diagnosis. 2) Therapeutic failure or intolerance to at least 1 prior chemotherapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

phenoxybenzamine

Products Affected

- **DIBENZYLINE**
- *phenoxybenzamine*

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

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 HR-positive, HER2-negative advanced or metastatic breast cancer in men and postmenopausal women with disease progression on or after endocrine-based therapy -AND- Used in combination with fulvestrant - AND- PI3K mutation positive as detected by an FDA approved test.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

pomalyst

Products Affected

- **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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

ponvory

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
Required Medical Information	Documentation of relapsing form of multiple sclerosis (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	

praluent

Products Affected

- **PRALUENT PEN**

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

PA Criteria	Criteria Details
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Praluent therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin or documentation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	

prenatal vitamins

Products Affected

- **PRENATAL VITAMIN PLUS LOW IRON**

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

prescription drug combo

Products Affected

- *acetaminophen-caff-dihydrocod*
- *acetaminophen-codeine oral solution 120-12 mg/5 ml*
- *acetaminophen-codeine oral tablet*
- **ALPRAZOLAM INTENSOL**
- *alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg*
- *alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- **ASCOMP WITH CODEINE**
- **BUTALBITAL COMPOUND W/CODEINE**
- *butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg*
- *codeine sulfate*
- **CONZIP**
- **DEMEROL (PF) INJECTION SYRINGE 25 MG/ML**
- **DEMEROL INJECTION SOLUTION 50 MG/ML**
- **DILAUDID ORAL LIQUID**
- **DILAUDID ORAL TABLET**
- **ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG**
- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr, 87.5 mcg/hour*
- **FIORICET WITH CODEINE**
- **HALCION ORAL TABLET 0.25 MG**
- *hydrocodone bitartrate oral capsule, oral only, er 12hr*
- *hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr*
- *hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml*
- *hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg*
- *hydrocodone-ibuprofen*
- *hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml*
- *hydromorphone oral liquid*
- *hydromorphone oral tablet*
- *hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg*
- **HYSINGLA ER**
- *levorphanol tartrate*
- *meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*
- *meperidine oral solution*
- *meperidine oral tablet 100 mg, 50 mg*
- *methadone oral solution 10 mg/5 ml, 5 mg/5 ml*
- *methadone oral tablet 10 mg, 5 mg*
- *morphine concentrate oral solution*
- *morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg*
- *morphine oral capsule,extend.release pellets*
- *morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)*
- *morphine oral tablet*
- *morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg*
- **MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 15 MG, 200 MG, 30 MG, 60 MG**
- **NUCYNTA**
- **NUCYNTA ER**
- *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,ext.rel.12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg*
- *oxycodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-325 mg*
- **OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG**
- *oxymorphone oral tablet*

- *oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg, 7.5 mg*
- **PERCOCET**
- **PROLATE ORAL TABLET**
- **ROXICODONE ORAL TABLET 15 MG, 30 MG, 5 MG**
- *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 100 mg, 50 mg*
- *tramadol oral tablet extended release 24 hr*
- *tramadol oral tablet, er multiphase 24 hr*
- *tramadol-acetaminophen*
- **TREZIX**
- *triazolam*
- **ULTRACET**
- **ULTRAM**
- **XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG**
- **XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 0.5 MG, 1 MG, 2 MG, 3 MG**
- **XTAMPZA ER**

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

PA Criteria	Criteria Details
Coverage Duration	Opiate+subs. abuse tx, approve opiate x 1mo. All other combos approve x 12mo.
Other Criteria	Opiate agonists will receive automatic approval if no recent claims for a substance abuse therapy (e.g. buprenorphine-naloxone) OR a benzodiazepine (e.g. triazolam, alprazolam) OR a benzodiazepine with a centrally acting skeletal muscle relaxant (e.g., carisoprodol) OR a gabapentinoid. Benzodiazepines (e.g. triazolam, alprazolam) will receive automatic approval if no recent claims for an opiate agonist (e.g. oxycodone, hydrocodone, oxymorphone) or an opiate agonist with a centrally acting skeletal muscle relaxant (e.g. carisoprodol). Infusible opiate agonists will be covered under Part B when administered via infusion pump.
Indications	All FDA-approved Indications.
Off Label Uses	

pretomanid

Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of extensively drug resistant, treatment intolerant or nonresponsive multidrug resistant tuberculosis -AND- Used as part of a combination regimen with bedaquiline and linezolid -AND- Therapeutic failure, contraindication or intolerance to both of the following (1 and 2): 1. A fluoroquinolone antibiotic 2. Isoniazid or Rifampin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	26 weeks
Other Criteria	For reauthorization, additional therapy required due to doses of the regimen being missed for safety reasons
Indications	All FDA-approved Indications.
Off Label Uses	

proair digihaler

Products Affected

- **PROAIR DIGIHALER**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of reversible obstructive airway disease (e.g. asthma) or exercise induced bronchospasm -AND- Inadequate response to non-digitized albuterol inhaler -AND- Attestation that a digital inhaler is required.
Age Restrictions	Deny if less than 4 years of age
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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	Deny if less than 1 year of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For granules, attestation of inability to swallow capsules or gastrostomy tube (g-tube) placement is required.
Indications	All FDA-approved Indications.
Off Label Uses	

prolia

Products Affected

- **PROLIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -And- For osteoporosis at high risk for fracture, meeting one of the following (1. thru 4.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) Age 50 years or older with T-score between -1.0 and -2.5 (i.e. osteopenia) -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 50 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For osteoporosis and osteopenia, documentation of trial/failure, intolerance, or contraindication to at least one oral bisphosphonate is required. Covered under Part B for patients eligible for home health services when provider certifies that patient sustained bone fracture related to post-menopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug.
Indications	All FDA-approved Indications.
Off Label Uses	

provigil

Products Affected

- *modafinil*
- **PROVIGIL**

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

PA Criteria	Criteria Details
Off Label Uses	Fatigue associated with Multiple Sclerosis (MS)

pulmonary arterial hypertension

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization, defined as a mean pulmonary arterial pressure (mPAP) of greater than or equal to 25 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than 3 Wood units -AND- WHO Group. For Adempas, additional diagnosis of CTEPH as documented by right heart catheterization and V/Q scan substantiating mPAP greater than or equal to 25 mmHg at rest and PWP less than or equal to 15 mmHg and documented presence of occlusive thrombi within the pulmonary arteries will be approved.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Ventavis covered under Part B when using via nebulizer in the home setting. For brand Adcirca, trial and failure of generic tadalafil is required. For brand Letairis, trial and failure of generic ambrisentan is required.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

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	Deny if less than 6 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	

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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

quinine

Products Affected

- **QUALAQUIN**
- *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 FDA-approved Indications.
Off Label Uses	

rasuvo

Products Affected

- **RASUVO (PF)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to oral generic methotrexate tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ravicti

Products Affected

- **RAVICTI**

PA Criteria	Criteria Details
Exclusion Criteria	Urea cycle disorders due to N-acetylglutamatesynthetase deficiency
Required Medical Information	Documentation of chronic management of a urea cycle disorders (UCDs)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

reditrex

Products Affected

- **REDITREX (PF)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to oral generic methotrexate tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

regranex

Products Affected

- **REGRANEX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of lower-extremity diabetic neuropathic ulcer(s) that extends into the subcutaneous tissue or beyond and have an adequate blood supply -AND- being used as an adjunct to standard ulcer care practices (e.g. sharp debridement, non-weight bearing regimen, infection control) -AND- attestation of a wound care plan.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

relistor

Products Affected

- **RELISTOR ORAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation due to chronic non-cancer pain -AND- documentation of opioid medication use for at least one month -AND- trial and failure, contraindication, or intolerance to 2 of the following 1.)Laxatives 2.)Amitiza 3.)Movantik.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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 due to chronic non-cancer pain, advanced illness or active cancer in palliative care -AND- documentation of opioid medication use for at least one month -AND- trial and failure, contraindication, or intolerance to 2 of the following 1.)Laxatives 2.)Amitiza 3.)Movantik.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

repatha

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1.HoFH supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL(or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 yrs or HeFH in both parents AND used with max tolerated statin unless all statins are contraindicated or not tolerated AND not used with lomitapide, mipomersen, or another PCSK9 inhibitor. 2. HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FD(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than 100 mg/dL AND Prior therapy with the highest dose of a high intensity statin (i.e. atorvastatin 80mg, rosuvastatin 40mg) or a maximally tolerated dose of high intensity statin with documentation demonstrating why higher strengths of the statin could not be tolerated, would not be tolerated (e.g., exacerbate existing skeletal muscle symptoms) or would not enable member to achieve LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. 3. Hypercholesterolemia ASCVD or Primary Hyperlipidemia AND unable to achieve LDL goal on prior therapy AND baseline LDL-C AND Prior therapy with the highest dose of a high intensity statin (i.e. atorvastatin 80mg, rosuvastatin 40mg) or a maximally tolerated dose of high intensity statin with documentation demonstrating why higher strengths of the statin could not be tolerated, would not be tolerated or would not enable member to achieve LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance.
Age Restrictions	Deny if less than 18 years of age for HeFH, ASCVD and Primary Hyperlipidemia, or less than 13 years of age for HoFH.
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	

repatha pushtronex

Products Affected

- **REPATHA PUSHTRONEX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1.HoFH supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL(or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 yrs or HeFH in both parents AND used with max tolerated statin unless all statins are contraindicated or not tolerated AND not used with lomitapide, mipomersen, or another PCSK9 inhibitor. 2. HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FD(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than 100 mg/dL AND Prior therapy with the highest dose of a high intensity statin (i.e. atorvastatin 80mg, rosuvastatin 40mg) or a maximally tolerated dose of high intensity statin with documentation demonstrating why higher strengths of the statin could not be tolerated, would not be tolerated (e.g., exacerbate existing skeletal muscle symptoms) or would not enable member to achieve LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. 3. Hypercholesterolemia ASCVD or Primary Hyperlipidemia AND unable to achieve LDL goal on prior therapy AND baseline LDL-C AND Prior therapy with the highest dose of a high intensity statin (i.e. atorvastatin 80mg, rosuvastatin 40mg) or a maximally tolerated dose of high intensity statin with documentation demonstrating why higher strengths of the statin could not be tolerated, would not be tolerated or would not enable member to achieve LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance.
Age Restrictions	Deny if less than 18 years of age for HeFH, ASCVD and Primary Hyperlipidemia, or less than 13 years of age for HoFH.
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	

retevmo

Products Affected

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

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

revlimid

Products Affected

- **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 -OR- diagnosis of marginal zone lymphoma in combination with a rituximab product after previous treatment.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

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	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

rinvoq

Products Affected

- **RINVOQ**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orencia, Stelara, Actemra, azathioprine, cyclosporine
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, an inadequate response or intolerance to at least one immunosuppressant (e.g., azathioprine, corticosteroid, methotrexate).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

rozlytrek

Products Affected

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

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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

rubraca

Products Affected

- **RUBRACA**

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

ruconest

Products Affected

- **RUCONEST**

PA Criteria	Criteria Details
Exclusion Criteria	Member should not be on two acute therapies simultaneously and acute therapy should not be used as prophylactic therapy
Required Medical Information	For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type I & II with the following (1-4): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. 4) Documentation of member's weight. For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type III with the following (5-9): 5) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 6) Documentation of family history of HAE or FXII mutation 7) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 8) Medications known to cause angioedema have been evaluated and discontinued. 9) Documentation of member's weight.
Age Restrictions	Deny if less than 13 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For 18 years of age or older, therapeutic failure, intolerance or contraindication to icatibant.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

rydapt

Products Affected

- **RYDAPT**

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

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- an adequate trial or intolerance to at least two alternative treatments (e.g. carbamazepine, lamotrigine, levetiracetam, oxcarbazepine, tiagabine) -OR- documentation of use as monotherapy in treatment of infantile spasms
Age Restrictions	Deny if less than 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	
Indications	All FDA-approved Indications.
Off Label Uses	

samsca

Products Affected

- **SAMSCA**
- *tolvaptan*

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

savella

Products Affected

- **SAVELLA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation to support a diagnosis of fibromyalgia and trial/failure or intolerance to duloxetine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

signifor

Products Affected

- **SIGNIFOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Cushing's disease AND patient is not a candidate for pituitary surgery or surgery has not been curative
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	4 months initial authorization, 12 months reauthorization
Other Criteria	For psoriasis, patients must have an adequate trial or intolerance to 2 preferred products Humira, Cosentyx, Otezla, Stelara, Enbrel, and Skyrizi. For psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For reauthorization, attestation supporting improvement in psoriatic lesions or disease stability is required.
Indications	All FDA-approved Indications.
Off Label Uses	

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	Concomitant use of Actemra, Kineret, Remicade, Humira, Orencia, Enbrel, Cimzia
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 100mg: Diagnosis of moderate to severe ulcerative colitis.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra, Xeljanz/Xeljanz XR and Rinvoq. For psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Cosentyx, Xeljanz/Xeljanz XR, Otezla, and Stelara. For ankylosing spondylitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel and Cosentyx. For ulcerative colitis, patients must have an adequate trial or intolerance to the preferred products Humira, Stelara and Xeljanz. For ulcerative colitis indication therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	

skyrizi

Products Affected

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

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, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For 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	

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 topical fluorouracil
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	

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	

sovaldi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance -AND- the member is unable to utilize regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
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	Doses greater than or less than 400 mg/day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

sprycel

Products Affected

- **SPRYCEL**

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

stelara

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Simponi
Required Medical Information	Documentation of diagnosis -AND- documentation of member weight and prescribed dose. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For Crohn's Disease, inadequate response or intolerance to two immunosuppressants (e.g. corticosteroids, azathioprine) -OR- intolerance to a TNF inhibitor (e.g. Humira) -OR- inadequate response or intolerance to an immunosuppressant and contraindication to a TNF inhibitor due to demyelinating disease or heart failure -OR- attestation of clinical response or remission following IV administration of Stelara within 2 months of initiating therapy with Stelara SC. For Ulcerative colitis, attestation of clinical response or remission following IV administration of Stelara within 2 months of initiating therapy with Stelara SC -AND- One of the following (1 or 2): 1. Intolerance to a TNF inhibitor or contraindication to a TNF inhibitor due to demyelinating disease or heart failure 3. Inadequate response or intolerance to Entyvio
Age Restrictions	Deny if less than 18 years of age for Psoriatic Arthritis, Crohn's Disease and Ulcerative Colitis or less than 6 years of age for Plaques Psoriasis
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	Must follow recommended dosing guidelines based upon weight. Psoriasis: For patients weighing less than 100 kilograms (220 pounds), 45 mg dosing will be approved. For patients weighing more than 100 kilograms (220 pounds), 90 mg dosing will be approved. Psoriatic Arthritis: 45 mg dosing will be approved. For patients with co-existent moderate to severe plaque psoriasis weighing greater than 100 kilograms (220 pounds), 90 mg dosing will be approved. 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	

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

sunosi

Products Affected

- **SUNOSI**

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

sutent

Products Affected

- *sunitinib*
- **SUTENT**

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

symdeko

Products Affected

- **SYMDEKO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis (CF) in patients who have either the homozygous F508del mutation or another mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to tezacaftor/ivacaftor based on clinical and or in vitro assay (e.g. E56K, R117C, A455E)
Age Restrictions	Deny if less than 6 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation supporting improvement or stabilization of FEV1 compared to baseline FEV1 -or- increase in body mass index -or- decreased pulmonary exacerbations -or- improved quality of life as demonstrated by CF Questionnaire is required.
Indications	All FDA-approved Indications.
Off Label Uses	

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- adequate trial or intolerance of a previous antiepileptic therapy -AND- unable to tolerate generic clobazam
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

symproic

Products Affected

- **SYMPROIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation due to chronic non-cancer pain -AND- documentation of opioid medication use for at least one month -AND- trial and failure, contraindication, or intolerance to at least 2 of the following 1.) Laxatives 2.) Amitiza 3.) Movantik
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

syndros

Products Affected

- **SYNDROS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of one of the following (1 or 2): 1) anorexia associated with weight loss in patients with AIDS -and- trial and failure, contraindication, or intolerance to generic dronabinol capsules -OR- 2) nausea and vomiting associated with cancer chemotherapy in adults who have trial and failure, contraindication, or intolerance to a conventional antiemetic treatment (e.g., metoclopramide, promethazine, ondansetron, perphenazine, etc.) -and- trial and failure, contraindication, or intolerance to generic dronabinol capsules
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Covered under Part B when the following are met: 1) used for chemotherapy-induced nausea and vomiting. 2) used as full replacement for IV anti-emetic therapy. 3) using within 48 hours of receiving chemotherapy.
Indications	All FDA-approved Indications.
Off Label Uses	

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

tagrisso

Products Affected

- **TAGRISSO**

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

takhzyro

Products Affected

- **TAKHZYRO**

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

PA Criteria	Criteria Details
Off Label Uses	

taltz

Products Affected

- **TALTZ AUTOINJECTOR**
- **TALTZ SYRINGE**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Simponi, Stelara
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For ankylosing spondylitis, inadequate response or intolerance to 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	12 months
Other Criteria	For psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Cosentyx, Xeljanz/Xeljanz XR, Otezla, and Stelara. For plaque psoriasis patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Cosentyx, Otezla, Stelara, Enbrel and Skyrizi. For ankylosing spondylitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel and Cosentyx. For psoriasis and psoriatic arthritis 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	

talzenna

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of deleterious or suspected deleterious gBRCAm, HER2-negative locally advanced or metastatic breast cancer
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

targretin

Products Affected

- *bexarotene*
- **TARGRETIN**

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

tasigna

Products Affected

- **TASIGNA**

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

tavalisse

Products Affected

- **TAVALISSE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For diagnosis of ITP, the following criteria apply (1 and 2): 1) trial, intolerance, or inadequate response to a corticosteroid, immunoglobulin, or splenectomy. 2) One of the following (A or B): A) Platelet count less than or equal to 50 x 10*9/L and has significant mucous member bleeding or at least one risk factor for bleeding (e.g. hypertension, peptic ulcer disease). B) Platelet count of less than or equal to 30 x 10*9/L.
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	

tazorac

Products Affected

- *tazarotene topical cream*
- **TAZORAC**

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	
Indications	All FDA-approved Indications.
Off Label Uses	

tazverik

Products Affected

- **TAZVERIK**

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

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 agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
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	Doses greater than 240 mg twice-daily will not be approved. For brand Tecfidera, documentation of failure on generic dimethyl fumarate
Indications	All FDA-approved Indications.
Off Label Uses	

tegsedi

Products Affected

- **TEGSEDI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of polyneuropathy associate with hereditary TTR amyloidosis (hATTR) with mutation in TTR gene confirmed by genetic testing -AND- Neurologic examination shows clinical signs and symptoms of the disease (e.g. peripheral/autonomic neuropathy, motor disability, carpel tunnel, etc.) -AND- Is not being used for sensorimotor or autonomic neuropathy that is unrelated to hATTR amyloidosis -AND- Baseline functional ambulation performance stage of 1 or 2 -AND- Attestation of peripheral neuropathy impairment score (NIS) of 10 or greater or Polyneuropathy disability score of IIIb or lower -AND- Not simultaneously utilizing other gene targeted therapy for polyneuropathy of hATTR
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive clinical response
Indications	All FDA-approved Indications.
Off Label Uses	

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

testosterone (androgens)

Products Affected

- **ANDRODERM**
- **ANDROGEL**
- **AVEED**
- **DEPO-TESTOSTERONE**
- **FORTESTA**
- **JATENZO ORAL CAPSULE 158 MG, 198 MG, 237 MG**
- **NATESTO**
- **TESTIM**
- *testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump*
- *testosterone transdermal gel in packet*
- *testosterone transdermal solution in metered pump w/app*
- **VOGELXO TRANSDERMAL GEL**
- **VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP**
- **XYOSTED**

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

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	HIV Wasting

thalomid

Products Affected

- **THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

thiola

Products Affected

- **THIOLA**
- **THIOLA EC**
- *tiopronin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following criteria must be met (1-2) 1) Confirmation of cystinuria by at least one 24-hour urine collection with measurement of urinary cysteine levels greater than 400 mg/day, 2) Attestation of failure of urine alkalization with potassium citrate (to achieve pH of 6.5 to 7.0).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of urine cystine concentration less than 250 mg/L-OR- decrease in production of cystine stones is required.
Indications	All FDA-approved Indications.
Off Label Uses	

thrombopoiesis stimulating agents

Products Affected

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

tibsovo

Products Affected

- **TIBSOVO**

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

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	

tiglutik

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	For reauthorization, attestation of stability or improvement in symptoms of ALS.
Indications	All FDA-approved Indications.
Off Label Uses	

tolsura

Products Affected

- **TOLSURA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Unable to tolerate generic itraconazole capsules -AND- Prescriber provides rationale for clinical need of SUBA technology
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation the member is still unable to tolerate generic itraconazole capsules
Indications	All FDA-approved Indications.
Off Label Uses	

topical lidocaine

Products Affected

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

transmucosal fentanyl citrate

Products Affected

- **ACTIQ BUCCAL LOZENGE ON A HANDLE 1,200 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**
- *fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg*
- *fentanyl citrate buccal tablet, effervescent 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg*
- **FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**
- **LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 400 MCG/SPRAY**
- **SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 1,200 MCG (600 MCG/SPRAY X 2), 1,600 MCG (800 MCG/SPRAY X 2), 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY**

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

trelstar

Products Affected

- **TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION**

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	

tremfya

Products Affected

- **TREMFYA**

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, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For psoriasis, patients must have an adequate trial or intolerance to 2 of the preferred products Cosentyx, Humira, Otezla, Stelara, Enbrel and Skyrizi. For psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the preferred products Cosentyx, Humira, Otezla, Stelara, Enbrel and Xeljanz/Xeljanz XR. For psoriasis and psoriatic arthritis 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	

tretinoin

Products Affected

- *adapalene topical cream*
- *adapalene topical gel*
- *adapalene topical solution*
- *adapalene topical swab*
- **AKLIEF**
- **ALTRENO**
- **ATRALIN**
- **AVITA**
- **DIFFERIN TOPICAL CREAM**
- **DIFFERIN TOPICAL GEL WITH PUMP**
- **DIFFERIN TOPICAL LOTION**
- **RETIN-A**
- **RETIN-A MICRO**
- **RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %**
- *tretinoin*
- *tretinoin microspheres topical gel*

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 topical acne medications (e.g. clindamycin, sulfacetamide, erythromycin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

trikafta

Products Affected

- **TRIKAFTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis (CF) in patients who have at least one F508del mutation or another mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to elexacaftor/tezacaftor/ivacaftor based on in vitro assay (e.g. E56K, R117C, A455E)
Age Restrictions	Deny if less than 6 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation supporting improvement or stabilization of FEV1 compared to baseline FEV1 -or- increase in body mass index -or- decreased pulmonary exacerbations -or- improved quality of life as demonstrated by CF Questionnaire is required.
Indications	All FDA-approved Indications.
Off Label Uses	

Truseltiq

Products Affected

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

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

tukysa

Products Affected

- **TUKYSA ORAL TABLET 150 MG, 50 MG**

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

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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

tykerb

Products Affected

- *lapatinib*
- **TYKERB**

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

tymlos

Products Affected

- **TYMLOS**

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of underlying hypercalcemic disorder such as hypercalcemia, hyperparathyroidism or hypoparathyroidism, or high risk for osteosarcoma (Paget's disease, prior radiation therapy, bone metastases, open epiphyses, etc.). Treatment duration greater than 24 months.
Required Medical Information	Documentation of diagnosis -AND- at high risk for fracture, meeting one of the following (1. thru 3.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) Age 50 years or older with T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Documentation of trial/failure, intolerance, or contraindication to at least one oral bisphosphonate. Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Tymlos and Forteo will be limited to a coverage duration of 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	

Ukoniq

Products Affected

- **UKONIQ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Follicular Lymphoma (FL) in patients who have received at least three (3) prior lines of systemic therapy (e.g. bendamustine plus obinutuzumab or rituximab, ibritumomab tiuxetan, idelalisib, etc.) -OR- Documentation of Marginal Zone Lymphoma (MZL) in patients who have received at least one (1) prior anti-CD20-based regimen (e.g. bendamustine plus obinutuzumab or rituximab, lenalidomide plus rituximab, etc.).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

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	

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 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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

valtoco

Products Affected

- **VALTOCO**

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

veltassa

Products Affected

- **VELTASSA**

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

venclexta

Products Affected

- **VENCLEXTA**
- **VENCLEXTA STARTING PACK**

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

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 sacubitril/valsartan -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	

verzenio

Products Affected

- **VERZENIO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) HR mutation status and HER2 mutation status 2) Alternatives tried/failed 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

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- no alcohol abuse in the previous six months -AND- trial/failure or intolerance to two of the following medications for IBS-D or documentation of contraindication to all: loperamide, cholestyramine, Colestipol, dicyclomine, tricyclic antidepressants, selective serotonin reuptake inhibitors.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VIEKIRA PAK

Products Affected

- **VIEKIRA PAK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member is unable to utilize regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than four tablets per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

viibryd

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis major depressive disorder and trial and failure of one other antidepressant
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

vimovo

Products Affected

- *naproxen-esomeprazole*
- **VIMOVO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Both of the following. 1) Trial/failure of naproxen used in combination with omeprazole. 2) Trial/failure of one additional generic formulary NSAID (other than naproxen) used in combination with another generic formulary PPI (other than omeprazole).
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

vivlodex

Products Affected

- *meloxicam submicronized*
- **VIVLODEX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure or intolerance to generic meloxicam and one additional generic NSAID
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

vizimpro

Products Affected

- **VIZIMPRO**

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

voriconazole

Products Affected

- **VFEND IV**
- *voriconazole intravenous*

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. histopathogy, positive cultures) is required
Indications	All FDA-approved Indications.
Off Label Uses	

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 is unable to utilize regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than one tablet per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

votrient

Products Affected

- **VOTRIENT**

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of adipocytic soft tissue sarcoma or gastrointestinal stromal tumor
Required Medical Information	Documentation of advanced renal cell carcinoma -OR- documentation of advanced soft tissue sarcoma and prior chemotherapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

vraylar

Products Affected

- **VRAYLAR ORAL CAPSULE**
- **VRAYLAR ORAL CAPSULE,DOSE PACK**

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

vumerity

Products Affected

- **VUMERITY**

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

wakix

Products Affected

- **WAKIX**

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

Welireg

Products Affected

- **WELIREG**

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

xalkori

Products Affected

- **XALKORI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For metastatic non-small cell lung cancer (NSCLC), documenation of anaplastic lymphoma kinase (ALK) positive -OR- ROS-1 positive as detected by an FDA approved test. For relapsed or refractory systemic anaplastic large cell lymphoma (ALCL), documentation of ALK positive.
Age Restrictions	Deny if less than 18 years of age for NSCLC. Deny if less than 1 year of age or greater than 21 years of age for ALCL.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

xcopri

Products Affected

- **XCOPRI**
- **XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)**
- **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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

xeljanz

Products Affected

- **XELJANZ ORAL TABLET**
- **XELJANZ XR**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orencia, Stelara, Actemra, azathioprine, cyclosporine
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis and an inadequate response or intolerance to methotrexate. Xeljanx immediate release for juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	Deny if less than 18 years of age for rheumatoid arthritis, psoriatic arthritis, ulcerative colitis or less than 2 years of age for juvenile idiopathic arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses greater than 10 mg per day for Xeljanz and 11 mg per day for Xeljanz XR will not be approved for rheumatoid arthritis and psoriatic arthritis. Doses greater than 20mg per day for Xeljanz and 22 mg per day for Xeljanz XR will not be approved for ulcerative colitis.
Indications	All FDA-approved Indications.
Off Label Uses	

xeljanz solution

Products Affected

- **XELJANZ ORAL SOLUTION**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of juvenile idiopathic arthritis -AND- Inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
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	

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- if requesting brand Xenazine, trial and failure or intolerance to generic tetrabenazine has been documented -AND- attestation that the beneficiary is not actively suicidal
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	In patients with comorbid depression, attestation of adequate treatment for depression is required. Doses above 50mg/day may be approved up to 100mg/day (FDA max) when documentation of adequate trial of 50mg/day had inadequate response and are an extensive metabolizer.
Indications	All FDA-approved Indications.
Off Label Uses	

xermelo

Products Affected

- **XERMELO**

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

xgeva

Products Affected

- **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- one of the following (1. or 2.)- 1.) the member is 18 years old or older -OR- 2.) the member is a skeletally mature adolescent (e.g. has at least one mature long bone)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

xifaxan

Products Affected

- **XIFAXAN ORAL TABLET 550 MG**

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

xolair

Products Affected

- **XOLAIR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic idiopathic urticaria with trial/failure or intolerance of a second-generation non-sedating H1 antihistamine at the maximum recommended doses (e.g., cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine) -OR- Documentation of moderate to severe persistent asthma in patients with a positive skin test or in vitro reactivity to a perennial aeroallergen -AND- Baseline IgE titre greater than or equal to 30 IU/mL -AND- symptoms that are inadequately controlled despite a 3 month trial of both 1. and 2. 1) medium-dose inhaled corticosteroid or systemic steroid 2) a long-acting beta-agonist or leukotriene antagonist -AND- patient is currently on the optimal dose of a long-acting beta2-agonist, leukotriene modifier, or theophylline -OR- Documentation of add-on maintenance treatment for nasal polyps -AND- trial & failure, intolerance or contraindication to intra-nasal corticosteroids.
Age Restrictions	Deny if less than 12 years of age in treatment for chronic idiopathic urticaria -OR- deny if less than 6 years of age for severe persistent asthma -OR- deny if less than 18 years of age for nasal polyps
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of improved asthma control while on Xolair in treatment of asthma -OR- improved symptoms in treatment of CIU -OR- reduction in nasal polyp score or nasal congestion/obstruction severity score in treatment of nasal polyps must be provided for consideration of reauthorization
Indications	All FDA-approved Indications.
Off Label Uses	

xospata

Products Affected

- **XOSPATA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- FLT3 mutations, if applicable to diagnosis
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

xpovio

Products Affected

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

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

xtandi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of castration-resistant prostate cancer -OR- Documentation of metastatic castration-sensitive prostate cancer
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

xuriden

Products Affected

- **XURIDEN**

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

xyrem

Products Affected

- **XYREM**

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

xywav

Products Affected

- **XYWAV**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) - AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. If the member has a diagnosis of cataplexy, provision of baseline number of cataplexy episodes is required. -OR- Diagnosis of idiopathic hypersomnia -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- Documentation the member does not have cataplexy -AND- documentation of less than 2 SOREMPs -AND- Documentation of the following (1, 2, or 3): 1) MSLT documenting MSL less than or equal to 8 minutes -OR- 2) polysomnography demonstrating total sleep time greater than or equal to 660 minutes per 24 hours -OR- 3) wrist actigraphy demonstrating total sleep time greater than or equal to 660 minutes per 24 hours.
Age Restrictions	For narcolepsy, deny if less than 7 years of age. For idiopathic hypersomnia, deny if less than 18 years of age.
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	If diagnosis of narcolepsy without cataplexy- trial and failure, intolerance, or contraindication to generic modafinil AND a generic CNS stimulant indicated for use in narcolepsy (e.g. methylphenidate, amphetamine salts) is required. For reauthorization, attestation supporting improvement in symptoms of narcolepsy, idiopathic hypersomnia and cataplexy (if applicable) is required.
Indications	All FDA-approved Indications.
Off Label Uses	

yonsa

Products Affected

- **YONSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic castration resistant prostate cancer and concurrent use with methylprednisolone.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

zavesca

Products Affected

- *miglustat*
- **ZAVESCA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of mild to moderate type 1 Gaucher disease confirmed by the following (A. or B.) A. (1, 2, 3, 4, or, 5): 1)Hepatomegaly. 2)Splenomegaly. 3)Bone disease (i.e. osteonecrosis, osteopenia, secondary pathologic fractures, bone infarct). 4)Bone marrow complications as defined by anemia with hemoglobin less than or equal to 11.5 g/dL for females or 12.5 g/dL for males -OR- 5)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). -OR- B. Glucocerebrosidase activity in peripheral leukocytes is less than or equal to 15 percent of normal activity or genetic testing confirms mutant alleles.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of trial/failure or intolerance to at least one enzyme replacement therapy product including Cerezyme, Elelyso, or VPRIV. For brand Zavesca, documentation of failure on generic miglustat.
Indications	All FDA-approved Indications.
Off Label Uses	

zejula

Products Affected

- **ZEJULA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients with a complete or partial response to first-line platinum-based chemotherapy -OR- Documentation of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients with a complete or partial response to platinum-based chemotherapy -OR- Documentation of advanced ovarian, fallopian tube, or primary peritoneal cancer in patients treated with 3 or more prior chemotherapy regimens -AND- cancer is associated with homologous recombination deficiency (HRD) status defined by one of the follow (1 or 2): 1. Deleterious or suspected deleterious BRCA mutation 2. Genomic instability with progression more than 6 months after response to the last platinum-based chemotherapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

zelboraf

Products Affected

- **TAFINLAR**
- **ZELBORAF**

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

zepatier

Products Affected

- **ZEPATIER**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member is unable to utilize regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than 1 tablet/day will not be approved
Indications	All FDA-approved Indications.
Off Label Uses	

zeposia

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Zeposia and other disease modifying agents such as interferons, Copaxone, Tysabri.
Required Medical Information	Documentation of diagnosis. For moderate to severe active ulcerative colitis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine). For relapsing forms of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease): new starts to therapy have the following baseline information documented within 6 months of initiating therapy: ophthalmologic evaluation, liver transaminase and bilirubin, complete blood count, and electrocardiogram -AND- new starts to therapy do not have any of the following: Mobitz type II second-degree, third-degree AV block, sick sinus syndrome or sino-atrial block, unless patient has a functioning pacemaker, severe untreated sleep apnea, concomitant use of a monoamine oxidase inhibitor, and history of myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, Class III/IV heart failure.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	For moderate to severe active ulcerative colitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Xeljanz/Xeljanz XR and Stelara SC.
Indications	All FDA-approved Indications.
Off Label Uses	

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

ztlido

Products Affected

- **ZTLIDO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of postherpetic neuralgia (PHN) -AND- One of the following (1,2 or 3): 1) trial and failure of 1 other agent used to treat PHN (e.g. gabapentin) 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	Patients must have an adequate trial/failure or contraindication to Lidoderm or lidocaine patch 5%.
Indications	All FDA-approved Indications.
Off Label Uses	

ZYDELIG

Products Affected

- **ZYDELIG**

PA Criteria	Criteria Details
Exclusion Criteria	First line treatment. Combination use with benadmustine and/or rituximab for the treatment of FL.
Required Medical Information	Documentation of relapsed chronic lymphocytic leukemia (CLL) and use in combination with rituximab in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities -OR- documentation of relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies (e.g. alkylating agents, single or multi-drug chemotherapy, target immunotherapy) -OR- documentation of relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies (e.g. alkylating agents, single or multi-drug chemotherapy, target immunotherapy)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

zykadia

Products Affected

- **ZYKADIA ORAL TABLET**

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	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

zytiga

Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*
- **ZYTIGA ORAL TABLET 250 MG, 500 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic castration-resistant prostate cancer and concurrent use with prednisone -OR- metastatic high-risk castration-sensitive prostate cancer and concurrent use with prednisone
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected indications.
Indications	All FDA-approved Indications.
Off Label Uses	

Index of Drugs

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 ER 1.25 MG/ML SUSPENSION, EXTENDED RELEASE 24HR**
- **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 1.25 mg/ml oral 24 hr extended-release suspension*
- **APTENSIO XR 10 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 15 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 20 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 30 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 40 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 50 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **APTENSIO XR 60 MG CAPSULE,EXTENDED RELEASE SPRINKLE**
- **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**
- **DEXEDRINE SPANSULE 15 MG CAPSULE,EXTENDED RELEASE**
- **DEXEDRINE SPANSULE 5 MG CAPSULE,EXTENDED RELEASE**
- **DYANAVEL XR 2.5 MG/ML ORAL 24**

HR EXTENDED RELEASE SUSPENSION

- **EVEKEO ODT 10 MG DISINTEGRATING TABLET**
- **EVEKEO ODT 15 MG DISINTEGRATING TABLET**
- **EVEKEO ODT 20 MG DISINTEGRATING TABLET**
- **EVEKEO ODT 5 MG DISINTEGRATING TABLET**
- **FOCALIN 10 MG TABLET**
- **FOCALIN 2.5 MG TABLET**
- **FOCALIN 5 MG TABLET**
- **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**
- **METHYLIN 10 MG/5 ML ORAL SOLUTION**
- **METHYLIN 5 MG/5 ML ORAL SOLUTION**
- *methylphenidate er 72 mg tablet,extended release 24 hr*
- **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 72 MG TABLET,EXTENDED RELEASE**
- **RITALIN 10 MG TABLET**
- **RITALIN 20 MG TABLET**
- **RITALIN 5 MG TABLET**
- **RITALIN LA 10 MG CAPSULE,EXTENDED RELEASE**
- **RITALIN LA 20 MG CAPSULE,EXTENDED RELEASE**
- **RITALIN LA 30 MG CAPSULE,EXTENDED RELEASE**
- **RITALIN LA 40 MG CAPSULE,EXTENDED RELEASE**
- **STRATTERA 10 MG CAPSULE**
- **STRATTERA 100 MG CAPSULE**
- **STRATTERA 18 MG CAPSULE**
- **STRATTERA 25 MG CAPSULE**
- **STRATTERA 40 MG CAPSULE**
- **STRATTERA 60 MG CAPSULE**
- **STRATTERA 80 MG CAPSULE**
- **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**

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, atomoxetine, or dextroamphetamine/amphetamine in the last 180 days

brand albuterol

Products Affected

- *albuterol sulfate hfa 90 mcg/actuation aerosol inhaler (nda020983)*
- **PROAIR HFA 90 MCG/ACTUATION AEROSOL INHALER**
- **PROAIR RESPICLICK 90 MCG/ACTUATION BREATH ACTIVATED**
- **PROVENTIL HFA 90 MCG/ACTUATION AEROSOL INHALER**

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**

Details

Criteria	Require a trial of 2 of the following (Step 1 drug): generic epinephrine injection, Epipen or Symjepi in the last 180 days

brand glaucoma

Products Affected

- **VYZULTA 0.024 % EYE DROPS**

Details

Criteria	Require a 1 month trial of generic latanoprost (Step 1 drug) plus one other preferred formulary glaucoma drug (Step 1 drug) in the last 180 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

celecoxib

Products Affected

- **CELEBREX 100 MG CAPSULE**
- **CELEBREX 200 MG CAPSULE**
- **CELEBREX 400 MG CAPSULE**
- **CELEBREX 50 MG CAPSULE**
- *celecoxib 100 mg capsule*
- *celecoxib 200 mg capsule*
- *celecoxib 400 mg capsule*
- *celecoxib 50 mg capsule*

Details

Criteria	Require a 1 month trial of 2 formulary generic NSAIDs (Step 1 drug) in the last 180 days

copaxone

Products Affected

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

Details

Criteria	Require a 1 month trial of generic glatiramer and Glatopa 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

Fortamet

Products Affected

- **FORTAMET 1,000 MG TABLET,EXTENDED RELEASE**
- *metformin er 1,000 mg tablet,extended release 24hr*
- *metformin er 500 mg tablet,extended release 24hr*

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

- **GLUMETZA 1,000 MG TABLET,EXTENDED RELEASE**
- **GLUMETZA 500 MG TABLET,EXTENDED RELEASE**
- *metformin er 1,000 mg 24 hr tablet,extended release*
- *metformin er 500 mg 24 hr tablet,extended release*

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 drop (Step 1 drug) in the last 90 days

Lubiprostone

Products Affected

- *lubiprostone 24 mcg capsule*
- *lubiprostone 8 mcg capsule*

Details

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

lupron

Products Affected

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

Details

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

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

Riomet

Products Affected

- *metformin 500 mg/5 ml oral solution* **SOLUTION**
- **RIOMET 500 MG/5 ML ORAL**

Details

Criteria	Require a 1 month trial of generic metformin IR tablets in the last 90 days -OR- documentation supporting the inability to swallow or difficulty swallowing tablets containing metformin

Roszet

Products Affected

- **ROSZET 10 MG-10 MG TABLET**
- **ROSZET 10 MG-20 MG TABLET**
- **ROSZET 10 MG-40 MG TABLET**
- **ROSZET 10 MG-5 MG TABLET**

Details

Criteria	Require a 1 month trial of generic rosuvastatin tablets and generic ezetimibe tablets in the last 180 days

rytary

Products Affected

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

Details

Criteria	Require a trial of generic carbidopa/levodopa product (Step 1 drug) in the last 90 days

suboxone

Products Affected

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

Products Affected

- **ERTACZO 2 % TOPICAL CREAM**
- **EXTINA 2 % TOPICAL FOAM**
- **KETODAN 2 % TOPICAL FOAM**
- *naftifine 1 % topical cream*
- *naftifine 2 % topical cream*
- **NAFTIN 1 % TOPICAL GEL**
- **NAFTIN 2 % TOPICAL GEL**
- *oxiconazole 1 % topical cream*
- **OXISTAT 1 % LOTION**
- **OXISTAT 1 % TOPICAL CREAM**
- **XOLEGEL 2 % TOPICAL**

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

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