2025 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 (DE) Pharmacy Service at 1-844-576-1246
Freedom Blue PPO (PA) Pharmacy Service at 1-800-550-8722
Freedom Blue PPO (WV) Pharmacy Service at 1-888-459-4020
Security Blue HMO-POS Pharmacy Service at 1-800-935-2583
Community Blue Medicare HMO Pharmacy Service at 1-888-234-5397
Community Blue Medicare PPO Pharmacy Service at 1-888-757-2946
Community Blue Medicare Plus PPO Pharmacy Service at 1-888-757-2946
Blue Rx PDP Pharmacy Service at 1-800-290-3914

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

Formulary ID: 25021 Version: 19

Updated: 7/2025

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

When this Drug List (Formulary) refers to “we,” “us,” or “our,” it means Highmark Senior Health Company, Highmark Choice Company, Highmark Senior Solutions Company, Highmark BCBSD Inc, or Highmark 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, or Blue Rx PDP.

This document includes a Drug List (formulary) for our plan, which is current as of January 1, 2025. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2026, and from time to time during the year.

What is the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, and Blue Rx PDP formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at 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 change?

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

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

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

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

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

  If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, and Blue Rx PDP’s Formulary?

  Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilar?”

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 31-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, and Blue Rx PDP’s Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of July 1, 2025. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, members will be notified by mail and prospective members will receive an update with this formulary. The most up-to-date formulary is available on our website, **medicare.highmark.com/formulary**.

How do I use the formulary?

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

Medical Condition

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

Alphabetical Listing

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

What are generic drugs?

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

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

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

- For discussion of drug types, please see the Evidence of Coverage, Chapters 5 for MA-PD and 3 for PDP, Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered.”

Are there any restrictions on my coverage?

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

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

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

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

What if my drug is not on the formulary?

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

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

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

How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, and Blue Rx PDP formulary?

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

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

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

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

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

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

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

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

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

For more information

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

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

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

Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, and Blue Rx PDP formulary

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

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

The information in the Requirements/Limits column tells you if our 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	QR-28

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lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs

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

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

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

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

Drug Name	Drug Tier	Requirements/Limits
amoxicillin-pot clavulanate oral suspension for reconstitution	T2	
amoxicillin-pot clavulanate oral tablet	T2	
amoxicillin-pot clavulanate oral tablet extended release 12 hr	T2	
amphotericin b	T4	PA-BvD
amphotericin b liposome	T5	PA-BvD
ampicillin oral capsule 500 mg	T2	
ampicillin sodium injection recon soln 1 gram, 10 gram	T2	
ampicillin-sulbactam injection	T2	
ANCOBON	T5	PA
APTIVUS	T5	
ARIKAYCE	T5	PA
atazanavir	T4	
atovaquone	T4	
atovaquone-proguanil	T2	
AUGMENTIN ES-600	T4	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	T4	
AVYCAZ	T5	
AZACTAM	T4	
azithromycin intravenous	T2	
azithromycin oral suspension for reconstitution	T2	
azithromycin oral tablet	T2	
aztreonam injection recon soln 1 gram	T4	
aztreonam injection recon soln 2 gram	T5	
BACTRIM	T4	
BACTRIM DS	T4	
BARACLUDE	T5	
BAXDELA	T5	
BETHKIS	T5	PA
BICILLIN C-R	T3	
BICILLIN L-A INTRAMUSCULAR SYRINGE 1,200,000 UNIT/2 ML, 600,000 UNIT/ML	T3	

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

Drug Name	Drug Tier	Requirements/Limits
BICILLIN L-A INTRAMUSCULAR SYRINGE 2,400,000 UNIT/4 ML	T4	
BIKTARVY	T5	QL (31 EA per 31 days)
caspofungin	T4	
CAYSTON	T5	PA
cefaclor oral capsule	T2	
cefaclor oral suspension for reconstitution 250 mg/5 ml	T2	
cefaclor oral tablet extended release 12 hr	T2	
cefadroxil oral capsule	T2	
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	T2	
cefadroxil oral tablet	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	
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	T3	QL (50 EA per 30 days)
chloroquine phosphate oral tablet 500 mg	T3	QL (25 EA per 30 days)
CIMDUO	T5	QL (31 EA per 31 days)
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON	T3	
CIPRO ORAL TABLET 250 MG, 500 MG	T4	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	T1	

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

Drug Name	Drug Tier	Requirements/Limits
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	
clotrimazole mucous membrane	T2	
COARTEM	T4	
colistin (colistimethate na)	T4	
COMPLERA	T5	
CRESEMBA ORAL	T5	PA
cycloserine	T4	
DALVANCE	T5	
dapsone oral	T3	
daptomycin	T4	
DARAPRIM	T5	PA
darunavir	T5	
DELSTRIGO	T5	QL (31 EA per 31 days)
demeclocycline oral tablet 150 mg	T2	
demeclocycline oral tablet 300 mg	T4	
DESCOVY	T5	QL (31 EA per 31 days)
dicloxacillin	T2	
DIFICID ORAL SUSPENSION FOR RECONSTITUTION	T5	QL (136 ML per 12 days)
DIFICID ORAL TABLET	T5	QL (20 EA per 10 days)
DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML	T4	
DIFLUCAN ORAL TABLET 100 MG	T4	
DORYX MPC ORAL TABLET,DELAYED RELEASE (DR/EC) 60 MG	T5	
DOVATO	T5	QL (31 EA per 31 days)
DOXY-100	T2	
doxycycline hyclate oral capsule	T2	

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

Drug Name	Drug Tier	Requirements/Limits
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 capsule,ir - delay rel,biphase	T4	
doxycycline monohydrate oral suspension for reconstitution	T2	
doxycycline monohydrate oral tablet	T2	
E.E.S. 400 ORAL TABLET	T4	
E.E.S. GRANULES	T4	
EDURANT	T5	
efavirenz oral tablet	T3	
efavirenz-emtricitabin-tenofov	T5	
efavirenz-lamivu-tenofov disop	T5	QL (31 EA per 31 days)
emtricitabine	T3	
emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg	T5	
emtricitabine-tenofovir (tdf) oral tablet 200-300 mg	T4	
EMTRIVA ORAL CAPSULE	T4	
EMTRIVA ORAL SOLUTION	T3	
EMVERM	T5	
entecavir	T4	
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	T5	PA; QL (28 EA per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	T5	PA; QL (56 EA per 28 days)
EPCLUSA ORAL TABLET	T5	PA; QL (28 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
EPIVIR	T4	
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG	T5	
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 50 MG	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 INTRAVENOUS RECON SOLN 500 MG	T3	
erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml	T2	
erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml	T5	
erythromycin ethylsuccinate oral tablet	T4	
erythromycin oral	T2	
ethambutol	T2	
etravirine	T5	
EVOTAZ	T5	
famciclovir	T2	
FIRVANQ	T4	
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml	T2	
fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml	T3	
fluconazole oral suspension for reconstitution	T3	
fluconazole oral tablet	T2	
flucytosine oral capsule 250 mg	T4	
flucytosine oral capsule 500 mg	T5	
fosamprenavir	T5	
fosfomycin tromethamine	T4	
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml	T2	

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

Drug Name	Drug Tier	Requirements/Limits
gentamicin injection	T1	
GENVOYA	T5	
griseofulvin microsize	T2	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	T2	
griseofulvin ultramicrosize oral tablet 165 mg	T5	PA; QL (124 EA per 31 days)
HARVONI	T5	PA; QL (28 EA per 28 days)
HIPREX	T4	
HUMATIN	T4	
hydroxychloroquine oral tablet 100 mg	T4	QL (93 EA per 31 days)
hydroxychloroquine oral tablet 200 mg	T2	QL (93 EA per 31 days)
hydroxychloroquine oral tablet 300 mg	T4	QL (62 EA per 31 days)
hydroxychloroquine oral tablet 400 mg	T4	QL (31 EA per 31 days)
imipenem-cilastatin	T2	
IMPAVIDO	T5	
INTELENCE ORAL TABLET 100 MG, 200 MG	T5	
INTELENCE ORAL TABLET 25 MG	T4	
INVANZ INJECTION	T4	
ISENTRESS HD	T5	
ISENTRESS ORAL POWDER IN PACKET	T5	
ISENTRESS ORAL TABLET	T5	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	T5	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	T3	
isoniazid oral solution	T2	
isoniazid oral tablet	T1	
itraconazole oral capsule	T2	PA
itraconazole oral solution	T4	PA
ivermectin oral tablet 3 mg	T2	PA
JULUCA	T5	
KALETRA ORAL SOLUTION	T5	
KALETRA ORAL TABLET	T4	
ketoconazole oral	T2	
KITABIS PAK	T4	PA
KRINTAFEL	T4	

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

Drug Name	Drug Tier	Requirements/Limits
LAGEVRIO (EUA)	T3	QL (360 EA per 365 days)
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 oral	T2	
linezolid in dextrose 5%	T4	
linezolid oral suspension for reconstitution	T5	
linezolid oral tablet	T4	
LIVTENCITY	T5	PA; QL (372 EA per 31 days)
lopinavir-ritonavir	T4	
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	
maraviroc oral tablet 150 mg	T5	
maraviroc oral tablet 300 mg	T4	
MAVYRET ORAL PELLETS IN PACKET	T5	PA; QL (140 EA per 28 days)
MAVYRET ORAL TABLET	T5	PA; QL (84 EA per 28 days)
mefloquine	T2	
MEPRON	T4	
meropenem intravenous recon soln 1 gram, 500 mg	T2	
methenamine hippurate	T2	
metronidazole in nacl (iso-os)	T2	
metronidazole oral capsule	T2	
metronidazole oral tablet 125 mg	T4	PA
metronidazole oral tablet 250 mg, 500 mg	T1	
micafungin	T4	
minocycline oral capsule	T2	
minocycline oral tablet	T2	

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

Drug Name	Drug Tier	Requirements/Limits
minocycline oral tablet extended release 24 hr 105 mg, 115 mg, 135 mg, 45 mg, 65 mg, 80 mg, 90 mg	T2	
minocycline oral tablet extended release 24 hr 55 mg	T4	
moxifloxacin oral	T3	
moxifloxacin-sod.chloride(iso)	T4	
MYCAMINE INTRAVENOUS RECON SOLN 50 MG	T4	
MYCOBUTIN	T4	
nafcillin injection recon soln 1 gram	T2	
nafcillin injection recon soln 10 gram, 2 gram	T4	
NEBUPENT	T4	PA-BvD
neomycin	T2	
nevirapine oral suspension	T2	
nevirapine oral tablet	T2	
nevirapine oral tablet extended release 24 hr 400 mg	T4	
nitazoxanide	T5	
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)
nitrofurantoin macrocrystal oral capsule 50 mg	T2	QL (180 EA per 365 days)
nitrofurantoin monohyd/m-cryst	T2	QL (90 EA per 365 days)
nitrofurantoin oral suspension 25 mg/5 ml	T5	QL (1800 ML per 365 days)
nitrofurantoin oral suspension 50 mg/5 ml	T5	QL (900 ML per 365 days)
NORVIR ORAL POWDER IN PACKET	T3	
NORVIR ORAL TABLET	T4	
NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON	T5	PA; QL (32 EA per 31 days)
NOXAFIL ORAL SUSPENSION	T5	PA
NUZYRA	T5	
nystatin oral	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
ofloxacin oral tablet 300 mg, 400 mg	T2	
ORACEA	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)

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

Drug Name	Drug Tier	Requirements/Limits
oseltamivir oral suspension for reconstitution	T3	QL (1080 ML per 365 days)
oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml	T2	
oxacillin injection recon soln 1 gram	T2	
oxacillin injection recon soln 10 gram	T4	
oxacillin injection recon soln 2 gram	T5	
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (10)- 100 MG (10)	T3	QL (180 EA per 365 days)
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (6)- 100 MG (5)	T3	QL (99 EA per 365 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	T3	QL (270 EA per 365 days)
penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml	T4	
penicillin g potassium injection recon soln 20 million unit	T2	
penicillin g sodium	T5	
penicillin v potassium	T1	
PENTAM	T4	
pentamidine inhalation	T4	PA-BvD
pentamidine injection	T4	
PIFELTRO	T5	QL (62 EA per 31 days)
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram	T4	
PLAQUENIL	T4	QL (93 EA per 31 days)
polymyxin b sulfate	T2	
posaconazole oral	T5	PA
praziquantel	T4	
pretomanid	T4	PA; QL (31 EA per 31 days)
PREVYMIS ORAL PELLETS IN PACKET	T5	PA; QL (124 EA per 31 days)
PREVYMIS ORAL TABLET	T5	QL (31 EA per 31 days)
PREZCOBIX	T5	
PREZISTA ORAL SUSPENSION	T5	
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	T5	
PRIFTIN	T4	
primaquine	T3	

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

Drug Name	Drug Tier	Requirements/Limits
PRIMAXIN IV INTRAVENOUS RECON SOLN 500 MG	T4	
pyrazinamide	T2	
pyrimethamine	T5	PA
quinine sulfate	T3	PA; QL (42 EA per 28 days)
RELENZA DISKHALER	T3	
RETROVIR ORAL CAPSULE	T4	
RETROVIR ORAL SYRUP	T4	
REYATAZ ORAL CAPSULE 200 MG, 300 MG	T5	
REYATAZ ORAL POWDER IN PACKET	T5	
ribavirin oral capsule	T3	
ribavirin oral tablet 200 mg	T2	
rifabutin	T2	
rifampin intravenous	T5	
rifampin oral	T2	
rimantadine	T2	
ritonavir	T3	
RUKOBIA	T5	QL (62 EA per 31 days)
SELZENTRY ORAL SOLUTION	T5	
SELZENTRY ORAL TABLET 150 MG, 300 MG	T5	
SEYSARA	T5	PA
SIRTURO	T5	PA
SIVEXTRO INTRAVENOUS	T5	
SIVEXTRO ORAL	T5	QL (6 EA per 31 days)
sofosbuvir-velpatasvir	T5	PA; QL (28 EA per 28 days)
SOLOSEC	T4	
SOVALDI	T5	PA; QL (28 EA per 28 days)
SOVUNA ORAL TABLET 200 MG	T4	QL (93 EA per 31 days)
SOVUNA ORAL TABLET 300 MG	T4	QL (62 EA per 31 days)
SPORANOX ORAL CAPSULE	T5	PA
streptomycin	T5	
STRIBILD	T5	
STROMECTOL	T4	PA
sulfadiazine	T2	

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

Drug Name	Drug Tier	Requirements/Limits
sulfamethoxazole-trimethoprim oral	T1	
SUNLENCA ORAL	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	
tenofovir disoproxil fumarate	T3	
terbinafine hcl oral	T1	QL (90 EA per 180 days)
tetracycline oral capsule	T2	
tigecycline	T5	
tinidazole	T2	
TIVICAY ORAL TABLET 50 MG	T5	
TIVICAY PD	T5	
TOBI	T5	PA
TOBI PODHALER	T5	PA; QL (224 EA per 56 days)
tobramycin in 0.225 % nacl	T5	PA
tobramycin inhalation	T5	PA
tobramycin sulfate injection solution	T1	
TOLSURA	T5	PA; QL (130 EA per 31 days)
TRECATOR	T4	
trimethoprim	T2	
TRIUMEQ	T5	
TRIUMEQ PD	T4	QL (186 EA per 31 days)
TRUVADA	T5	
TYBOST	T3	
TYGACIL	T4	
UNASYN INJECTION RECON SOLN 15 GRAM, 3 GRAM	T4	
VABOMERE	T5	
valacyclovir	T2	

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

Drug Name	Drug Tier	Requirements/Limits
VALCYTE	T5	
valganciclovir oral recon soln	T4	
valganciclovir oral tablet	T3	
VALTREX	T4	
VANCOCIN ORAL CAPSULE 125 MG	T4	PA; QL (124 EA per 31 days)
VANCOCIN ORAL CAPSULE 250 MG	T5	PA; QL (248 EA per 31 days)
vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg	T2	
vancomycin oral capsule 125 mg	T4	PA; QL (124 EA per 31 days)
vancomycin oral capsule 250 mg	T4	PA; QL (248 EA per 31 days)
vancomycin oral recon soln	T4	
VEMLIDY	T5	QL (31 EA per 31 days)
VFEND IV	T4	PA
VFEND ORAL SUSPENSION FOR RECONSTITUTION	T5	
VFEND ORAL TABLET 50 MG	T4	
VIRACEPT ORAL TABLET	T5	
VIREAD	T5	
VIVJOA	T4	PA; QL (18 EA per 84 days)
voriconazole intravenous	T5	PA
voriconazole oral	T4	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	T4	QL (27 EA per 365 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	
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	

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

Drug Name	Drug Tier	Requirements/Limits
ZITHROMAX Z-PAK	T4	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML	T4	
ZYVOX INTRAVENOUS PIGGYBACK 600 MG/300 ML	T4	
ZYVOX ORAL	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)
ABIRTEGA	T3	PA-NS; QL (124 EA per 31 days)
AFINITOR	T5	PA-NS; QL (31 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 5 MG	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG	T5	PA-NS; QL (93 EA per 31 days)
AKEEGA	T5	PA-NS; QL (62 EA per 31 days)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	T5	PA-NS; QL (31 EA per 31 days)
ALUNBRIG ORAL TABLET 30 MG	T5	PA-NS; QL (186 EA per 31 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	T5	PA-NS; QL (60 EA per 365 days)
anastrozole	T2	
ARIMIDEX	T5	
AROMASIN	T5	
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG	T3	PA-BvD
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 5 MG	T5	PA-BvD
AUGTYRO ORAL CAPSULE 160 MG	T5	PA-NS; QL (62 EA per 31 days)
AUGTYRO ORAL CAPSULE 40 MG	T5	PA-NS; QL (248 EA per 31 days)
AYVAKIT	T5	PA-NS; QL (31 EA per 31 days)
AZASAN	T4	PA-BvD
azathioprine oral tablet 100 mg, 75 mg	T4	PA-BvD
azathioprine oral tablet 50 mg	T2	PA-BvD
BALVERSA	T5	PA-NS

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

Drug Name	Drug Tier	Requirements/Limits
bexarotene oral	T5	PA-NS
bexarotene topical	T5	PA-NS; QL (60 GM per 28 days)
bicalutamide	T2	
BOSULIF ORAL CAPSULE 100 MG	T5	PA-NS; QL (186 EA per 31 days)
BOSULIF ORAL CAPSULE 50 MG	T5	PA-NS; QL (341 EA per 31 days)
BOSULIF ORAL TABLET 100 MG	T5	PA-NS; QL (93 EA per 31 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	T5	PA-NS; QL (31 EA per 31 days)
BRAFTOVI	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)
CALQUENCE (ACALABRUTINIB MAL)	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 300 MG	T5	PA-NS; QL (31 EA per 31 days)
CASODEX	T4	
CELLCEPT	T5	PA-BvD
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	T5	PA-NS; QL (112 EA per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	T5	PA-NS; QL (84 EA per 28 days)
COPIKTRA	T5	PA-NS; QL (62 EA per 31 days)
COTELLIC	T5	PA-NS; LA; QL (63 EA per 28 days)
cyclophosphamide oral	T3	PA-BvD
cyclosporine modified oral capsule	T2	PA-BvD
cyclosporine modified oral solution	T4	PA-BvD
cyclosporine oral capsule	T2	PA-BvD
DANZITEN	T5	PA-NS; QL (124 EA per 31 days)
dasatinib	T5	PA-NS; QL (31 EA per 31 days)
DAURISMO ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
DAURISMO ORAL TABLET 25 MG	T5	PA-NS; QL (62 EA per 31 days)
ELIGARD	T4	ST-NS; QL (1 EA per 30 days)
ELIGARD (3 MONTH)	T4	ST-NS; QL (1 EA per 90 days)
ELIGARD (4 MONTH)	T4	ST-NS; QL (1 EA per 120 days)
ELIGARD (6 MONTH)	T4	ST-NS; QL (1 EA per 180 days)

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

Drug Name	Drug Tier	Requirements/Limits
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 ORAL TABLET 240 MG	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA ORAL TABLET 60 MG	T5	PA-NS; QL (93 EA per 31 days)
erlotinib	T5	PA-NS; QL (31 EA per 31 days)
EULEXIN	T4	
everolimus (antineoplastic) oral tablet 10 mg, 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 (antineoplastic) oral tablet for suspension 2 mg, 5 mg	T5	PA-NS; QL (62 EA per 31 days)
everolimus (antineoplastic) oral tablet for suspension 3 mg	T5	PA-NS; QL (93 EA per 31 days)
everolimus (immunosuppressive)	T5	PA-BvD
exemestane	T2	
FEMARA	T4	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	T5	PA-NS
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	T4	PA-NS
FOTIVDA	T5	PA-NS; QL (21 EA per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	T5	PA-NS; QL (84 EA per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	T5	PA-NS; QL (21 EA per 28 days)
GAVRETO	T5	PA-NS; QL (124 EA per 31 days)
gefitinib	T5	PA-NS; QL (31 EA per 31 days)
GENGRAF ORAL CAPSULE	T2	PA-BvD
GILOTRIF	T5	PA-NS; QL (31 EA per 31 days)
GLEEVEC ORAL TABLET 100 MG	T5	PA-NS; QL (93 EA per 31 days)
GLEEVEC ORAL TABLET 400 MG	T5	PA-NS; QL (62 EA per 31 days)
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG	T5	PA-NS
GLEOSTINE ORAL CAPSULE 40 MG	T4	PA-NS
GOMEKLI ORAL CAPSULE 1 MG	T5	PA-NS; QL (126 EA per 28 days)
GOMEKLI ORAL CAPSULE 2 MG	T5	PA-NS; QL (84 EA per 28 days)
GOMEKLI ORAL TABLET FOR SUSPENSION	T5	PA-NS; QL (168 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
HYDREA	T4	
hydroxyurea	T2	
IBRANCE	T5	PA-NS; QL (21 EA per 28 days)
ICLUSIG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 50 MG	T5	PA-NS; QL (62 EA per 31 days)
imatinib oral tablet 100 mg	T5	PA-NS; QL (93 EA per 31 days)
imatinib oral tablet 400 mg	T5	PA-NS; QL (62 EA per 31 days)
IMBRUVICA ORAL CAPSULE 140 MG	T5	PA-NS; QL (124 EA per 31 days)
IMBRUVICA ORAL CAPSULE 70 MG	T5	PA-NS; QL (31 EA per 31 days)
IMBRUVICA ORAL SUSPENSION	T5	PA-NS; QL (216 ML per 25 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	T5	PA-NS; QL (31 EA per 31 days)
IMKELDI	T5	PA-NS; QL (280 ML per 28 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; QL (31 EA per 31 days)
ITOVEBI ORAL TABLET 3 MG	T5	PA-NS; QL (62 EA per 31 days)
ITOVEBI ORAL TABLET 9 MG	T5	PA-NS; QL (31 EA per 31 days)
IWILFIN	T5	PA-NS; QL (248 EA per 31 days)
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
JAYPIRCA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
JAYPIRCA ORAL TABLET 50 MG	T5	PA-NS; QL (31 EA per 31 days)
JYLAMVO	T4	PA-BvD
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 (250 MG)	T5	PA

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

Drug Name	Drug Tier	Requirements/Limits
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)
KRAZATI	T5	PA-NS; QL (186 EA per 31 days)
lapatinib	T5	PA-NS; QL (186 EA per 31 days)
LAZCLUZE ORAL TABLET 240 MG	T5	PA-NS; QL (30 EA per 30 days)
LAZCLUZE ORAL TABLET 80 MG	T5	PA-NS; QL (60 EA per 30 days)
lenalidomide	T5	PA-NS; QL (21 EA per 28 days)
LENVIMA	T5	PA-NS
letrozole	T2	
leucovorin calcium oral	T2	
LEUKERAN	T5	
leuprolide (3 month)	T4	QL (1 EA per 84 days)
leuprolide subcutaneous kit	T2	QL (2 EA per 28 days)
LONSURF	T5	PA-NS
LORBRENA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
LORBRENA ORAL TABLET 25 MG	T5	PA-NS; QL (93 EA per 31 days)
LUMAKRAS ORAL TABLET 120 MG	T5	PA-NS; QL (124 EA per 31 days)
LUMAKRAS ORAL TABLET 240 MG	T5	PA-NS; QL (62 EA per 31 days)
LUMAKRAS ORAL TABLET 320 MG	T5	PA-NS; QL (93 EA per 31 days)
LUPKYNIS	T5	PA; QL (186 EA per 31 days)
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	T5	QL (1 EA per 90 days)
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 22.5 MG	T5	QL (1 EA per 84 days)
LUPRON DEPOT (4 MONTH)	T5	QL (1 EA per 112 days)
LUPRON DEPOT (6 MONTH)	T5	QL (1 EA per 168 days)
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	T5	QL (1 EA per 30 days)
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG	T5	QL (1 EA per 28 days)
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	T5	PA; QL (1 EA per 90 days)
LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)	T5	PA; QL (1 EA per 30 days)
LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT	T5	PA; QL (1 EA per 168 days)

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

Drug Name	Drug Tier	Requirements/Limits
LUTRATE DEPOT (3 MONTH)	T4	ST-NS; QL (1 EA per 84 days)
LYNPARZA	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T5	
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)	T5	PA-NS; QL (93 EA per 31 days)
LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)	T5	PA-NS; QL (124 EA per 31 days)
LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)	T5	PA-NS; QL (155 EA per 31 days)
MATULANE	T5	
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)	T2	PA
megestrol oral tablet	T2	PA-NS
MEKINIST ORAL RECON SOLN	T5	PA-NS; QL (1260 ML per 31 days)
MEKINIST ORAL TABLET 0.5 MG	T5	PA-NS; QL (93 EA per 31 days)
MEKINIST ORAL TABLET 2 MG	T5	PA-NS; QL (31 EA per 31 days)
MEKTOVI	T5	PA-NS; QL (186 EA per 31 days)
mercaptopurine oral suspension	T5	
mercaptopurine oral tablet	T2	
mesna oral	T3	
MESNEX ORAL	T4	
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 oral capsule	T2	PA-BvD
mycophenolate mofetil oral suspension for reconstitution	T4	PA-BvD
mycophenolate mofetil oral tablet	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
MYHIBBIN	T5	PA-BvD
NEMLUVIO	T5	PA; QL (2 EA per 28 days)
NEORAL	T3	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
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; QL (3 EA per 28 days)
NUBEQA	T5	PA-NS; QL (124 EA per 31 days)
octreotide acetate injection solution 1,000 mcg/ml	T3	PA
octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml	T2	PA
octreotide acetate injection solution 200 mcg/ml, 500 mcg/ml	T4	PA
ODOMZO	T5	PA-NS; LA; QL (31 EA per 31 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG	T5	PA-NS; QL (62 EA per 31 days)
OGSIVEO ORAL TABLET 50 MG	T5	PA-NS; QL (186 EA per 31 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	T5	PA-NS; QL (96 ML per 28 days)
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)	T5	PA-NS; QL (16 EA per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	T5	PA-NS; QL (20 EA per 28 days)
OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)	T5	PA-NS; QL (24 EA per 28 days)
OJJAARA	T5	PA-NS; QL (31 EA per 31 days)
ONUREG	T5	PA-NS; QL (14 EA per 28 days)
ORGOVYX	T5	PA-NS; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 345 MG	T5	PA-NS; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 86 MG	T5	PA-NS; QL (93 EA per 31 days)
pazopanib	T5	PA-NS; QL (124 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)
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 CAPSULE 0.5 MG, 1 MG	T4	PA-BvD
PROGRAF ORAL CAPSULE 5 MG	T5	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
PROGRAF ORAL GRANULES IN PACKET	T4	PA-BvD
PURIXAN	T5	
QINLOCK	T5	PA-NS; QL (93 EA per 31 days)
RAPAMUNE ORAL TABLET 1 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)
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	T5	PA-NS; QL (62 EA per 31 days)
RETEVMO ORAL TABLET 40 MG	T5	PA-NS; QL (93 EA per 31 days)
REVLIMID	T5	PA-NS; QL (21 EA per 28 days)
REVUFORJ ORAL TABLET 110 MG	T5	PA-NS; QL (124 EA per 31 days)
REVUFORJ ORAL TABLET 160 MG	T5	PA-NS; QL (62 EA per 31 days)
REVUFORJ ORAL TABLET 25 MG	T5	PA-NS; QL (248 EA per 31 days)
REZLIDHIA	T5	PA-NS; QL (62 EA per 31 days)
REZUROCK	T5	PA; QL (62 EA per 31 days)
ROMVIMZA	T5	PA-NS; QL (8 EA per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	T5	PA-NS; QL (155 EA per 31 days)
ROZLYTREK ORAL CAPSULE 200 MG	T5	PA-NS; QL (93 EA per 31 days)
ROZLYTREK ORAL PELLETS IN PACKET	T5	PA-NS; QL (372 EA per 31 days)
RUBRACA	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE ORAL CAPSULE 100 MG	T4	PA-BvD
SANDIMMUNE ORAL CAPSULE 25 MG	T3	PA-BvD
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML	T5	PA
SANDOSTATIN INJECTION SOLUTION 50 MCG/ML, 500 MCG/ML	T4	PA
SCEMBLIX ORAL TABLET 100 MG	T5	PA-NS; QL (124 EA per 31 days)
SCEMBLIX ORAL TABLET 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SCEMBLIX ORAL TABLET 40 MG	T5	PA-NS; QL (310 EA per 31 days)
SIGNIFOR	T5	PA
SIKLOS	T4	
sirolimus oral solution	T5	PA-BvD
sirolimus oral tablet	T2	PA-BvD
SOLTAMOX	T4	
sorafenib	T5	PA-NS; QL (124 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
SPRYCEL	T5	PA-NS; QL (31 EA per 31 days)
STIVARGA	T5	PA-NS; QL (84 EA per 28 days)
sunitinib malate	T5	PA-NS; QL (31 EA per 31 days)
SUTENT	T5	PA-NS; QL (31 EA per 31 days)
TABLOID	T4	
TABRECTA	T5	PA-NS; QL (124 EA per 31 days)
tacrolimus oral capsule	T2	PA-BvD
TAFINLAR ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	T5	PA-NS; QL (930 EA per 31 days)
TAGRISSO	T5	PA-NS; LA; QL (31 EA per 31 days)
TALZENNA	T5	PA-NS; QL (31 EA per 31 days)
tamoxifen	T1	
TARGRETIN ORAL	T5	PA-NS
TARGRETIN TOPICAL	T5	PA-NS; QL (60 GM per 28 days)
TASIGNA	T5	PA-NS; QL (124 EA per 31 days)
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, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
TIBSOVO	T5	PA-NS; QL (62 EA per 31 days)
toremifene	T4	
TORPENZ	T5	PA-NS; QL (31 EA per 31 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG	T4	ST-NS; QL (1 EA per 84 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 22.5 MG	T4	ST-NS; QL (1 EA per 168 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG	T4	ST-NS; QL (1 EA per 28 days)
tretinoin (antineoplastic)	T5	
TREXALL	T3	PA-BvD
TRUQAP	T5	PA-NS; QL (64 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)

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

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

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

Drug Name	Drug Tier	Requirements/Limits
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	T5	PA-NS; QL (32 EA per 28 days)
XROMI	T5	
XTANDI ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
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 ORAL TABLET	T5	PA-NS; QL (31 EA per 31 days)
ZELBORAF	T5	PA-NS; QL (248 EA per 31 days)
ZOLINZA	T5	PA-NS
ZORTRESS ORAL TABLET 0.25 MG	T4	PA-BvD
ZORTRESS ORAL TABLET 0.5 MG, 0.75 MG, 1 MG	T5	PA-BvD
ZYDELIG	T5	PA-NS; QL (62 EA per 31 days)
ZYKADIA	T5	PA-NS; QL (93 EA per 31 days)
ZYTIGA ORAL TABLET 250 MG	T5	PA-NS; QL (124 EA per 31 days)
ZYTIGA ORAL TABLET 500 MG	T5	PA-NS; QL (62 EA per 31 days)
Autonomic / Cns Drugs, Neurology / Psych		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	T5	QL (2.4 ML per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	T5	QL (3.2 ML per 56 days)
ABILIFY MAINTENA	T5	QL (1 EA per 28 days)
ABILIFY ORAL TABLET	T4	PA-NS
acetaminophen-codeine oral solution 120-12 mg/5 ml	T1	PA; QL (5167 ML per 31 days)
acetaminophen-codeine oral tablet	T2	PA; QL (403 EA per 31 days)
ADDERALL ORAL TABLET 20 MG	T4	ST; QL (93 EA per 31 days)
ADDERALL ORAL TABLET 5 MG, 7.5 MG	T4	ST; QL (62 EA per 31 days)
ADDERALL XR	T4	ST; QL (31 EA per 31 days)
ADLARITY	T4	PA; QL (4 EA per 28 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)

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

Drug Name	Drug Tier	Requirements/Limits
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	T3	PA; QL (2 ML per 28 days)
AJOVY AUTOINJECTOR	T3	PA; QL (1.5 ML per 28 days)
AJOVY SYRINGE	T3	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	PA; QL (31 EA per 31 days)
AMBIEN CR	T4	PA; QL (31 EA per 31 days)
amitriptyline	T2	PA-NS
amitriptyline-chlordiazepoxide	T2	PA-NS
amoxapine	T1	
amphetamine sulfate	T4	PA
AMPYRA	T5	PA; QL (62 EA per 31 days)
AMRIX	T5	QL (31 EA per 31 days)
ANAFRANIL	T4	PA-NS
APLENZIN	T5	QL (31 EA per 31 days)
APOKYN	T5	PA; QL (60 ML per 30 days)
apomorphine	T5	PA; QL (60 ML per 30 days)
APTENSIO XR	T4	ST; QL (31 EA per 31 days)
APTIOM ORAL TABLET 200 MG	T4	QL (186 EA per 31 days)
APTIOM ORAL TABLET 400 MG	T5	QL (93 EA per 31 days)
APTIOM ORAL TABLET 600 MG, 800 MG	T5	QL (62 EA per 31 days)
ARICEPT	T4	

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

Drug Name	Drug Tier	Requirements/Limits
aripiprazole oral solution	T3	PA-NS
aripiprazole oral tablet	T3	
aripiprazole oral tablet,disintegrating	T5	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	T4	PA; QL (372 EA per 31 days)
asenapine maleate	T4	PA-NS; QL (62 EA per 31 days)
ATIVAN ORAL TABLET 0.5 MG	T5	PA; QL (124 EA per 31 days)
ATIVAN ORAL TABLET 1 MG	T5	PA; QL (186 EA per 31 days)
ATIVAN ORAL TABLET 2 MG	T5	PA; QL (155 EA per 31 days)
atomoxetine oral capsule 10 mg, 25 mg, 40 mg	T4	QL (62 EA per 31 days)
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)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG	T5	PA; QL (93 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 18 MG, 30 MG, 36 MG, 42 MG, 48 MG	T5	PA; QL (31 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 24 MG	T5	PA; QL (62 EA per 31 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 6 MG	T5	PA; QL (217 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG	T5	PA; QL (56 EA per 365 days)
AUVELITY	T5	PA-NS; QL (62 EA per 31 days)
AZILECT ORAL TABLET 0.5 MG	T4	
AZILECT ORAL TABLET 1 MG	T5	
AZSTARYS	T4	ST; QL (31 EA per 31 days)
baclofen oral solution 10 mg/5 ml (2 mg/ml)	T4	PA; QL (1240 ML per 31 days)
baclofen oral solution 5 mg/5 ml	T4	PA; QL (2480 ML per 31 days)
baclofen oral suspension	T4	PA; QL (496 ML per 31 days)
baclofen oral tablet 10 mg	T1	
baclofen oral tablet 15 mg	T4	
baclofen oral tablet 20 mg, 5 mg	T2	
BAFIERTAM	T5	PA; QL (124 EA per 31 days)
BANZEL	T5	PA-NS
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG	T4	PA; QL (62 EA per 31 days)
BELBUCA BUCCAL FILM 900 MCG	T5	PA; QL (62 EA per 31 days)
BELSOMRA	T4	ST; QL (31 EA per 31 days)
benztropine oral	T2	PA
BRIVIACT ORAL SOLUTION	T5	QL (620 ML per 31 days)
BRIVIACT ORAL TABLET	T5	QL (62 EA per 31 days)
bromocriptine	T2	
buprenorphine	T4	PA; QL (4 EA per 28 days)
buprenorphine hcl sublingual tablet 2 mg	T3	QL (93 EA per 31 days)
buprenorphine hcl sublingual tablet 8 mg	T3	QL (62 EA per 31 days)
buprenorphine-naloxone sublingual film 12-3 mg, 4-1 mg, 8-2 mg	T2	QL (62 EA per 31 days)
buprenorphine-naloxone sublingual film 2-0.5 mg	T2	QL (93 EA per 31 days)
buprenorphine-naloxone sublingual tablet	T4	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	QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
bupropion hcl oral tablet sustained-release 12 hr	T2	QL (62 EA per 31 days)
buspirone	T2	
butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg	T4	PA; QL (403 EA per 31 days)
butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg	T4	PA; QL (372 EA per 31 days)
butalbital-acetaminophen oral capsule	T4	QL (403 EA per 31 days)
butalbital-acetaminophen oral tablet 50-300 mg	T2	QL (403 EA per 31 days)
butalbital-acetaminophen oral tablet 50-325 mg	T2	QL (372 EA per 31 days)
butalbital-acetaminophen-caff oral capsule 50-300-40 mg	T4	QL (403 EA per 31 days)
butalbital-acetaminophen-caff oral capsule 50-325-40 mg	T4	QL (372 EA per 31 days)
butalbital-acetaminophen-caff oral tablet	T2	QL (372 EA per 31 days)
butalbital-aspirin-caffeine oral capsule	T4	
butorphanol nasal	T2	QL (5 ML per 28 days)
BUTRANS	T4	PA; QL (4 EA per 28 days)
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 100 mg	T1	
carbamazepine oral tablet,chewable 200 mg	T4	
CARBATROL	T4	
carbidopa	T4	
carbidopa-levodopa	T2	
carbidopa-levodopa-entacapone	T2	
carisoprodol	T2	PA
CELEBREX	T4	ST; QL (62 EA per 31 days)
celecoxib	T2	QL (62 EA per 31 days)
CELEXA ORAL TABLET	T4	
CELONTIN ORAL CAPSULE 300 MG	T4	
chlordiazepoxide hcl	T2	PA
chlorpromazine oral	T2	
chlorzoxazone oral tablet 250 mg	T5	PA

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

Drug Name	Drug Tier	Requirements/Limits
chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg	T2	PA
citalopram oral capsule	T4	PA-NS; QL (31 EA per 31 days)
citalopram oral solution	T2	
citalopram oral tablet	T1	
clobazam oral suspension	T4	PA-NS; QL (496 ML per 31 days)
clobazam oral tablet	T3	PA-NS; QL (62 EA per 31 days)
clomipramine	T4	PA-NS
clonazepam oral tablet 0.5 mg	T2	PA-NS; QL (93 EA per 31 days)
clonazepam oral tablet 1 mg	T2	PA-NS; QL (124 EA per 31 days)
clonazepam oral tablet 2 mg	T2	PA-NS; QL (310 EA per 31 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg	T2	PA-NS; QL (93 EA per 31 days)
clonazepam oral tablet,disintegrating 1 mg	T2	PA-NS; QL (124 EA per 31 days)
clonazepam oral tablet,disintegrating 2 mg	T2	PA-NS; QL (310 EA per 31 days)
clonidine hcl oral tablet extended release 12 hr	T2	PA
clorazepate dipotassium oral tablet 15 mg	T2	PA-NS; QL (186 EA per 31 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	T2	PA-NS; 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)
COBENFY	T5	PA-NS; QL (62 EA per 31 days)
COBENFY STARTER PACK	T5	PA-NS; QL (112 EA per 365 days)
codeine sulfate	T2	PA; QL (186 EA per 31 days)
codeine-butalbital-asa-caff	T4	PA; QL (372 EA per 31 days)
CONCERTA	T4	ST; QL (31 EA per 31 days)
CONZIP	T4	PA; QL (30 EA per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (31 ML per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	T5	PA; QL (12 ML per 28 days)
COTEMPLA XR-ODT	T4	ST; QL (62 EA per 31 days)
CREXONT	T4	ST
cyclobenzaprine oral capsule,extended release 24hr	T4	QL (31 EA per 31 days)
cyclobenzaprine oral tablet 10 mg, 7.5 mg	T2	QL (93 EA per 31 days)
cyclobenzaprine oral tablet 5 mg	T2	QL (155 EA per 31 days)
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	T4	
dantrolene oral	T2	
DAYBUE	T5	PA; QL (3600 ML per 30 days)
DAYPRO	T4	
DAYTRANA	T4	PA; QL (30 EA per 30 days)
DAYVIGO	T4	ST; QL (31 EA per 31 days)
DEMEROL (PF) INJECTION SYRINGE 25 MG/ML	T4	PA; QL (496 ML per 31 days)
DEMEROL INJECTION	T4	PA; QL (248 ML per 31 days)
DEPAKOTE	T4	
DEPAKOTE ER	T4	
DEPAKOTE SPRINKLES	T4	
desipramine	T2	
desvenlafaxine oral tablet extended release 24 hr 100 mg	T4	QL (124 EA per 31 days)
desvenlafaxine oral tablet extended release 24 hr 50 mg	T4	QL (31 EA per 31 days)
desvenlafaxine succinate	T3	QL (31 EA per 31 days)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG	T5	ST; QL (186 EA per 31 days)
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)

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

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

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

Drug Name	Drug Tier	Requirements/Limits
diclofenac sodium topical drops	T2	QL (450 ML per 28 days)
diclofenac sodium topical solution in metered-dose pump	T5	ST; QL (224 GM per 28 days)
diclofenac-misoprostol	T3	
diflunisal	T2	
dihydroergotamine nasal	T5	PA; QL (8 ML per 28 days)
DILANTIN	T4	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	
DILANTIN-125	T4	
DILAUDID ORAL LIQUID	T4	PA; QL (1240 ML per 31 days)
DILAUDID ORAL TABLET 2 MG, 4 MG	T4	PA; QL (186 EA per 31 days)
DILAUDID ORAL TABLET 8 MG	T5	PA; QL (155 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	
divalproex oral tablet,delayed release (dr/ec)	T2	
DOLOBID ORAL TABLET 250 MG	T4	
donepezil oral tablet 10 mg, 5 mg	T1	
donepezil oral tablet 23 mg	T2	QL (31 EA per 31 days)
donepezil oral tablet,disintegrating	T2	
doxepin oral capsule	T2	PA-NS
doxepin oral concentrate	T2	PA-NS
doxepin oral tablet	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)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 60 mg	T2	QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
duloxetine oral capsule,delayed release(dr/ec) 30 mg	T2	QL (31 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 40 mg	T3	QL (31 EA per 31 days)
DUOPA	T5	PA-BvD
DYANAVEL XR ORAL SUSPEN, IR - ER, BIPHASIC 24HR	T4	ST; QL (248 ML per 31 days)
DYANAVEL XR ORAL TABLET, IR - ER, BIPHASIC 24HR	T4	ST; QL (31 EA per 31 days)
EDLUAR	T4	PA; QL (31 EA per 31 days)
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 37.5 MG	T4	QL (31 EA per 31 days)
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 75 MG	T4	QL (93 EA per 31 days)
eletriptan oral tablet 20 mg	T4	QL (12 EA per 28 days)
eletriptan oral tablet 40 mg	T4	QL (6 EA per 28 days)
ELYXYB	T4	PA
EMGALITY PEN	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	T5	PA; QL (3 ML per 28 days)
EMSAM	T5	QL (30 EA per 30 days)
ENDOCET	T3	PA; QL (372 EA per 31 days)
entacapone	T2	
EPIDIOLEX	T5	PA-NS
EPITOL	T1	
EPRONTIA	T4	PA-NS; QL (496 ML per 31 days)
EQUETRO	T4	
ERGOMAR	T4	PA
ergotamine-caffeine	T3	PA
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)
estazolam	T2	PA
eszopiclone	T2	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
ethosuximide oral capsule	T3	
ethosuximide oral solution	T2	
etodolac	T2	
EVEKEO	T4	PA
EVRYSDI ORAL RECON SOLN	T5	PA; QL (240 ML per 31 days)
EVRYSDI ORAL TABLET	T5	PA; QL (31 EA per 31 days)
EXELON PATCH	T4	QL (30 EA per 30 days)
FANAPT ORAL TABLET 1 MG	T4	PA-NS; QL (62 EA per 31 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	T5	PA-NS; QL (62 EA per 31 days)
FANAPT ORAL TABLETS,DOSE PACK	T4	PA-NS; QL (16 EA per 365 days)
felbamate oral suspension	T4	
felbamate oral tablet	T2	
FELBATOL ORAL TABLET	T5	
fenoprofen oral capsule 400 mg	T4	
FENOPRON	T4	
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 75 mcg/hr	T3	PA; QL (10 EA per 30 days)
fentanyl transdermal patch 72 hour 25 mcg/hr, 50 mcg/hr	T2	PA; QL (10 EA per 30 days)
fentanyl transdermal patch 72 hour 37.5 mcg/hour, 62.5 mcg/hour	T4	PA; QL (10 EA per 30 days)
fentanyl transdermal patch 72 hour 87.5 mcg/hour	T5	PA; QL (10 EA per 30 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	T4	PA-NS; QL (56 EA per 365 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG	T4	PA-NS; QL (31 EA per 31 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	T4	PA-NS; QL (93 EA per 31 days)
fingolimod	T5	PA; QL (31 EA per 31 days)
FINTEPLA	T5	PA-NS; QL (360 ML per 30 days)
FIORICET	T4	QL (403 EA per 31 days)
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)
FLEQSUVY	T4	PA; QL (496 ML per 31 days)
fluoxetine (pmdd)	T1	

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

Drug Name	Drug Tier	Requirements/Limits
fluoxetine oral capsule	T1	
fluoxetine oral capsule,delayed release(dr/ec)	T2	
fluoxetine oral solution	T3	
fluoxetine oral tablet 10 mg, 20 mg	T1	
fluoxetine oral tablet 60 mg	T4	
fluphenazine decanoate	T2	
fluphenazine hcl injection	T2	
fluphenazine hcl oral concentrate	T2	
fluphenazine hcl oral elixir	T1	
fluphenazine hcl oral tablet	T1	
flurazepam	T2	PA
flurbiprofen oral tablet 100 mg	T2	
fluvoxamine oral capsule,extended release 24hr	T4	
fluvoxamine oral tablet	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)
FROVA	T4	QL (12 EA per 28 days)
frovatriptan	T3	QL (12 EA per 28 days)
FYCOMPA ORAL SUSPENSION	T5	QL (744 ML per 31 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	T5	QL (31 EA per 31 days)
FYCOMPA ORAL TABLET 2 MG	T4	QL (31 EA per 31 days)
gabapentin oral capsule 100 mg, 400 mg	T2	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)
gabapentin oral tablet extended release 24 hr 300 mg	T4	PA; QL (155 EA per 31 days)
gabapentin oral tablet extended release 24 hr 600 mg	T4	PA; QL (93 EA per 31 days)
GABARONE ORAL TABLET 100 MG	T5	PA-NS; QL (558 EA per 31 days)
GABARONE ORAL TABLET 400 MG	T5	PA-NS; QL (279 EA per 31 days)
galantamine oral capsule,ext rel. pellets 24 hr	T2	
galantamine oral solution	T4	

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

Drug Name	Drug Tier	Requirements/Limits
galantamine oral tablet	T2	
GEODON INTRAMUSCULAR	T4	
GEODON ORAL	T5	QL (62 EA per 31 days)
GILENYA	T5	PA; QL (31 EA per 31 days)
glatiramer subcutaneous syringe 20 mg/ml	T5	PA; QL (31 ML per 31 days)
glatiramer subcutaneous syringe 40 mg/ml	T5	PA; QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (31 ML per 31 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	T5	PA; QL (12 ML per 28 days)
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG	T5	PA; QL (62 EA per 31 days)
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 68.5 MG	T5	PA; QL (124 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T4	PA; QL (155 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG	T4	PA; QL (31 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T4	PA; QL (93 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 750 MG, 900 MG	T4	PA; QL (62 EA per 31 days)
guanfacine oral tablet extended release 24 hr	T2	PA
HALCION ORAL TABLET 0.25 MG	T4	PA
HALDOL DECANOATE INTRAMUSCULAR SOLUTION 100 MG/ML	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)

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

Drug Name	Drug Tier	Requirements/Limits
hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr 100 mg, 120 mg	T5	PA; QL (31 EA per 31 days)
hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	T4	PA; QL (31 EA per 31 days)
hydrocodone-acetaminophen oral solution 10-325 mg/15 ml, 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, 2.5-325 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	T4	PA; QL (124 ML per 31 days)
hydromorphone oral liquid	T2	PA; QL (1240 ML per 31 days)
hydromorphone oral tablet 2 mg, 4 mg	T2	PA; QL (186 EA per 31 days)
hydromorphone oral tablet 8 mg	T2	PA; QL (155 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 (31 EA per 31 days)
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 80 MG	T5	PA; QL (31 EA per 31 days)
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 20 MG, 30 MG, 40 MG, 60 MG	T4	PA; QL (31 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	
ibuprofen oral suspension	T1	
ibuprofen oral tablet 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 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	T5	QL (18 EA per 28 days)
IMITREX STATDOSE PEN SUBCUTANEOUS PEN INJECTOR 4 MG/0.5 ML	T4	QL (6 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
IMITREX STATDOSE REFILL SUBCUTANEOUS CARTRIDGE 6 MG/0.5 ML	T5	QL (4 ML per 28 days)
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	T5	PA; QL (300 EA per 30 days)
INDOCIN ORAL	T4	
INDOCIN RECTAL	T5	
indomethacin oral capsule	T1	
indomethacin oral capsule, extended release	T1	
indomethacin oral suspension	T4	
indomethacin rectal suppository 50 mg	T5	
INGREZZA INITIATION PK(TARDIV)	T5	PA; QL (56 EA per 365 days)
INGREZZA ORAL CAPSULE 40 MG	T5	PA; QL (62 EA per 31 days)
INGREZZA ORAL CAPSULE 60 MG, 80 MG	T5	PA; QL (31 EA per 31 days)
INGREZZA SPRINKLE	T5	PA; QL (31 EA per 31 days)
INTUNIV ER	T4	PA
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	T5	QL (3.5 ML per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	T5	QL (5 ML per 180 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 3 MG, 9 MG	T4	QL (31 EA per 31 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG	T4	QL (62 EA per 31 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	T5	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	T5	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	T5	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T4	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	T5	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	T5	QL (0.88 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	T5	QL (1.32 ML per 84 days)

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

Drug Name	Drug Tier	Requirements/Limits
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	T5	QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	T5	QL (2.63 ML per 84 days)
JORNAY PM	T4	ST; QL (31 EA per 31 days)
JOURNAVX	T4	PA; QL (29 EA per 90 days)
KEPPRA ORAL SOLUTION	T5	
KEPPRA ORAL TABLET 1,000 MG	T5	
KEPPRA ORAL TABLET 250 MG, 500 MG, 750 MG	T4	
KEPPRA XR 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 25 mg, 50 mg	T2	
ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg	T2	
ketorolac oral	T2	
KEVEYIS	T5	PA; QL (124 EA per 31 days)
KIPROFEN	T2	
KLONOPIN ORAL TABLET 0.5 MG	T4	PA-NS; QL (93 EA per 31 days)
KLONOPIN ORAL TABLET 1 MG	T4	PA-NS; QL (124 EA per 31 days)
KLONOPIN ORAL TABLET 2 MG	T4	PA-NS; QL (310 EA per 31 days)
KLOXXADO	T3	
lacosamide oral	T4	
LAMICTAL ODT ORAL TABLET,DISINTEGRATING 100 MG	T5	
LAMICTAL ODT ORAL TABLET,DISINTEGRATING 200 MG, 25 MG, 50 MG	T4	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG	T5	
LAMICTAL ORAL TABLET 25 MG	T4	
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	T4	
LAMICTAL STARTER (BLUE) KIT	T4	
LAMICTAL STARTER (GREEN) KIT	T4	

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

Drug Name	Drug Tier	Requirements/Limits
LAMICTAL STARTER (ORANGE) KIT	T4	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR 100 MG, 200 MG, 25 MG	T5	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR 250 MG, 300 MG, 50 MG	T4	
LAMICTAL XR STARTER (BLUE)	T4	
LAMICTAL XR STARTER (GREEN)	T4	
LAMICTAL XR STARTER (ORANGE)	T4	
lamotrigine oral tablet	T2	
lamotrigine oral tablet disintegrating, dose pk	T4	
lamotrigine oral tablet extended release 24hr	T2	
lamotrigine oral tablet, chewable dispersible	T2	
lamotrigine oral tablet,disintegrating	T4	
lamotrigine oral tablets,dose pack	T4	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	T5	PA-NS; QL (31 EA per 31 days)
LATUDA ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
levetiracetam oral solution 100 mg/ml	T2	
levetiracetam oral tablet	T2	
levetiracetam oral tablet extended release 24 hr	T2	
levetiracetam oral tablet for suspension	T4	
levorphanol tartrate	T5	PA; QL (186 EA per 31 days)
LEXAPRO ORAL TABLET 10 MG	T4	QL (45 EA per 30 days)
LEXAPRO ORAL TABLET 20 MG, 5 MG	T4	QL (30 EA per 30 days)
LICART	T4	PA; QL (31 EA per 31 days)
lisdexamfetamine	T4	ST; QL (31 EA per 31 days)
lithium carbonate	T1	
lithium citrate	T1	
LITHOBID	T4	
LODINE ORAL TABLET	T4	
LODOSYN	T4	
LOFENA	T5	
lofexidine	T5	
LORAZEPAM INTENSOL	T2	PA; QL (155 ML per 31 days)
lorazepam oral tablet 0.5 mg	T2	PA; QL (124 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
lorazepam oral tablet 1 mg	T2	PA; QL (186 EA per 31 days)
lorazepam oral tablet 2 mg	T2	PA; QL (155 EA per 31 days)
LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1 MG, 3 MG	T4	PA; QL (93 EA per 31 days)
LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1.5 MG, 2 MG	T4	PA; QL (155 EA per 31 days)
loxapine succinate	T2	
LUCEMYRA	T5	
LUMRYZ	T5	PA; QL (31 EA per 31 days)
LUMRYZ STARTER PACK	T5	PA; QL (56 EA per 365 days)
LUNESTA	T4	PA; QL (31 EA per 31 days)
lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg	T4	PA-NS; QL (31 EA per 31 days)
lurasidone oral tablet 80 mg	T4	PA-NS; QL (62 EA per 31 days)
LYBALVI	T5	PA-NS; QL (31 EA per 31 days)
LYRICA CR	T4	PA; QL (31 EA per 31 days)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	T4	PA-NS; QL (93 EA per 31 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	T4	PA-NS; QL (62 EA per 31 days)
LYRICA ORAL SOLUTION	T4	PA-NS; QL (930 ML per 31 days)
LYVISPAH	T4	PA; QL (124 EA 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)
MAVENCLAD (9 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAXALT ORAL TABLET 10 MG	T4	QL (12 EA per 28 days)
MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG	T4	QL (12 EA per 28 days)
MAYZENT ORAL TABLET 0.25 MG	T5	PA; QL (155 EA per 31 days)
MAYZENT ORAL TABLET 1 MG, 2 MG	T5	PA; QL (31 EA per 31 days)
MAYZENT STARTER(FOR 1MG MAINT)	T4	PA; QL (14 EA per 365 days)
MAYZENT STARTER(FOR 2MG MAINT)	T4	PA; QL (24 EA per 365 days)
meclofenamate	T2	

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

Drug Name	Drug Tier	Requirements/Limits
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	T2	
memantine oral tablets,dose pack	T4	
memantine-donepezil	T4	PA
meperidine (pf) injection solution 100 mg/ml, 50 mg/ml	T4	PA; QL (248 ML per 31 days)
meperidine (pf) injection solution 25 mg/ml	T4	PA; QL (496 ML per 31 days)
meperidine oral solution	T2	PA; QL (1860 ML per 31 days)
meperidine oral tablet 50 mg	T2	PA; QL (372 EA per 31 days)
meprobamate oral tablet 200 mg	T2	QL (341 EA per 31 days)
meprobamate oral tablet 400 mg	T2	QL (186 EA per 31 days)
MESTINON ORAL	T5	
MESTINON TIMESPAN	T5	
METADATE CD	T4	ST; QL (31 EA per 31 days)
metaxalone oral tablet 400 mg	T2	PA
metaxalone oral tablet 800 mg	T3	PA
methadone oral solution 10 mg/5 ml	T2	PA; QL (620 ML per 31 days)
methadone oral solution 5 mg/5 ml	T2	PA; QL (1240 ML per 31 days)
methadone oral tablet 10 mg	T2	PA; QL (124 EA per 31 days)
methadone oral tablet 5 mg	T2	PA; QL (248 EA per 31 days)
methamphetamine	T4	PA
methocarbamol oral tablet 1,000 mg	T4	
methocarbamol oral tablet 500 mg, 750 mg	T2	
methsuximide	T4	
METHYLIN ORAL SOLUTION	T4	ST
methylphenidate	T4	PA; QL (30 EA per 30 days)
methylphenidate hcl oral cap,er sprinkle,biphasic 40-60	T4	ST; QL (31 EA per 31 days)
methylphenidate hcl oral capsule, er biphasic 30-70	T2	QL (31 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 10 mg	T2	QL (186 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
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 (186 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 45 mg, 63 mg, 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	
MIPLYFFA	T5	PA; QL (93 EA per 31 days)
mirtazapine	T2	
modafinil	T2	PA; QL (31 EA per 31 days)
molindone	T4	
morphine concentrate oral solution	T2	PA; QL (310 ML per 31 days)
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	T3	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG	T4	PA-NS; QL (31 EA per 31 days)
MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 200 MG	T5	PA-NS; QL (62 EA per 31 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG, 60 MG	T4	PA; QL (100 EA per 31 days)
MYDAYIS	T4	ST; QL (31 EA per 31 days)
MYSOLINE	T5	
nabumetone	T1	
NALOCET	T4	PA; QL (403 EA per 31 days)
naloxone injection solution	T2	
naloxone injection syringe	T2	
naltrexone	T2	
NAMENDA TITRATION PAK	T4	PA
NAMZARIC	T4	PA
NAPRELAN CR	T4	
naproxen oral suspension	T4	
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	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 (9 EA per 28 days)
NARDIL	T4	
NAYZILAM	T4	PA-NS; QL (10 EA per 30 days)
nefazodone	T2	
NEUPRO	T4	
NEURONTIN ORAL CAPSULE 100 MG	T4	PA-NS; QL (270 EA per 30 days)
NEURONTIN ORAL CAPSULE 300 MG	T5	PA-NS; QL (360 EA per 30 days)
NEURONTIN ORAL CAPSULE 400 MG	T5	PA-NS; QL (270 EA per 30 days)
NEURONTIN ORAL SOLUTION	T4	PA-NS; QL (2160 ML per 30 days)
NEURONTIN ORAL TABLET 600 MG	T5	PA-NS; QL (180 EA per 30 days)
NEURONTIN ORAL TABLET 800 MG	T4	PA-NS; QL (120 EA per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
NORGESIC	T4	PA; QL (248 EA per 31 days)
NORGESIC FORTE	T4	PA; QL (124 EA per 31 days)
NORPRAMIN ORAL TABLET 10 MG, 25 MG	T4	
nortriptyline	T2	
NOURIANZ	T5	PA; QL (31 EA per 31 days)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 150 MG, 200 MG, 250 MG	T5	PA; QL (62 EA per 31 days)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 50 MG	T4	PA; QL (62 EA per 31 days)
NUCYNTA ORAL TABLET 100 MG, 75 MG	T5	PA; QL (186 EA per 31 days)
NUCYNTA ORAL TABLET 50 MG	T4	PA; QL (186 EA per 31 days)
NUEDEXTA	T3	PA; QL (62 EA per 31 days)
NUPLAZID	T5	PA-NS; QL (31 EA per 31 days)
NURTEC ODT	T3	PA; QL (18 EA per 28 days)
NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG	T5	PA; QL (31 EA per 31 days)
NUVIGIL ORAL TABLET 50 MG	T4	PA; QL (31 EA per 31 days)
olanzapine intramuscular	T2	
olanzapine oral	T2	QL (31 EA per 31 days)
olanzapine-fluoxetine	T2	
ONAPGO	T5	PA; QL (620 ML per 31 days)
ONFI ORAL SUSPENSION	T5	PA-NS; QL (496 ML per 31 days)
ONFI ORAL TABLET	T5	PA-NS; QL (62 EA per 31 days)
ONGENTYS	T4	PA; QL (31 EA per 31 days)
ONYDA XR	T4	PA; QL (120 ML per 30 days)
ONZETRA XSAIL	T4	QL (16 EA per 28 days)
OPIPZA	T5	PA-NS
OPVEE	T4	
ORMALVI	T5	PA; QL (124 EA per 31 days)
orphenadrine citrate oral	T2	PA
orphenadrine-asa-caffeine oral tablet 25-385-30 mg	T4	PA; QL (248 EA per 31 days)
oxaprozin oral tablet	T2	
oxazepam	T2	PA
oxcarbazepine oral suspension	T2	

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

Drug Name	Drug Tier	Requirements/Limits
oxcarbazepine oral tablet	T2	
oxcarbazepine oral tablet extended release 24 hr 150 mg, 300 mg	T4	
oxcarbazepine oral tablet extended release 24 hr 600 mg	T5	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG	T4	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T5	
oxycodone oral capsule	T2	PA; QL (186 EA per 31 days)
oxycodone oral concentrate	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	T5	PA; QL (186 EA per 31 days)
oxycodone-acetaminophen oral solution 5-325 mg/5 ml	T4	PA; QL (1907 ML per 31 days)
oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	T5	PA; QL (403 EA per 31 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg	T3	PA; QL (372 EA per 31 days)
oxycodone-acetaminophen oral tablet 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG	T4	PA; QL (100 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG	T5	PA; QL (69 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	T5	PA; QL (62 EA per 31 days)
oxymorphone oral tablet	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	T5	PA; QL (69 EA per 31 days)
oxymorphone oral tablet extended release 12 hr 40 mg	T5	PA; QL (51 EA per 31 days)
OZOBAX DS	T4	PA; QL (1240 ML per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	T4	QL (31 EA per 31 days)
paliperidone oral tablet extended release 24hr 6 mg	T4	QL (62 EA per 31 days)
PARLODEL	T4	
PARNATE	T4	
paroxetine hcl oral suspension	T4	
paroxetine hcl oral tablet	T1	
paroxetine hcl oral tablet extended release 24 hr	T2	
paroxetine mesylate(menop.sym)	T4	
PAXIL CR	T4	
PAXIL ORAL TABLET	T4	
pentazocine-naloxone	T2	QL (335 EA per 31 days)
PERCOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	T5	PA; QL (372 EA per 31 days)
PERCOCET ORAL TABLET 2.5-325 MG	T4	PA; QL (372 EA per 31 days)
perphenazine	T2	
perphenazine-amitriptyline	T2	PA-NS
PERSERIS	T5	QL (1 EA per 28 days)
phenelzine	T2	
phenobarbital	T2	PA-NS
PHENYTEK	T4	
phenytoin oral suspension 125 mg/5 ml	T2	
phenytoin oral tablet,chewable	T2	
phenytoin sodium extended oral capsule 100 mg	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 oral tablet 125 mg	T4	
primidone oral tablet 250 mg, 50 mg	T2	

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

Drug Name	Drug Tier	Requirements/Limits
PRISTIQ	T4	QL (31 EA per 31 days)
PROCENTRA	T3	
PROLATE ORAL SOLUTION	T4	PA; QL (2066 ML per 31 days)
PROLATE ORAL TABLET 10-300 MG	T5	PA; QL (403 EA per 31 days)
PROLATE ORAL TABLET 5-300 MG, 7.5-300 MG	T4	PA; QL (403 EA per 31 days)
protriptyline	T2	
PROVIGIL	T5	PA; QL (31 EA per 31 days)
PROZAC ORAL CAPSULE 10 MG, 20 MG	T4	
PROZAC ORAL CAPSULE 40 MG	T5	
pyridostigmine bromide oral syrup	T5	
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, 200 MG	T4	PA; QL (93 EA per 31 days)
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG	T4	PA; QL (62 EA per 31 days)
QUDEXY XR ORAL CAPSULE,SPRINKLE,ER 24HR 100 MG, 150 MG, 25 MG, 50 MG	T4	
QUDEXY XR ORAL CAPSULE,SPRINKLE,ER 24HR 200 MG	T5	
quetiapine oral tablet 100 mg, 200 mg, 300 mg, 400 mg, 50 mg	T2	QL (62 EA per 31 days)
quetiapine oral tablet 150 mg	T3	QL (62 EA per 31 days)
quetiapine oral tablet 25 mg	T1	QL (62 EA per 31 days)
quetiapine oral tablet extended release 24 hr	T3	QL (62 EA per 31 days)
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 20 MG, 40 MG	T4	ST; QL (31 EA per 31 days)
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 30 MG	T4	ST; QL (62 EA per 31 days)
QUILLIVANT XR	T4	ST; QL (360 ML per 30 days)
QULIPTA	T3	PA; QL (31 EA per 31 days)
QUVIVIQ	T4	ST; QL (31 EA per 31 days)
RADICAVA ORS STARTER KIT SUSP	T5	PA; QL (70 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
RALDESY	T5	
ramelteon	T4	QL (31 EA per 31 days)
rasagiline	T3	
RELAFEN DS	T5	
RELEXXII ORAL TABLET EXTENDED RELEASE 24HR 18 MG, 27 MG, 36 MG, 45 MG, 54 MG, 63 MG	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	PA; QL (31 EA per 31 days)
REXULTI ORAL TABLET	T5	PA-NS; QL (31 EA per 31 days)
REYVOW ORAL TABLET 100 MG	T4	PA; QL (8 EA per 28 days)
REYVOW ORAL TABLET 50 MG	T4	PA; QL (4 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML	T4	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 50 MG/2 ML	T5	QL (2 EA per 28 days)
RISPERDAL ORAL SOLUTION	T4	QL (496 ML per 31 days)
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG	T4	QL (31 EA per 31 days)
RISPERDAL ORAL TABLET 3 MG	T4	QL (93 EA per 31 days)
RISPERDAL ORAL TABLET 4 MG	T4	QL (124 EA per 31 days)
risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml, 25 mg/2 ml, 37.5 mg/2 ml	T4	QL (2 EA per 28 days)
risperidone microspheres intramuscular suspension,extended rel recon 50 mg/2 ml	T5	QL (2 EA per 28 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)

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

Drug Name	Drug Tier	Requirements/Limits
risperidone oral tablet,disintegrating 3 mg	T1	QL (93 EA per 31 days)
risperidone oral tablet,disintegrating 4 mg	T1	QL (124 EA per 31 days)
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	T4	PA; QL (186 EA per 31 days)
ROXICODONE ORAL TABLET 30 MG	T5	PA; QL (138 EA per 31 days)
ROXYBOND	T5	PA; QL (186 EA per 31 days)
ROZEREM	T4	QL (31 EA per 31 days)
rufinamide oral suspension	T5	PA-NS
rufinamide oral tablet 200 mg	T4	PA-NS
rufinamide oral tablet 400 mg	T5	PA-NS
RYTARY	T3	ST
SABRIL	T5	PA-NS
SAPHRIS SUBLINGUAL TABLET 10 MG, 2.5 MG	T4	PA-NS; QL (62 EA per 31 days)
SAPHRIS SUBLINGUAL TABLET 5 MG	T5	PA-NS; QL (62 EA per 31 days)
SECUADO	T5	PA-NS; QL (31 EA per 31 days)
selegiline hcl	T2	
SEROQUEL	T4	QL (62 EA per 31 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG, 300 MG, 50 MG	T4	QL (62 EA per 31 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 400 MG	T5	QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
sertraline oral capsule	T4	PA-NS; QL (31 EA per 31 days)
sertraline oral concentrate	T2	
sertraline oral tablet	T1	
SILENOR	T4	PA
SINEMET ORAL TABLET 10-100 MG, 25-100 MG	T4	
SKYCLARYS	T5	PA; QL (93 EA per 31 days)
sodium oxybate	T5	PA; QL (540 ML per 30 days)
SOMA	T4	PA
SPRITAM	T4	
SPRIX	T5	QL (5 EA per 31 days)
STALEVO 100	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, 4-1 MG, 8-2 MG	T4	ST; QL (62 EA per 31 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG	T4	ST; QL (93 EA per 31 days)
SUBVENITE	T2	
SUBVENITE STARTER (BLUE) KIT	T4	
SUBVENITE STARTER (GREEN) KIT	T4	
SUBVENITE STARTER (ORANGE) KIT	T4	
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 6 mg/0.5 ml	T4	QL (4 ML per 28 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml	T4	QL (6 ML per 28 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	T4	QL (4 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
sumatriptan succinate subcutaneous solution	T4	QL (4 ML per 28 days)
sumatriptan-naproxen	T4	QL (9 EA per 28 days)
SUNOSI	T4	PA; QL (31 EA per 31 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SYMPAZAN ORAL FILM 5 MG	T4	PA-NS; QL (62 EA per 31 days)
TANLOR	T4	
TASCENSO ODT	T5	PA; QL (31 EA per 31 days)
tasimelteon	T5	PA; QL (31 EA per 31 days)
TASMAR ORAL TABLET 100 MG	T5	
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG (14)- 240 MG (46)	T5	PA; QL (120 EA per 365 days)
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 240 MG	T5	PA; QL (62 EA per 31 days)
TEGRETOL ORAL SUSPENSION	T4	
TEGRETOL ORAL TABLET	T4	
TEGRETOL XR	T4	
temazepam	T4	PA; QL (31 EA per 31 days)
TENCON	T2	QL (372 EA per 31 days)
teriflunomide	T5	PA; QL (31 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	
TOLECTIN 600	T5	
tolmetin oral capsule	T2	
TOPAMAX ORAL CAPSULE, SPRINKLE	T4	
TOPAMAX ORAL TABLET 100 MG, 200 MG	T5	
TOPAMAX ORAL TABLET 25 MG, 50 MG	T4	
topiramate oral capsule, sprinkle 15 mg, 25 mg	T2	
topiramate oral capsule, sprinkle 50 mg	T4	
topiramate oral capsule,extended release 24hr 100 mg, 25 mg, 50 mg	T4	

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

Drug Name	Drug Tier	Requirements/Limits
topiramate oral capsule,extended release 24hr 200 mg	T5	
topiramate oral capsule,sprinkle,er 24hr 100 mg, 150 mg, 25 mg, 50 mg	T4	
topiramate oral capsule,sprinkle,er 24hr 200 mg	T5	
topiramate oral tablet	T2	
TOSYMRA	T4	QL (12 EA per 28 days)
tramadol oral capsule,er biphase 24 hr 17-83	T4	PA; QL (30 EA per 30 days)
tramadol oral capsule,er biphase 24 hr 25-75 100 mg, 200 mg	T4	PA; QL (30 EA per 30 days)
tramadol oral tablet 100 mg	T4	PA; QL (124 EA per 31 days)
tramadol oral tablet 25 mg	T4	PA; QL (496 EA per 31 days)
tramadol oral tablet 50 mg	T1	PA; QL (240 EA per 30 days)
tramadol oral tablet 75 mg	T4	PA; QL (155 EA per 31 days)
tramadol oral tablet extended release 24 hr	T2	PA; QL (30 EA per 30 days)
tramadol-acetaminophen	T2	PA; QL (372 EA per 31 days)
tranylcypromine	T2	
trazodone oral tablet 100 mg, 150 mg, 50 mg	T1	
trazodone oral tablet 300 mg	T2	
TREXIMET	T5	QL (9 EA per 28 days)
triazolam	T2	PA
trifluoperazine	T2	
trihexyphenidyl	T2	
TRILEPTAL ORAL SUSPENSION	T4	
TRILEPTAL ORAL TABLET 150 MG, 300 MG	T4	
TRILEPTAL ORAL TABLET 600 MG	T5	
trimipramine	T3	PA-NS
TRINTELLIX	T4	PA-NS
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 25 MG, 50 MG	T4	
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 200 MG	T5	
TRUDHESA	T5	PA; QL (12 ML per 28 days)
UBRELVY ORAL TABLET 100 MG	T3	PA; QL (17 EA per 28 days)
UBRELVY ORAL TABLET 50 MG	T3	PA; QL (34 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 100 MG/0.28 ML	T5	QL (0.28 ML per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 125 MG/0.35 ML	T5	QL (0.35 ML per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 150 MG/0.42 ML	T5	QL (0.42 ML per 60 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 200 MG/0.56 ML	T5	QL (0.56 ML per 60 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 250 MG/0.7 ML	T5	QL (0.7 ML per 60 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 50 MG/0.14 ML	T5	QL (0.14 ML per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 75 MG/0.21 ML	T5	QL (0.21 ML per 30 days)
VALIUM	T4	PA-NS; QL (124 EA per 31 days)
valproic acid	T2	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	T2	
VALTOCO NASAL SPRAY,NON-AEROSOL 10 MG/SPRAY (0.1 ML), 5 MG/SPRAY (0.1 ML)	T4	PA-NS; QL (10 EA per 30 days)
VALTOCO NASAL SPRAY,NON-AEROSOL 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2)	T5	PA-NS; QL (10 EA per 30 days)
venlafaxine besylate	T4	PA-NS; QL (62 EA per 31 days)
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	T2	QL (31 EA per 31 days)
venlafaxine oral capsule,extended release 24hr 75 mg	T2	QL (93 EA per 31 days)
venlafaxine oral tablet	T2	
venlafaxine oral tablet extended release 24hr 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)

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

Drug Name	Drug Tier	Requirements/Limits
VERSACLOZ	T5	QL (558 ML per 31 days)
vigabatrin	T5	PA-NS
VIGADRONE	T5	PA-NS
VIGAFYDE	T5	PA-NS
VIGPODER	T5	PA-NS
VIIBRYD ORAL TABLET	T4	PA-NS; QL (31 EA per 31 days)
vilazodone	T3	PA-NS; QL (31 EA per 31 days)
VIMPAT ORAL SOLUTION	T5	
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG	T5	
VIMPAT ORAL TABLET 50 MG	T4	
VIVITROL	T5	
VRAYLAR ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
VUMERITY	T5	PA; QL (124 EA per 31 days)
VYVANSE	T4	ST; QL (31 EA per 31 days)
WAINUA	T5	PA; QL (0.8 ML per 30 days)
WAKIX	T5	PA; QL (62 EA per 31 days)
WELLBUTRIN SR	T4	QL (62 EA per 31 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG	T5	QL (93 EA per 31 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T5	QL (31 EA per 31 days)
XANAX ORAL TABLET 0.25 MG, 0.5 MG	T4	PA; QL (93 EA per 31 days)
XANAX ORAL TABLET 1 MG, 2 MG	T4	PA; QL (155 EA per 31 days)
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 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	T5	PA-NS
XCOPRI MAINTENANCE PACK	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

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

Drug Name	Drug Tier	Requirements/Limits
XELSTRYM	T4	ST; QL (30 EA per 30 days)
XENAZINE ORAL TABLET 12.5 MG	T5	PA; QL (93 EA per 31 days)
XENAZINE ORAL TABLET 25 MG	T5	PA; QL (124 EA per 31 days)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 13.5 MG, 18 MG, 27 MG, 9 MG	T4	PA; QL (62 EA per 31 days)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 36 MG	T5	PA; QL (62 EA per 31 days)
XYREM	T5	PA; QL (540 ML per 30 days)
XYWAV	T5	PA; QL (540 ML per 30 days)
zaleplon oral capsule 10 mg	T2	PA; QL (62 EA per 31 days)
zaleplon oral capsule 5 mg	T2	PA; QL (93 EA per 31 days)
ZANAFLEX ORAL TABLET	T4	
ZARONTIN	T4	
ZAVZPRET	T5	PA; QL (8 EA per 30 days)
ZELAPAR	T5	
ZEMBRACE SYMTOUCH	T5	QL (8 ML per 28 days)
ZENZEDI	T4	QL (62 EA per 31 days)
ZEPOSIA	T5	PA; QL (31 EA per 31 days)
ZEPOSIA STARTER KIT (28-DAY)	T5	PA; QL (56 EA per 365 days)
ZEPOSIA STARTER PACK (7-DAY)	T5	PA; QL (14 EA per 365 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML	T5	PA; QL (11.648 ML per 28 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 23 MG/0.574 ML	T5	PA; QL (16 ML per 28 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 32.4 MG/0.81 ML	T5	PA; QL (22.68 ML per 28 days)
ZIMHI	T4	
ziprasidone hcl	T2	QL (62 EA per 31 days)
ziprasidone mesylate	T2	
ZIPSOR	T4	
zolmitriptan nasal spray,non-aerosol 2.5 mg	T4	QL (16 EA per 28 days)
zolmitriptan nasal spray,non-aerosol 5 mg	T4	QL (8 EA per 28 days)
zolmitriptan oral tablet 2.5 mg	T2	QL (16 EA per 28 days)
zolmitriptan oral tablet 5 mg	T2	QL (8 EA per 28 days)
zolmitriptan oral tablet,disintegrating 2.5 mg	T2	QL (16 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
zolmitriptan oral tablet,disintegrating 5 mg	T2	QL (8 EA per 28 days)
ZOLOFT	T4	
zolpidem oral capsule	T4	PA; QL (31 EA per 31 days)
zolpidem oral tablet	T2	PA; QL (31 EA per 31 days)
zolpidem oral tablet,ext release multiphase	T2	PA; QL (31 EA per 31 days)
zolpidem sublingual	T3	PA; QL (31 EA per 31 days)
ZOMIG NASAL SPRAY,NON-AEROSOL 2.5 MG	T4	QL (16 EA per 28 days)
ZOMIG NASAL SPRAY,NON-AEROSOL 5 MG	T4	QL (8 EA per 28 days)
ZOMIG ORAL TABLET 2.5 MG	T4	QL (16 EA per 28 days)
ZOMIG ORAL TABLET 5 MG	T4	QL (8 EA per 28 days)
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG	T5	
ZONISADE	T4	PA-NS; QL (930 ML per 31 days)
zonisamide	T2	
ZTALMY	T5	PA-NS; QL (1100 ML per 30 days)
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 2.9-0.71 MG, 8.6-2.1 MG	T3	QL (62 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG	T3	QL (93 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 5.7-1.4 MG	T3	QL (31 EA per 31 days)
ZUNVEYL	T4	PA; QL (62 EA per 31 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	T5	PA-NS; QL (28 EA per 180 days)
ZURZUVAE ORAL CAPSULE 30 MG	T5	PA-NS; QL (14 EA per 180 days)
ZYPREXA INTRAMUSCULAR	T4	
ZYPREXA ORAL TABLET 20 MG	T5	QL (31 EA per 31 days)
Cardiovascular, Hypertension / Lipids		
acebutolol	T1	
ALDACTONE	T4	
aliskiren	T4	
ALTACE ORAL CAPSULE 10 MG	T4	QL (93 EA per 31 days)
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR 20 MG	T5	

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

Drug Name	Drug Tier	Requirements/Limits
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR 40 MG, 60 MG	T4	
ALVAIZ ORAL TABLET 18 MG, 9 MG	T5	PA; QL (31 EA per 31 days)
ALVAIZ ORAL TABLET 36 MG, 54 MG	T5	PA; QL (62 EA per 31 days)
amiloride	T1	
amiloride-hydrochlorothiazide	T1	
amiodarone oral	T2	
amlodipine	T1	
amlodipine-atorvastatin	T2	
amlodipine-benazepril	T1	
amlodipine-olmesartan	T3	QL (31 EA per 31 days)
amlodipine-valsartan	T2	
amlodipine-valsartan-hcthiazid	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	
ATORVALIQ	T4	PA; QL (600 ML per 30 days)
atorvastatin	T1	
ATTRUBY	T5	PA; QL (124 EA per 31 days)
AVALIDE	T4	QL (31 EA per 31 days)
AVAPRO ORAL TABLET 150 MG, 300 MG	T4	QL (31 EA per 31 days)
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	

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

Drug Name	Drug Tier	Requirements/Limits
bisoprolol fumarate oral tablet 10 mg, 5 mg	T1	
bisoprolol-hydrochlorothiazide	T1	
BRILINTA ORAL TABLET 60 MG	T3	
BRILINTA ORAL TABLET 90 MG	T4	
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	
CAMZYOS	T5	PA; QL (31 EA per 31 days)
candesartan	T1	
candesartan-hydrochlorothiazid	T1	
captopril	T1	
CARDIZEM CD	T5	
CARDIZEM LA	T4	
CARDIZEM ORAL TABLET 120 MG	T4	
CARDIZEM ORAL TABLET 30 MG, 60 MG	T5	
CARDURA	T4	
CARDURA XL	T4	
CAROSPIR	T4	
CARTIA XT	T1	
carvedilol	T1	
carvedilol phosphate	T4	
chlorthalidone oral tablet 25 mg, 50 mg	T1	
cholestyramine (with sugar) oral powder in packet	T2	
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET	T2	
cilostazol	T2	
clonidine	T2	
clonidine hcl oral tablet	T1	
clonidine hcl oral tablet extended release 24 hr	T4	ST
clopidogrel oral tablet 75 mg	T1	
colesevelam	T3	
COLESTID ORAL TABLET	T4	

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

Drug Name	Drug Tier	Requirements/Limits
colestipol oral packet	T2	
colestipol oral tablet	T2	
COREG	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	
dabigatran etexilate oral capsule 110 mg	T4	QL (124 EA per 31 days)
dabigatran etexilate oral capsule 150 mg, 75 mg	T4	QL (62 EA per 31 days)
DEMSER	T5	PA
DIBENZYLINE	T5	PA
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)
digoxin oral tablet 62.5 mcg (0.0625 mg)	T4	QL (124 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	
diltiazem hcl oral tablet extended release 24 hr	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

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

Drug Name	Drug Tier	Requirements/Limits
DOPTELET (30 TAB PACK)	T5	PA
doxazosin	T1	
DYRENIUM	T4	
EDARBI	T4	
EDARBYCLOR	T4	
EDECRIN	T5	
EFFIENT	T4	
ELIQUIS DVT-PE TREAT 30D START	T3	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 30 days)
enalapril maleate oral solution	T4	
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)
ENTRESTO SPRINKLE	T5	PA; QL (248 EA per 31 days)
eplerenone	T2	
ethacrynic acid	T2	
EXFORGE	T4	
EXFORGE HCT	T4	
ezetimibe	T2	
ezetimibe-simvastatin	T3	QL (31 EA per 31 days)
felodipine	T2	
fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg	T2	
fenofibrate nanocrystallized	T2	
fenofibrate oral capsule	T4	
fenofibrate oral tablet 120 mg, 40 mg	T4	
fenofibrate oral tablet 160 mg, 54 mg	T2	
fenofibric acid (choline)	T3	
FILSPARI	T5	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
flecainide	T2	
FLOLIPID	T4	PA
fluvastatin oral capsule	T1	
fluvastatin oral tablet extended release 24 hr	T3	
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 7.5 mg/0.6 ml	T5	
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml, 5 mg/0.4 ml	T4	
fosinopril	T1	
fosinopril-hydrochlorothiazide	T1	
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 18,000 ANTI-XA UNIT/0.72 ML, 7,500 ANTI-XA UNIT/0.3 ML	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML	T3	
FUROSCIX	T5	PA; QL (8 EA per 30 days)
furosemide injection solution	T2	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	T2	
furosemide oral tablet	T1	
gemfibrozil	T1	
guanfacine oral tablet	T2	
heparin (porcine) injection solution	T2	PA-BvD
hydralazine oral	T1	
hydrochlorothiazide	T1	
HYZAAR	T4	
icosapent ethyl oral capsule 0.5 gram	T4	QL (248 EA per 31 days)
icosapent ethyl oral capsule 1 gram	T4	QL (124 EA per 31 days)
indapamide	T1	
INDERAL LA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 60 MG, 80 MG	T4	
INDERAL LA ORAL CAPSULE,EXTENDED RELEASE 24 HR 160 MG	T5	
INNOPRAN XL	T5	

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

Drug Name	Drug Tier	Requirements/Limits
INSPRA	T4	
INZIRQO	T4	QL (310 ML per 31 days)
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	
isosorbide-hydralazine	T4	
isradipine	T2	
ivabradine oral tablet 5 mg	T4	PA; QL (93 EA per 31 days)
ivabradine oral tablet 7.5 mg	T4	PA; QL (62 EA per 31 days)
JANTOVEN	T1	
JUXTAPID	T5	PA
KATERZIA	T4	PA
KERENDIA	T4	PA; QL (31 EA per 31 days)
labetalol oral tablet 100 mg, 200 mg, 300 mg	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	
LODOCO	T4	PA; QL (31 EA per 31 days)
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)

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

Drug Name	Drug Tier	Requirements/Limits
losartan-hydrochlorothiazide	T1	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	T4	
LOTREL	T4	
lovastatin	T1	
LOVAZA	T3	PA; QL (124 EA per 31 days)
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	
methyldopa oral tablet 500 mg	T4	
metolazone	T2	
metoprolol succinate	T1	
metoprolol ta-hydrochlorothiaz	T1	
metoprolol tartrate oral	T1	
metyrosine	T5	PA
mexiletine	T3	
MICARDIS HCT	T4	
minoxidil oral	T2	
moexipril	T1	
MULPLETA	T5	PA
MULTAQ	T3	
nadolol	T1	
nebivolol oral tablet 10 mg, 2.5 mg	T2	QL (93 EA per 31 days)
nebivolol oral tablet 20 mg	T2	QL (62 EA per 31 days)
nebivolol oral tablet 5 mg	T2	QL (217 EA per 31 days)
NEXICLON XR	T4	ST
NEXLETOL	T4	PA; QL (31 EA per 31 days)
NEXLIZET	T4	PA; QL (31 EA per 31 days)
niacin oral tablet 500 mg	T4	
niacin oral tablet extended release 24 hr 1,000 mg, 750 mg	T3	
niacin oral tablet extended release 24 hr 500 mg	T3	QL (31 EA per 31 days)
NIACOR	T4	
nicardipine oral capsule 20 mg	T2	

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

Drug Name	Drug Tier	Requirements/Limits
nicardipine oral capsule 30 mg	T5	
nifedipine	T2	
nimodipine oral capsule	T2	
nimodipine oral solution	T5	
nisoldipine	T2	
NITRO-BID	T2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.4 MG/HR, 0.6 MG/HR	T3	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	T5	
nitroglycerin sublingual	T2	
nitroglycerin transdermal patch 24 hour	T2	
nitroglycerin translingual	T2	
NITROLINGUAL	T4	
NITROSTAT	T4	
NORLIQVA	T4	PA; QL (300 ML per 30 days)
NORPACE	T4	
NORPACE CR	T4	
NORVASC	T4	
NYMALIZE ORAL SYRINGE 60 MG/10 ML	T5	
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	QL (124 EA per 31 days)
ORENITRAM MONTH 1 TITRATION KT	T5	PA; QL (336 EA per 365 days)
ORENITRAM MONTH 2 TITRATION KT	T5	PA; QL (672 EA per 365 days)
ORENITRAM MONTH 3 TITRATION KT	T5	PA; QL (504 EA per 365 days)
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)

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

Drug Name	Drug Tier	Requirements/Limits
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	T2	
pentoxifylline	T2	
perindopril erbumine	T1	
phenoxybenzamine	T5	PA
pindolol	T1	
pitavastatin calcium	T3	
PLAVIX ORAL TABLET 75 MG	T4	
PRADAXA ORAL CAPSULE 110 MG	T4	QL (124 EA per 31 days)
PRADAXA ORAL CAPSULE 150 MG, 75 MG	T4	QL (62 EA per 31 days)
PRADAXA ORAL PELLETS IN PACKET 110 MG, 30 MG, 40 MG, 50 MG	T5	QL (120 EA per 30 days)
PRADAXA ORAL PELLETS IN PACKET 150 MG, 20 MG	T5	QL (60 EA per 30 days)
PRALUENT PEN	T4	PA; QL (2 ML per 28 days)
prasugrel hcl	T3	
pravastatin	T1	
prazosin	T1	
PREVALITE ORAL POWDER IN PACKET	T2	
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	T5	
QUESTRAN LIGHT	T4	
QUESTRAN ORAL POWDER	T4	
quinapril	T1	
quinapril-hydrochlorothiazide	T1	

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

Drug Name	Drug Tier	Requirements/Limits
quinidine gluconate oral	T2	
quinidine sulfate oral tablet	T2	
ramipril	T1	
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)
rivaroxaban	T4	QL (62 EA per 31 days)
rosuvastatin	T1	
SAVAYSA	T4	QL (31 EA per 31 days)
simvastatin	T1	
SOAANZ	T4	ST
SOTALOL AF	T1	
sotalol oral	T1	
SOTYLIZE	T4	
spironolactone oral suspension	T4	
spironolactone oral tablet	T1	
spironolacton-hydrochlorothiaz	T1	
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	T4	
TAVALISSE	T5	PA; QL (62 EA per 31 days)
TEKTURNA	T4	
telmisartan	T1	
telmisartan-amlodipine	T1	
telmisartan-hydrochlorothiazid	T1	
TENORETIC 100	T4	
TENORETIC 50	T4	
TENORMIN	T4	
terazosin	T1	
TEZRULY	T4	PA; QL (620 ML per 31 days)
THALITONE	T4	
TIADYLT ER	T1	
TIAZAC	T4	
ticagrelor oral tablet 90 mg	T2	
TIKOSYN	T3	
timolol maleate oral	T1	

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

Drug Name	Drug Tier	Requirements/Limits
TOPROL XL	T4	
torsemide oral	T1	
trandolapril	T1	
trandolapril-verapamil	T2	
triamterene	T4	
triamterene-hydrochlorothiazid	T1	
TRIBENZOR	T4	
TRYNGOLZA	T5	PA; QL (0.8 ML per 28 days)
TRYVIO	T4	PA; QL (31 EA per 31 days)
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	T5	PA; QL (62 EA per 31 days)
UPTRAVI ORAL TABLET 200 MCG	T5	PA; QL (224 EA per 28 days)
UPTRAVI ORAL TABLETS,DOSE PACK	T5	PA; QL (400 EA per 365 days)
valsartan oral solution	T5	QL (2480 ML per 31 days)
valsartan oral tablet 160 mg, 40 mg, 80 mg	T1	QL (62 EA per 31 days)
valsartan oral tablet 320 mg	T1	QL (31 EA per 31 days)
valsartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
VANRAFIA	T5	PA; QL (30 EA per 30 days)
VASCEPA ORAL CAPSULE 0.5 GRAM	T4	QL (248 EA per 31 days)
VASCEPA ORAL CAPSULE 1 GRAM	T4	QL (124 EA per 31 days)
VASERETIC	T4	
VASOTEC ORAL TABLET 10 MG	T5	
VASOTEC ORAL TABLET 2.5 MG, 20 MG, 5 MG	T4	
VECAMYL	T5	
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	QL (31 EA per 31 days)
VYTORIN 10-20	T4	QL (31 EA per 31 days)
VYTORIN 10-40	T4	QL (31 EA per 31 days)
VYTORIN 10-80	T4	QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
warfarin	T1	
WELCHOL	T4	
XARELTO DVT-PE TREAT 30D START	T3	QL (51 EA per 30 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	T3	QL (930 ML per 31 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	
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG	T4	
ZYPITAMAG	T4	
Dermatologicals/Topical Therapy		
ABSORICA	T5	
ABSORICA LD	T5	
ACANYA TOPICAL GEL WITH PUMP	T4	
ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG	T2	
acitretin	T4	PA
acyclovir topical cream	T3	QL (5 GM per 28 days)
acyclovir topical ointment	T1	QL (30 GM per 30 days)
ACZONE	T4	QL (90 GM per 28 days)
adapalene topical cream	T2	PA
adapalene topical gel 0.3 %	T2	PA
adapalene topical swab	T2	PA
adapalene-benzoyl peroxide	T4	PA
ADBRY	T5	PA; QL (4 ML per 28 days)
AKLIEF	T4	PA
ALA-CORT TOPICAL CREAM 1 %	T1	
ALA-SCALP	T4	
alclometasone	T1	
ALTRENO	T4	PA; QL (45 GM per 28 days)
amcinonide topical cream	T2	
amcinonide topical ointment	T2	

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

Drug Name	Drug Tier	Requirements/Limits
ammonium lactate	T2	
AMNESTEEM	T2	
ARAZLO	T4	PA; QL (45 GM per 28 days)
ATRALIN	T4	PA; QL (45 GM per 28 days)
azelaic acid	T4	ST; QL (50 GM per 28 days)
AZELEX	T4	QL (50 GM per 28 days)
BENZAMYCIN	T4	
betamethasone dipropionate	T1	
betamethasone valerate topical cream	T1	
betamethasone valerate topical foam	T4	
betamethasone valerate topical lotion	T1	
betamethasone valerate topical ointment	T1	
betamethasone, augmented	T2	
BIMZELX	T5	PA; QL (2 ML per 28 days)
BIMZELX AUTOINJECTOR	T5	PA; QL (2 ML per 28 days)
brimonidine topical	T4	ST
BRYHALI	T4	QL (100 GM per 28 days)
CABTREO	T4	PA; QL (50 GM per 28 days)
calcipotriene scalp	T2	QL (60 ML per 28 days)
calcipotriene topical cream	T2	QL (60 GM per 28 days)
calcipotriene topical foam	T5	ST; QL (120 GM per 28 days)
calcipotriene topical ointment	T2	QL (60 GM per 28 days)
calcipotriene-betamethasone	T4	ST; QL (400 GM per 28 days)
calcitriol topical	T3	ST
CIBINQO	T5	PA; QL (31 EA per 31 days)
ciclopirox topical cream	T2	QL (90 GM per 28 days)
ciclopirox topical gel	T2	QL (45 GM per 28 days)
ciclopirox topical shampoo	T2	QL (120 ML per 28 days)
ciclopirox topical solution	T2	
ciclopirox topical suspension	T2	QL (60 ML per 28 days)
CLARAVIS	T2	
CLEOCIN T TOPICAL LOTION	T4	QL (60 ML per 28 days)
CLINDACIN	T2	QL (100 GM per 28 days)
CLINDACIN ETZ TOPICAL SWAB	T4	
CLINDAGEL	T5	QL (75 ML per 28 days)
clindamycin phosphate topical foam	T2	QL (100 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
clindamycin phosphate topical gel	T2	QL (60 GM per 28 days)
clindamycin phosphate topical gel, once daily	T4	QL (75 ML per 28 days)
clindamycin phosphate topical lotion	T2	QL (60 ML per 28 days)
clindamycin phosphate topical solution	T2	QL (60 ML per 28 days)
clindamycin phosphate topical swab	T2	
clindamycin-benzoyl peroxide topical gel	T2	
clindamycin-benzoyl peroxide topical gel with pump 1.2 %(1 % base) -3.75 %	T4	
clindamycin-benzoyl peroxide topical gel with pump 1.2-2.5 %	T2	
clindamycin-tretinoin	T2	PA; QL (60 GM per 28 days)
clobetasol scalp	T2	QL (50 ML per 28 days)
clobetasol topical cream 0.05 %	T3	QL (60 GM per 28 days)
clobetasol topical foam	T2	QL (100 GM per 28 days)
clobetasol topical gel	T2	QL (60 GM per 28 days)
clobetasol topical lotion	T2	QL (118 ML per 28 days)
clobetasol topical ointment	T3	QL (60 GM per 28 days)
clobetasol topical shampoo	T2	QL (118 ML per 28 days)
clobetasol topical spray,non-aerosol	T2	QL (125 ML per 28 days)
clobetasol-emollient topical cream	T3	QL (60 GM per 28 days)
clobetasol-emollient topical foam	T3	QL (100 GM per 28 days)
CLOBEX TOPICAL LOTION	T4	QL (118 ML per 28 days)
CLOBEX TOPICAL SHAMPOO	T4	QL (118 ML per 28 days)
CLOBEX TOPICAL SPRAY,NON-AEROSOL	T4	QL (125 ML per 28 days)
clocortolone pivalate	T4	
CLODAN	T2	QL (118 ML per 28 days)
clotrimazole topical cream	T2	QL (45 GM per 28 days)
clotrimazole topical solution	T2	QL (30 ML per 28 days)
clotrimazole-betamethasone topical cream	T2	QL (45 GM per 28 days)
clotrimazole-betamethasone topical lotion	T2	QL (60 ML per 28 days)
CONDYLOX TOPICAL GEL	T4	
CORDRAN TAPE LARGE ROLL	T4	
COSENTYX (2 SYRINGES)	T5	PA; QL (2 ML per 28 days)
COSENTYX PEN (2 PENS)	T5	PA; QL (2 ML per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
COSENTYX UNOREADY PEN	T5	PA; QL (2 ML per 28 days)
CROTAN	T4	
dapsone topical gel 5 %	T4	QL (90 GM per 28 days)
dapsone topical gel with pump	T4	QL (90 GM per 28 days)
DENAVIR	T4	QL (5 GM per 28 days)
DERMA-SMOOTHE/FS SCALP OIL	T4	QL (118.28 ML per 28 days)
desonide topical cream	T3	QL (60 GM per 28 days)
desonide topical gel	T3	QL (60 GM per 28 days)
desonide topical lotion	T3	QL (118 ML per 28 days)
desonide topical ointment	T3	QL (60 GM per 28 days)
DESOWEN TOPICAL CREAM	T4	QL (60 GM per 28 days)
desoximetasone topical cream	T2	QL (100 GM per 28 days)
desoximetasone topical gel	T2	QL (60 GM per 28 days)
desoximetasone topical ointment 0.05 %	T4	QL (100 GM per 28 days)
desoximetasone topical ointment 0.25 %	T2	QL (100 GM per 28 days)
desoximetasone topical spray,non-aerosol	T2	QL (100 ML per 28 days)
diclofenac sodium topical gel 3 %	T4	PA; QL (100 GM per 28 days)
DIFFERIN TOPICAL CREAM	T4	PA
DIFFERIN TOPICAL GEL WITH PUMP	T4	PA
diflorasone	T4	QL (60 GM per 28 days)
DIPROLENE (AUGMENTED) TOPICAL OINTMENT	T4	
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 (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
EBGLYSS PEN	T5	PA; QL (2 ML per 28 days)
EBGLYSS SYRINGE	T5	PA; QL (2 ML per 28 days)
econazole nitrate	T2	QL (85 GM per 28 days)
ELIDEL	T4	QL (100 GM per 28 days)
ELIMITE	T4	

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

Drug Name	Drug Tier	Requirements/Limits
ENSTILAR	T5	ST; QL (60 GM per 28 days)
EPIDUO FORTE	T4	PA
EPIDUO TOPICAL GEL WITH PUMP	T4	PA
EPSOLAY	T4	ST; QL (30 GM per 28 days)
ERTACZO	T4	ST; QL (60 GM per 28 days)
ERY PADS	T2	
erythromycin with ethanol topical gel	T2	QL (60 GM per 28 days)
erythromycin with ethanol topical solution	T2	QL (60 ML per 28 days)
erythromycin-benzoyl peroxide	T2	
EUCRISA	T4	PA; QL (60 GM per 30 days)
FABIOR	T4	PA; QL (100 GM per 28 days)
FILSUVEZ	T5	PA
FINACEA TOPICAL FOAM	T4	ST; QL (50 GM per 28 days)
fluocinolone and shower cap	T2	QL (118.28 ML per 28 days)
fluocinolone topical cream 0.01 %	T2	QL (60 GM per 28 days)
fluocinolone topical cream 0.025 %	T2	QL (120 GM per 28 days)
fluocinolone topical ointment	T2	QL (120 GM per 28 days)
fluocinolone topical solution	T2	QL (90 ML per 28 days)
fluocinonide topical cream 0.05 %	T2	QL (60 GM per 28 days)
fluocinonide topical cream 0.1 %	T4	QL (120 GM per 28 days)
fluocinonide topical gel	T2	QL (60 GM per 28 days)
fluocinonide topical ointment	T2	QL (60 GM per 28 days)
fluocinonide topical solution	T2	QL (60 ML per 28 days)
fluocinonide-emollient	T2	QL (60 GM per 28 days)
fluorouracil topical cream 5 %	T2	
fluorouracil topical solution	T2	
flurandrenolide topical lotion	T3	QL (120 ML per 28 days)
fluticasone propionate topical cream	T2	
fluticasone propionate topical lotion	T4	QL (120 ML per 28 days)
fluticasone propionate topical ointment	T2	
gentamicin topical	T2	QL (60 GM per 28 days)
halcinonide topical cream	T4	QL (60 GM per 28 days)
halobetasol propionate topical cream	T2	QL (50 GM per 28 days)
halobetasol propionate topical foam	T4	QL (120 GM per 28 days)
halobetasol propionate topical ointment	T2	QL (50 GM per 28 days)
HALOG TOPICAL CREAM	T4	QL (60 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
hydrocortisone butyrate topical cream	T2	QL (45 GM per 28 days)
hydrocortisone butyrate topical lotion	T4	QL (118 ML per 28 days)
hydrocortisone butyrate topical ointment	T2	QL (45 GM per 28 days)
hydrocortisone butyrate topical solution	T2	QL (60 ML per 28 days)
hydrocortisone topical cream 1 %	T1	
hydrocortisone topical lotion 2 %	T4	QL (118.4 ML per 28 days)
hydrocortisone topical lotion 2.5 %	T1	QL (118 ML per 28 days)
hydrocortisone topical ointment 1 %, 2.5 %	T1	
hydrocortisone topical solution	T4	
hydrocortisone valerate	T2	QL (60 GM per 28 days)
HYFTOR	T5	PA; QL (30 GM per 30 days)
ILUMYA	T5	PA; QL (1 ML per 84 days)
imiquimod topical cream in metered-dose pump	T4	
imiquimod topical cream in packet 5 %	T2	
isotretinoin	T2	
ivermectin topical cream	T4	ST; QL (45 GM per 28 days)
JUBLIA	T5	QL (8 ML per 28 days)
ketoconazole topical cream	T2	QL (60 GM per 28 days)
ketoconazole topical foam	T4	QL (100 GM per 28 days)
ketoconazole topical shampoo	T2	QL (120 ML per 28 days)
KETODAN	T2	ST; QL (100 GM per 28 days)
KLARON	T4	
LEXETTE	T4	QL (200 GM per 28 days)
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)
LIDOCAN III	T4	PA; QL (93 EA per 31 days)
luliconazole	T4	QL (60 GM per 28 days)
LUZU	T4	QL (60 GM per 28 days)
malathion	T2	
methoxsalen	T5	
METROCREAM	T4	ST
METROGEL TOPICAL GEL 1 %	T4	ST

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

Drug Name	Drug Tier	Requirements/Limits
METROLOTION	T4	ST
metronidazole topical cream	T2	
metronidazole topical gel 0.75 %	T2	
metronidazole topical gel 1 %	T1	
metronidazole topical lotion	T2	
MIRVASO	T4	ST
mometasone topical	T2	
mupirocin	T2	
mupirocin calcium	T4	ST
naftifine topical cream 1 %	T4	ST; QL (90 GM per 28 days)
naftifine topical cream 2 %	T4	ST; QL (60 GM per 28 days)
naftifine topical gel	T4	ST; QL (60 GM per 28 days)
NAFTIN TOPICAL GEL 2 %	T4	ST; QL (60 GM per 28 days)
NATROBA	T4	
NEO-SYNALAR	T4	
NEUAC	T2	
NORITATE	T5	ST
NYAMYC	T2	QL (60 GM per 28 days)
nystatin topical cream	T2	QL (30 GM per 28 days)
nystatin topical ointment	T2	QL (30 GM per 28 days)
nystatin topical powder	T2	QL (60 GM per 28 days)
nystatin-triamcinolone	T3	QL (60 GM per 28 days)
NYSTOP	T2	QL (60 GM per 28 days)
ONEXTON TOPICAL GEL WITH PUMP	T4	
OPZELURA	T5	PA; QL (240 GM per 28 days)
OTULFI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
OTULFI SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
OVIDE	T4	
oxiconazole	T4	ST; QL (90 GM per 28 days)
OXISTAT TOPICAL LOTION	T4	ST; QL (60 ML per 28 days)
PANRETIN	T5	PA-NS
penciclovir	T3	QL (5 GM per 28 days)
permethrin	T2	
pimecrolimus	T3	QL (100 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
podofilox topical gel	T4	
podofilox topical solution	T2	
PRUDOXIN	T4	PA; QL (45 GM per 28 days)
PYZCHIVA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
PYZCHIVA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
REGRANEX	T5	PA
RETIN-A	T4	PA; QL (45 GM per 28 days)
RETIN-A MICRO	T4	PA; QL (45 GM per 28 days)
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %	T4	PA; QL (50 GM per 28 days)
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.08 %	T5	PA; QL (50 GM per 28 days)
RHOFADE	T4	ST
SANTYL	T4	QL (180 GM per 30 days)
SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
SELARSDI SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
selenium sulfide topical lotion	T1	
SILIQ	T5	PA; QL (6 ML per 28 days)
SILVADENE	T4	
silver sulfadiazine	T1	
SKYRIZI SUBCUTANEOUS PEN INJECTOR	T5	PA; QL (1 ML per 84 days)
SKYRIZI SUBCUTANEOUS SYRINGE	T5	PA; QL (1 ML per 84 days)
SOOLANTRA	T4	ST; QL (45 GM per 28 days)
SORILUX	T5	ST; QL (120 GM per 28 days)
SOTYKTU	T5	PA; QL (31 EA per 31 days)
SPEVIGO SUBCUTANEOUS	T5	PA; QL (2 ML per 28 days)
spinosad	T4	
SSD	T4	
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)

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

Drug Name	Drug Tier	Requirements/Limits
STEQEYMA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
STEQEYMA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
sulfacetamide sodium (acne)	T1	
SULFAMYLON TOPICAL CREAM	T3	
SYNALAR TOPICAL CREAM	T4	QL (120 GM per 28 days)
SYNALAR TOPICAL OINTMENT	T4	QL (120 GM per 28 days)
TACLONEX TOPICAL SUSPENSION	T5	ST; QL (400 GM per 28 days)
tacrolimus topical	T2	QL (100 GM per 28 days)
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML	T5	PA; QL (0.25 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 40 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML	T5	PA; QL (1 ML per 28 days)
tavaborole	T4	QL (10 ML per 28 days)
tazarotene topical cream	T4	PA; QL (60 GM per 28 days)
tazarotene topical foam	T4	PA; QL (100 GM per 28 days)
tazarotene topical gel	T4	PA; QL (100 GM per 28 days)
TAZORAC TOPICAL CREAM	T4	PA; QL (60 GM per 28 days)
TAZORAC TOPICAL GEL	T4	PA; QL (100 GM per 28 days)
TEXACORT	T4	
TOPICORT TOPICAL CREAM	T4	QL (100 GM per 28 days)
TOPICORT TOPICAL GEL	T4	QL (60 GM per 28 days)
TOPICORT TOPICAL OINTMENT 0.05 %	T4	QL (100 GM per 28 days)
TOPICORT TOPICAL SPRAY,NON-AEROSOL	T4	QL (100 ML per 28 days)
TOVET EMOLLIENT	T3	QL (100 GM per 28 days)
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML	T5	PA; QL (2 ML per 28 days)
TREMFYA SUBCUTANEOUS AUTO-INJECTOR	T5	PA; QL (1 ML per 56 days)
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (1 ML per 56 days)
TREMFYA SUBCUTANEOUS SYRINGE 200 MG/2 ML	T5	PA; QL (2 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
tretinoin microspheres topical gel	T2	PA; QL (50 GM per 28 days)
tretinoin microspheres topical gel with pump 0.08 %	T4	PA; QL (50 GM per 28 days)
tretinoin topical cream	T2	PA; QL (45 GM per 28 days)
tretinoin topical gel 0.01 %, 0.025 %	T2	PA; QL (45 GM per 28 days)
tretinoin topical gel 0.05 %	T3	PA; QL (45 GM per 28 days)
triamcinolone acetonide topical cream	T1	
triamcinolone acetonide topical lotion	T1	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	T1	
triamcinolone acetonide topical ointment 0.05 %	T4	
TRIDACAINE II	T4	PA; QL (93 EA per 31 days)
TRIDERM TOPICAL CREAM 0.5 %	T1	
TWYNEO	T4	PA; QL (30 GM per 28 days)
ustekinumab-ttwe subcutaneous syringe 45 mg/0.5 ml	T4	PA; QL (0.5 ML per 84 days)
ustekinumab-ttwe subcutaneous syringe 90 mg/ml	T5	PA; QL (1 ML per 56 days)
VALCHLOR	T5	PA-NS
VANOS	T5	QL (120 GM per 28 days)
VECTICAL	T4	ST
VEREGEN	T5	QL (30 GM per 28 days)
VTAMA	T5	PA; QL (60 GM per 28 days)
WEZLANA SUBCUTANEOUS SOLUTION	T5	PA; QL (0.5 ML per 84 days)
WEZLANA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 84 days)
WEZLANA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
WINLEVI	T4	PA; QL (60 GM per 28 days)
XERESE	T5	
YESINTEK SUBCUTANEOUS SOLUTION	T4	PA; QL (0.5 ML per 84 days)
YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T4	PA; QL (0.5 ML per 84 days)
YESINTEK SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
ZENATANE	T2	
ZIANA	T4	PA; QL (60 GM per 28 days)
ZONALON	T4	PA; QL (30 GM per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
ZORYVE	T4	PA; QL (60 GM per 28 days)
ZOVIRAX TOPICAL CREAM	T4	QL (5 GM per 28 days)
ZOVIRAX TOPICAL OINTMENT	T4	QL (30 GM per 30 days)
ZTLIDO	T4	PA; QL (93 EA per 31 days)
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP	T5	
Diagnostics / Miscellaneous Agents		
acamprosate	T2	
AGRYLIN	T4	
anagrelide	T2	
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
BUPHENYL	T5	PA
bupropion hcl (smoking deter)	T2	QL (62 EA per 31 days)
CARBAGLU	T5	PA
carglumic acid	T5	PA
CARNITOR ORAL	T4	PA-BvD
cevimeline	T2	
CHEMET	T4	
CLINIMIX 4.25%/D5W SULFIT FREE	T4	PA-BvD
CLINIMIX E 2.75%/D5W SULF FREE	T4	PA-BvD
CUVRIOR	T5	PA; QL (310 EA per 31 days)
d10 %-0.45 % sodium chloride	T2	
d2.5 %-0.45 % sodium chloride	T2	
d5 % and 0.9 % sodium chloride	T2	
d5 %-0.45 % sodium chloride	T2	
deferasirox oral granules in packet	T5	PA
deferasirox oral tablet 180 mg, 360 mg	T5	PA
deferasirox oral tablet 90 mg	T3	PA
deferasirox oral tablet, dispersible 125 mg	T3	PA
deferasirox oral tablet, dispersible 250 mg, 500 mg	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	

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

Drug Name	Drug Tier	Requirements/Limits
dextrose 5%-0.2 % sod chloride	T2	
disulfiram	T2	
droxidopa oral capsule 100 mg	T5	PA; QL (465 EA per 31 days)
droxidopa oral capsule 200 mg, 300 mg	T5	PA; QL (186 EA per 31 days)
DUVYZAT	T5	PA; QL (420 ML per 35 days)
ENDARI	T5	PA; QL (180 EA per 30 days)
EVOXAC	T4	
EXJADE	T5	PA
FABHALTA	T5	PA; QL (62 EA per 31 days)
FERRIPROX (2 TIMES A DAY)	T5	PA
FERRIPROX ORAL SOLUTION	T5	PA
FERRIPROX ORAL TABLET 1,000 MG	T5	PA
GLASSIA	T5	PA
glutamine (sickle cell)	T5	PA; QL (180 EA per 30 days)
INCRELEX	T5	PA
JADENU	T5	PA
JADENU SPRINKLE	T5	PA
JOENJA	T5	PA; QL (60 EA per 30 days)
KIONEX (WITH SORBITOL)	T2	
levocarnitine (with sugar)	T2	PA-BvD
levocarnitine oral tablet	T2	PA-BvD
LITFULO	T5	PA; QL (28 EA per 28 days)
LITHOSTAT	T4	
LOKELMA	T3	PA; QL (93 EA per 31 days)
midodrine	T2	
NICOTROL NS	T4	
nitisinone	T5	PA
NITYR	T5	PA
NORTHERA ORAL CAPSULE 100 MG	T5	PA; QL (465 EA per 31 days)
NORTHERA ORAL CAPSULE 200 MG, 300 MG	T5	PA; QL (186 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 2 GRAM, 3 GRAM	T5	PA; QL (186 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 4 GRAM	T5	PA; QL (155 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 5 GRAM	T5	PA; QL (124 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
OLPRUVA ORAL PELLETS IN PACKET 6 GRAM	T5	PA; QL (93 EA per 31 days)
OLPRUVA ORAL PELLETS IN PACKET 6.67 GRAM	T5	PA; QL (62 EA per 31 days)
ORFADIN	T5	PA
PHEBURANE	T5	PA; QL (620 GM per 31 days)
pilocarpine hcl oral	T2	
PROLASTIN-C INTRAVENOUS SOLUTION	T5	PA
PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG	T5	PA; QL (56 EA per 28 days)
PYRUKYND ORAL TABLET 5 MG	T5	PA; QL (14 EA per 365 days)
PYRUKYND ORAL TABLETS,DOSE PACK	T5	PA; QL (28 EA per 365 days)
RAVICTI	T5	PA
REVCOVI	T5	
REZDIFFRA	T5	PA; QL (31 EA per 31 days)
riluzole	T4	
risedronate oral tablet 30 mg	T3	
SALAGEN (PILOCARPINE)	T4	
sodium chloride 0.9 % intravenous parenteral solution	T2	
sodium chloride irrigation	T2	
sodium phenylbutyrate	T5	PA
sodium polystyrene sulfonate oral powder	T2	
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 2.5 MG, 5 MG	T5	PA; QL (31 EA per 31 days)
SOHONOS ORAL CAPSULE 10 MG	T5	PA; QL (62 EA per 31 days)
SPS (WITH SORBITOL) ORAL	T2	
SYPRINE	T5	QL (248 EA per 31 days)
TAVNEOS	T5	PA; QL (186 EA per 31 days)
THIOLA	T5	PA
THIOLA EC	T5	PA
TIGLUTIK	T5	PA
tiopronin	T5	PA
trientine oral capsule 250 mg	T5	QL (248 EA per 31 days)
trientine oral capsule 500 mg	T5	PA; QL (124 EA per 31 days)
varenicline tartrate oral tablet	T4	QL (60 EA per 30 days)
varenicline tartrate oral tablets,dose pack	T4	QL (106 EA per 365 days)

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

Drug Name	Drug Tier	Requirements/Limits
VELTASSA ORAL POWDER IN PACKET 1 GRAM	T5	PA; QL (120 EA per 30 days)
VELTASSA ORAL POWDER IN PACKET 16.8 GRAM, 8.4 GRAM	T4	PA; QL (30 EA per 30 days)
VELTASSA ORAL POWDER IN PACKET 25.2 GRAM	T5	PA; QL (30 EA per 30 days)
VENXXIVA	T5	PA
VOYDEYA	T5	PA; QL (180 EA per 30 days)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG	T5	PA; QL (93 EA per 31 days)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 25 MG	T5	PA; QL (124 EA per 31 days)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 75 MG	T5	PA; QL (217 EA per 31 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML	T5	PA; QL (2 ML per 28 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 1.7 MG/0.75 ML, 2.4 MG/0.75 ML	T5	PA; QL (3 ML per 28 days)
ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
ZEPBOUND SUBCUTANEOUS PEN INJECTOR	T4	PA; QL (2 ML per 28 days)
Ear, Nose / Throat Medications		
acetic acid otic (ear)	T2	
azelastine nasal spray,non-aerosol 137 mcg (0.1 %)	T2	QL (30 ML per 25 days)
chlorhexidine gluconate mucous membrane	T1	
CIPRO HC	T4	
ciprofloxacin-dexamethasone	T3	
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)
KOURZEQ	T2	

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

Drug Name	Drug Tier	Requirements/Limits
neomycin-polymyxin-hc otic (ear)	T2	
ofloxacin otic (ear)	T2	
olopatadine nasal	T2	QL (30.5 GM per 30 days)
PERIOGARD	T1	
triamcinolone acetonide dental	T2	
Endocrine/Diabetes		
acarbose	T1	QL (93 EA per 31 days)
ACTHAR	T5	PA
ACTHAR SELFJECT	T5	PA
ACTOPLUS MET	T4	QL (93 EA per 31 days)
ACTOS	T4	QL (31 EA per 31 days)
ADMELOG SOLOSTAR U-100 INSULIN	T4	
ADMELOG U-100 INSULIN LISPRO	T4	
AFREZZA INHALATION CARTRIDGE WITH INHALER 12 UNIT, 4 UNIT (90)/ 8 UNIT (90), 4 UNIT/8 UNIT/ 12 UNIT (60), 8 UNIT (90)/ 12 UNIT (90)	T5	ST
AFREZZA INHALATION CARTRIDGE WITH INHALER 4 UNIT, 8 UNIT	T4	ST
AGAMREE	T5	PA; QL (300 ML per 40 days)
ALCOHOL PADS	T2	PA
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG	T4	PA
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 1 MG, 2 MG, 5 MG	T5	PA
alogliptin	T4	ST; QL (31 EA per 31 days)
alogliptin-metformin	T4	ST; QL (62 EA per 31 days)
alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg	T4	ST; QL (31 EA per 31 days)
APIDRA SOLOSTAR U-100 INSULIN	T4	
APIDRA U-100 INSULIN	T4	
AVEED	T4	PA
BAQSIMI	T3	
BASAGLAR KWIKPEN U-100 INSULIN	T4	
BASAGLAR TEMPO PEN(U-100)INSLN	T4	
cabergoline	T2	
calcitonin (salmon) nasal	T2	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
calcitriol oral capsule	T2	PA-BvD
calcitriol oral solution	T3	PA-BvD
CERDELGA	T5	PA; QL (62 EA per 31 days)
cinacalcet oral tablet 30 mg, 60 mg	T3	PA-BvD; QL (62 EA per 31 days)
cinacalcet oral tablet 90 mg	T3	PA-BvD; QL (124 EA per 31 days)
CORTEF	T4	
CORTROPHIN GEL INJECTION	T5	PA
CRENESSITY ORAL CAPSULE 100 MG	T5	PA; QL (124 EA per 31 days)
CRENESSITY ORAL CAPSULE 50 MG	T5	PA; QL (62 EA per 31 days)
CRENESSITY ORAL SOLUTION	T5	PA; QL (124 ML per 31 days)
CYCLOSET	T4	
CYTOMEL	T4	
danazol	T2	
dapagliflozin propaned-metformin oral tablet, ir - er, biphasic 24hr 10-1,000 mg	T4	ST; QL (31 EA per 31 days)
dapagliflozin propaned-metformin oral tablet, ir - er, biphasic 24hr 5-1,000 mg	T4	ST; QL (62 EA per 31 days)
dapagliflozin propanediol	T4	ST; QL (31 EA per 31 days)
DDAVP ORAL	T4	
deflazacort	T5	PA
DEPO-TESTOSTERONE	T4	PA
desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)	T4	
desmopressin oral	T2	
dexamethasone oral solution	T1	
dexamethasone oral tablet	T1	
dexamethasone oral tablets,dose pack	T2	
diazoxide	T5	
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)
EMFLAZA	T5	PA
ERMEZA	T4	
EUTHYROX	T4	
FARXIGA	T3	QL (31 EA per 31 days)
FIASP FLEXTOUCH U-100 INSULIN	T3	

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Drug Name	Drug Tier	Requirements/Limits
FIASP PENFILL U-100 INSULIN	T3	
FIASP U-100 INSULIN	T3	
fludrocortisone	T2	
GALAFOLD	T5	PA; QL (14 EA per 28 days)
glimepiride oral tablet 1 mg, 2 mg, 4 mg	T1	
glipizide oral tablet 10 mg, 5 mg	T1	
glipizide oral tablet 2.5 mg	T3	
glipizide oral tablet extended release 24hr	T1	
glipizide-metformin	T1	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG, 5 MG	T4	
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 1,000 MG	T5	ST; QL (62 EA per 31 days)
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 500 MG	T5	ST; QL (31 EA per 31 days)
glyburide	T2	
glyburide micronized	T2	
glyburide-metformin	T2	
GLYXAMBI	T3	QL (31 EA per 31 days)
GVOKE	T3	
GVOKE HYPOPEN 2-PACK	T3	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	T3	
HEMADY	T4	PA-NS
HUMALOG JUNIOR KWIKPEN U-100	T3	
HUMALOG KWIKPEN INSULIN	T3	
HUMALOG MIX 50-50 KWIKPEN	T3	
HUMALOG MIX 75-25 KWIKPEN	T3	
HUMALOG MIX 75-25(U-100)INSULN	T3	
HUMALOG TEMPO PEN(U-100)INSULN	T3	
HUMALOG U-100 INSULIN	T3	
HUMULIN 70/30 U-100 INSULIN	T3	
HUMULIN 70/30 U-100 KWIKPEN	T3	
HUMULIN N NPH INSULIN KWIKPEN	T3	
HUMULIN N NPH U-100 INSULIN	T3	
HUMULIN R REGULAR U-100 INSULN	T3	

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

Drug Name	Drug Tier	Requirements/Limits
HUMULIN R U-500 (CONC) INSULIN	T3	
HUMULIN R U-500 (CONC) KWIKPEN	T3	
hydrocortisone oral	T1	
INPEFA ORAL TABLET 200 MG	T4	ST; QL (62 EA per 31 days)
INPEFA ORAL TABLET 400 MG	T4	ST; QL (31 EA per 31 days)
insulin asp prt-insulin aspart	T3	
insulin aspart u-100	T3	
insulin degludec	T4	
insulin glargine u-300 conc	T4	
insulin glargine-yfgn	T4	
insulin lispro	T3	
insulin lispro protamin-lispro	T3	
INVOKAMET	T4	ST; QL (62 EA per 31 days)
INVOKAMET XR	T4	ST; QL (62 EA per 31 days)
INVOKANA ORAL TABLET 100 MG	T4	ST; QL (62 EA per 31 days)
INVOKANA ORAL TABLET 300 MG	T4	ST; QL (31 EA per 31 days)
ISTURISA ORAL TABLET 1 MG	T5	PA; QL (558 EA per 31 days)
ISTURISA ORAL TABLET 5 MG	T5	PA; QL (372 EA per 31 days)
JANUMET	T3	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 ORAL TABLET 10 MG	T3	QL (62 EA per 31 days)
JARDIANCE ORAL TABLET 25 MG	T3	QL (31 EA per 31 days)
JATENZO ORAL CAPSULE 158 MG, 198 MG	T4	PA; QL (124 EA per 31 days)
JATENZO ORAL CAPSULE 237 MG	T4	PA; QL (62 EA per 31 days)
JAVYGTOR	T5	PA
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG	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)

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

Drug Name	Drug Tier	Requirements/Limits
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	T3	QL (31 EA per 31 days)
JYNARQUE ORAL TABLET	T5	PA; QL (112 EA per 28 days)
JYNARQUE ORAL TABLETS, SEQUENTIAL	T5	PA; QL (56 EA per 28 days)
KORLYM	T5	PA; QL (124 EA per 31 days)
KUVAN	T5	PA
LANTUS SOLOSTAR U-100 INSULIN	T3	
LANTUS U-100 INSULIN	T3	
levothyroxine oral capsule	T4	
levothyroxine oral tablet	T1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	T3	
liothyronine oral	T2	
liraglutide	T4	PA; QL (9 ML per 30 days)
LYUMJEV KWIKPEN U-100 INSULIN	T4	
LYUMJEV KWIKPEN U-200 INSULIN	T4	
LYUMJEV TEMPO PEN(U-100)INSULN	T4	
LYUMJEV U-100 INSULIN	T4	
MEDROL (PAK)	T4	
MEDROL ORAL TABLET 16 MG, 2 MG, 4 MG, 8 MG	T4	
metformin oral solution	T4	ST; QL (791 ML per 31 days)
metformin oral tablet 1,000 mg, 500 mg, 850 mg	T1	
metformin oral tablet 625 mg	T4	QL (124 EA per 31 days)
metformin oral tablet 750 mg	T5	ST; QL (93 EA per 31 days)
metformin oral tablet extended release 24 hr	T1	
metformin oral tablet extended release 24hr 1,000 mg	T4	ST; QL (62 EA per 31 days)
metformin oral tablet extended release 24hr 500 mg	T4	ST; QL (31 EA per 31 days)
metformin oral tablet,er gast.retention 24 hr 1,000 mg	T5	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	

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

Drug Name	Drug Tier	Requirements/Limits
METHITEST	T5	PA
methylprednisolone	T2	
methyltestosterone oral capsule	T5	PA
mifepristone oral tablet 300 mg	T5	PA; QL (124 EA per 31 days)
miglitol	T2	
miglustat	T5	PA; QL (93 EA per 31 days)
MOUNJARO	T3	PA; QL (2 ML per 28 days)
MYALEPT	T5	PA
nateglinide	T1	QL (93 EA per 31 days)
NOVOLIN 70/30 U-100 INSULIN	T3	
NOVOLIN 70-30 FLEXPEN U-100	T3	
NOVOLIN N FLEXPEN	T3	
NOVOLIN N NPH U-100 INSULIN	T3	
NOVOLIN R FLEXPEN	T3	
NOVOLIN R REGULAR U100 INSULIN	T3	
NOVOLOG FLEXPEN U-100 INSULIN	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	
ORAPRED ODT	T4	
ORILISSA ORAL TABLET 150 MG	T5	PA; QL (31 EA per 31 days)
ORILISSA ORAL TABLET 200 MG	T5	PA; QL (62 EA per 31 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	T3	PA; QL (3 ML per 28 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	T5	PA; QL (15 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	T5	PA; QL (4 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (90 ML per 30 days)
paricalcitol oral	T2	PA-BvD
pioglitazone	T1	QL (31 EA per 31 days)
pioglitazone-glimepiride	T1	QL (31 EA per 31 days)
pioglitazone-metformin	T1	QL (93 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
prednisolone	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	
QTERN	T4	ST; QL (31 EA per 31 days)
RAYALDEE	T5	QL (62 EA per 31 days)
RECORLEV	T5	PA; QL (248 EA per 31 days)
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)
REZVOGLAR KWIKPEN	T4	
ROCALTROL	T4	PA-BvD
RYBELSUS	T3	PA; QL (31 EA per 31 days)
SAMSCA	T5	PA
sapropterin	T5	PA
saxagliptin	T4	ST; QL (31 EA per 31 days)
saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg	T4	ST; QL (62 EA per 31 days)
saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg	T4	ST; QL (31 EA per 31 days)
SEGLUROMET	T4	ST; QL (62 EA per 31 days)
SEMGLEE(INSULIN GLARGINE-YFGN)	T4	
SEMGLEE(INSULIN GLARG-YFGN)PEN	T4	
sitagliptin oral tablet 100 mg, 50 mg	T4	ST; QL (31 EA per 31 days)
sitagliptin oral tablet 25 mg	T4	ST; QL (93 EA per 31 days)
sitagliptin-metformin oral tablet	T4	ST; QL (62 EA per 31 days)
SOLIQUA 100/33	T3	QL (18 ML per 30 days)
SOMAVERT	T5	PA
STEGLATRO	T4	ST; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
STEGLUJAN	T4	ST; QL (31 EA per 31 days)
SYMLINPEN 120	T5	QL (10.8 ML per 28 days)
SYMLINPEN 60	T5	QL (6 ML per 28 days)
SYNAREL	T5	PA
SYNJARDY	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	T3	QL (31 EA per 31 days)
SYNTHROID	T3	
TARPEYO	T5	PA; QL (124 EA per 31 days)
TESTIM	T4	PA
testosterone cypionate	T2	PA
testosterone enanthate	T2	PA
testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 12.5 mg/ 1.25 gram (1 %)	T4	PA
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	
TLANDO	T4	PA; QL (124 EA per 31 days)
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	

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

Drug Name	Drug Tier	Requirements/Limits
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	T3	QL (31 EA per 31 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	T3	QL (62 EA per 31 days)
TRULICITY	T3	PA; QL (2 ML per 28 days)
UNDECATREX	T4	PA; QL (124 EA per 31 days)
UNITHROID	T3	
VICTOZA 3-PAK	T4	PA; QL (9 ML per 30 days)
VOGELXO TRANSDERMAL GEL	T4	PA
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	T4	PA
VOXZOGO	T5	PA; QL (31 EA per 31 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 5-500 MG	T3	QL (31 EA per 31 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
XULTOPHY 100/3.6	T3	QL (15 ML per 30 days)
XYOSTED	T4	PA
YARGESA	T5	PA; QL (93 EA per 31 days)
YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML	T5	PA; QL (1.12 ML per 28 days)
YORVIPATH SUBCUTANEOUS PEN INJECTOR 294 MCG/0.98 ML	T5	PA; QL (1.96 ML per 28 days)
YORVIPATH SUBCUTANEOUS PEN INJECTOR 420 MCG/1.4 ML	T5	PA; QL (2.8 ML per 28 days)
ZAVESCA	T5	PA; QL (93 EA per 31 days)
ZEGALOGUE AUTOINJECTOR	T3	
ZEGALOGUE SYRINGE	T3	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	T4	PA-BvD
ZITUVIMET	T4	ST; QL (62 EA per 31 days)
ZITUVIMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	T4	ST; QL (31 EA per 31 days)
ZITUVIMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	T4	ST; QL (62 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
ZITUVIO ORAL TABLET 100 MG, 50 MG	T4	ST; QL (31 EA per 31 days)
ZITUVIO ORAL TABLET 25 MG	T4	ST; QL (93 EA per 31 days)
Gastroenterology		
ACIPHEX	T4	QL (62 EA per 31 days)
alosetron oral tablet 0.5 mg	T4	PA; QL (93 EA per 31 days)
alosetron oral tablet 1 mg	T5	PA; QL (62 EA per 31 days)
AMITIZA	T4	PA; QL (62 EA per 31 days)
amoxicil-clarithromy-lansopraz	T2	
ANUSOL-HC TOPICAL	T4	
aprepitant oral capsule 125 mg	T5	PA-BvD
aprepitant oral capsule 40 mg, 80 mg	T4	PA-BvD
aprepitant oral capsule,dose pack	T4	PA-BvD
APRISO	T4	QL (124 EA per 31 days)
AZULFIDINE	T4	
AZULFIDINE EN-TABS	T4	
balsalazide	T2	
betaine	T5	
bismuth subcit k-metronidz-tcn	T4	
BONJESTA	T4	PA; QL (62 EA per 31 days)
budesonide oral capsule,delayed,extend.release	T4	
budesonide oral tablet,delayed and ext.release	T5	
budesonide rectal	T4	
BYLVAY ORAL CAPSULE 1,200 MCG	T5	PA; QL (186 EA per 31 days)
BYLVAY ORAL CAPSULE 400 MCG	T5	PA; QL (558 EA per 31 days)
BYLVAY ORAL PELLET 200 MCG	T5	PA; QL (1116 EA per 31 days)
BYLVAY ORAL PELLET 600 MCG	T5	PA; QL (372 EA per 31 days)
CANASA	T5	QL (31 EA per 31 days)
CARAFATE ORAL SUSPENSION	T3	
CARAFATE ORAL TABLET	T4	
CHENODAL	T5	PA
chlordiazepoxide-clidinium	T2	
CHOLBAM	T5	PA
cimetidine	T2	
cimetidine hcl oral	T2	
CIMZIA POWDER FOR RECONST	T5	PA; QL (2 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	T5	PA; QL (2 EA per 28 days)
CLENPIQ ORAL SOLUTION 10 MG-3.5 GRAM- 12 GRAM/175 ML	T4	
COLAZAL	T5	
COMPRO	T2	
CONSTULOSE	T2	
CREON	T3	
cromolyn oral	T4	
CTEXLI	T5	PA; QL (93 EA per 31 days)
CUVPOSA	T4	
CYSTADANE	T5	
CYTOTEC	T4	
DEXILANT	T4	QL (31 EA per 31 days)
dexlansoprazole	T4	QL (31 EA per 31 days)
DICLEGIS	T4	PA; QL (124 EA per 31 days)
dicyclomine oral capsule	T2	
dicyclomine oral solution	T2	
dicyclomine oral tablet	T2	
DIPENTUM	T5	
diphenoxylate-atropine oral liquid	T3	
diphenoxylate-atropine oral tablet	T2	
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
ENTYVIO PEN	T5	PA; QL (1.36 ML per 28 days)
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	T4	QL (31 EA per 31 days)
famotidine oral suspension for reconstitution	T1	
famotidine oral tablet 20 mg, 40 mg	T1	

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

Drug Name	Drug Tier	Requirements/Limits
GASTROCROM	T4	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T1	
GAVILYTE-G	T1	
GAVILYTE-N	T1	
GENERLAC	T2	
GIMOTI	T5	PA; QL (9.8 ML per 28 days)
GLYCATE	T4	PA; QL (155 EA per 31 days)
glycopyrrolate oral solution	T4	
glycopyrrolate oral tablet 1 mg, 2 mg	T2	
glycopyrrolate oral tablet 1.5 mg	T4	PA; QL (155 EA per 31 days)
GOLYTELY	T4	
granisetron hcl oral	T2	PA-BvD
HELIDAC	T4	
hydrocortisone rectal	T3	
hydrocortisone topical cream with perineal applicator 2.5 %	T1	
hydrocortisone-pramoxine rectal cream 1-1 %	T4	
IBSRELA	T5	PA; QL (62 EA per 31 days)
IQIRVO	T5	PA; QL (31 EA per 31 days)
KONVOMEP	T4	
KRISTALOSE	T4	ST
lactulose oral packet 10 gram	T5	ST
lactulose oral packet 20 gram	T4	ST
lactulose oral solution	T1	
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	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	QL (124 EA per 31 days)
LIBRAX (WITH CLIDINIUM)	T4	
LINZESS	T3	QL (31 EA per 31 days)
LIVDELZI	T5	PA; QL (31 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
LIVMARLI ORAL SOLUTION 19 MG/ML	T5	PA; QL (60 ML per 30 days)
LIVMARLI ORAL SOLUTION 9.5 MG/ML	T5	PA; QL (93 ML per 31 days)
LOMOTIL	T4	
loperamide oral capsule	T2	
LOTRONEX ORAL TABLET 0.5 MG	T5	PA; QL (93 EA per 31 days)
LOTRONEX ORAL TABLET 1 MG	T5	PA; QL (62 EA per 31 days)
lubiprostone	T3	QL (62 EA per 31 days)
MARINOL ORAL CAPSULE 10 MG, 5 MG	T5	PA-BvD
MARINOL ORAL CAPSULE 2.5 MG	T4	PA-BvD
meclizine oral tablet 12.5 mg, 25 mg	T2	
mesalamine oral capsule (with del rel tablets)	T3	QL (186 EA per 31 days)
mesalamine oral capsule, extended release	T4	QL (248 EA per 31 days)
mesalamine oral capsule,extended release 24hr	T4	QL (124 EA per 31 days)
mesalamine oral tablet,delayed release (dr/ec) 1.2 gram	T3	QL (124 EA per 31 days)
mesalamine oral tablet,delayed release (dr/ec) 800 mg	T4	QL (186 EA per 31 days)
mesalamine rectal enema	T2	QL (1860 ML per 31 days)
mesalamine rectal suppository	T4	QL (31 EA per 31 days)
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	T5	QL (62 EA per 31 days)
NEXIUM	T4	QL (31 EA per 31 days)
NEXIUM PACKET	T4	QL (31 EA per 31 days)
nitroglycerin rectal	T4	
nizatidine oral capsule	T2	
OCALIVA	T5	PA; QL (31 EA per 31 days)
omeprazole oral capsule,delayed release(dr/ec)	T1	
omeprazole-sodium bicarbonate oral capsule	T2	
omeprazole-sodium bicarbonate oral packet	T5	
OMVOH PEN SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (2 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
OMVOH PEN SUBCUTANEOUS PEN INJECTOR 300MG/3ML(100MG /ML-200 MG/2ML)	T5	PA; QL (3 ML per 28 days)
OMVOH SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (2 ML per 28 days)
OMVOH SUBCUTANEOUS SYRINGE 300MG/3ML(100MG /ML-200 MG/2ML)	T5	PA; QL (3 ML per 28 days)
ondansetron hcl oral solution	T2	PA-BvD
ondansetron hcl oral tablet 4 mg, 8 mg	T2	PA-BvD
ondansetron oral tablet,disintegrating 4 mg, 8 mg	T2	PA-BvD
PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,500-35,500- 61,500 UNIT, 16,800-56,800- 98,400 UNIT, 2,600-8,800- 15,200 UNIT, 21,000-54,700- 83,900 UNIT, 4,200-14,200- 24,600 UNIT	T4	ST
PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 37,000-97,300- 149,900 UNIT	T5	ST
pantoprazole oral granules dr for susp in packet	T4	
pantoprazole oral tablet,delayed release (dr/ec)	T1	
peg 3350-electrolytes	T1	
peg3350-sod sul-nacl-kcl-asb-c	T4	
peg-electrolyte soln	T1	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	T3	QL (496 EA per 31 days)
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	T5	QL (248 EA per 31 days)
PEPCID ORAL TABLET	T4	
PERTZYE	T4	ST
PLENVU	T4	
PREVACID	T4	QL (62 EA per 31 days)
PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 15 MG	T4	QL (31 EA per 31 days)
PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 30 MG	T4	QL (62 EA per 31 days)
PRILOSEC ORAL SUSP,DELAYED RELEASE FOR RECON	T4	
prochlorperazine	T2	

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

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

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

Drug Name	Drug Tier	Requirements/Limits
URSO FORTE	T4	ST
ursodiol oral capsule 200 mg, 400 mg	T4	ST
ursodiol oral capsule 300 mg	T3	
ursodiol oral tablet	T3	
VARUBI	T5	PA-BvD
VELSIPITY	T5	PA; QL (31 EA per 31 days)
VIBERZI	T5	PA; QL (62 EA per 31 days)
VIOKACE	T4	
VOQUEZNA DUAL PAK	T4	PA; QL (112 EA per 14 days)
VOQUEZNA ORAL TABLET 10 MG	T4	PA; QL (31 EA per 31 days)
VOQUEZNA ORAL TABLET 20 MG	T4	PA; QL (62 EA per 31 days)
VOQUEZNA TRIPLE PAK	T4	PA; QL (112 EA per 14 days)
VOWST	T5	PA; QL (12 EA per 14 days)
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT	T4	ST
ZYMFENTRA	T5	PA; QL (1 EA per 28 days)
Immunology, Vaccines / Biotechnology		
ABRYSVO (PF)	T3	QL (1 EA per 365 days)
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML	T5	PA-BvD; ST
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	T4	PA-BvD; ST
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML	T4	PA-BvD; ST
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML, 60 MCG/0.3 ML	T5	PA-BvD; ST

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

Drug Name	Drug Tier	Requirements/Limits
ARCALYST	T5	PA
AREXVY (PF)	T3	QL (1 EA per 365 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	PA; QL (1 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	PA; QL (1 EA per 28 days)
bcg vaccine, live (pf)	T4	
BESREMI	T5	PA-NS; QL (2 ML per 28 days)
BETASERON SUBCUTANEOUS KIT	T5	PA; QL (14 EA per 28 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T3	
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
EGRIFTA SV	T5	PA
ENGERIX-B (PF)	T3	PA-BvD
ENGERIX-B PEDIATRIC (PF)	T3	PA-BvD
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T4	PA-BvD; ST
EPOGEN INJECTION SOLUTION 20,000 UNIT/ML	T5	PA-BvD; ST
FULPHILA	T5	
FYLNETRA	T5	ST
GAMMAGARD LIQUID	T5	PA
GAMMAGARD S-D (IGA < 1 MCG/ML)	T5	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GAMMAPLEX	T5	PA
GAMMAPLEX (WITH SORBITOL)	T5	PA
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GARDASIL 9 (PF)	T3	
GENOTROPIN	T5	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	T4	PA

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

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

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

Drug Name	Drug Tier	Requirements/Limits
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
PANZYGA	T5	PA
PEDIARIX (PF)	T3	PA-BvD
PEDVAX HIB (PF)	T3	
PEGASYS	T5	PA
PENBRAYA (PF)	T3	
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-20MCG-5LF- 62 DU/0.5 ML	T3	
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	T5	PA; QL (1 ML per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	T5	PA; QL (1 ML per 28 days)
PRIORIX (PF)	T3	
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	T5	PA-BvD
PROQUAD (PF)	T3	
QUADRACEL (PF)	T3	
RABAVERT (PF)	T3	PA-BvD
REBIF (WITH ALBUMIN)	T5	PA; QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	T5	PA; QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	T5	PA; QL (4.2 ML per 365 days)
REBIF TITRATION PACK	T5	PA; QL (8.4 ML per 365 days)
RECOMBIVAX HB (PF)	T3	PA-BvD
RELEUKO SUBCUTANEOUS	T4	ST
RETACRIT	T3	PA-BvD
ROTARIX ORAL SUSPENSION	T3	
ROTATEQ VACCINE	T3	

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

Drug Name	Drug Tier	Requirements/Limits
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	T5	PA
SHINGRIX (PF)	T3	QL (2 EA per 999 days)
SKYTROFA	T5	PA
SOGROYA	T5	PA
STIMUFEND	T5	ST
TENIVAC (PF)	T3	
TICOVAC	T3	
TRUMENBA	T3	
TWINRIX (PF)	T3	
TYPHIM VI	T3	
UDENYCA	T5	ST
UDENYCA AUTOINJECTOR	T5	ST
VAQTA (PF)	T3	
VARIVAX (PF)	T3	
VAXCHORA VACCINE	T3	QL (200 ML per 365 days)
VIMKUNYA	T3	
VIVOTIF	T3	
XOLREMDI	T5	PA; QL (124 EA per 31 days)
YF-VAX (PF)	T3	
ZARXIO	T5	
ZIEXTENZO	T5	
ZOMACTON	T4	PA
Miscellaneous Supplies		
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T2	PA
insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge	T3	
pen needle, diabetic needle 29 gauge x 1/2"	T3	
Musculoskeletal / Rheumatology		
ABRILADA(CF)	T5	PA; QL (2 EA per 28 days)
ABRILADA(CF) PEN	T5	PA; QL (2 EA per 28 days)
ACTEMRA ACTPEN	T5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
ACTONEL ORAL TABLET 150 MG, 35 MG	T4	

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

Drug Name	Drug Tier	Requirements/Limits
adalimumab-aacf subcutaneous pen injector kit	T5	PA; QL (2 EA per 28 days)
adalimumab-aacf subcutaneous syringe kit	T5	PA; QL (2 EA per 28 days)
ADALIMUMAB-AACF(CF) PEN CROHNS	T5	PA; QL (12 EA per 365 days)
ADALIMUMAB-AACF(CF) PEN PS-UV	T5	PA; QL (8 EA per 365 days)
adalimumab-aaty	T5	PA; QL (2 EA per 28 days)
adalimumab-adaz subcutaneous pen injector 40 mg/0.4 ml	T5	PA; QL (0.8 ML per 28 days)
adalimumab-adaz subcutaneous pen injector 80 mg/0.8 ml	T5	PA; QL (1.6 ML per 28 days)
adalimumab-adaz subcutaneous syringe 10 mg/0.1 ml	T5	PA; QL (0.2 ML per 28 days)
adalimumab-adaz subcutaneous syringe 20 mg/0.2 ml	T5	PA; QL (0.4 ML per 28 days)
adalimumab-adaz subcutaneous syringe 40 mg/0.4 ml	T5	PA; QL (0.8 ML per 28 days)
adalimumab-adbm	T5	PA; QL (2 EA per 28 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS	T5	PA; QL (12 EA per 365 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV	T5	PA; QL (8 EA per 365 days)
adalimumab-fkjp subcutaneous pen injector kit	T5	PA; QL (2 EA per 28 days)
adalimumab-fkjp subcutaneous syringe kit	T5	PA; QL (2 EA per 28 days)
adalimumab-ryvk	T5	PA; QL (2 EA per 28 days)
alendronate oral solution	T1	
alendronate oral tablet 10 mg, 35 mg, 70 mg	T1	
allopurinol oral tablet 100 mg, 300 mg	T1	
allopurinol oral tablet 200 mg	T4	
AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.8 ML	T5	PA; QL (1.6 EA per 28 days)
AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 80 MG/0.8 ML	T5	PA; QL (1.6 ML per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML, 20 MG/0.2 ML	T5	PA; QL (0.4 ML per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 20 MG/0.4 ML	T5	PA; QL (0.8 EA per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 40 MG/0.8 ML	T5	PA; QL (1.6 EA per 28 days)
ARAVA	T5	
ATELVIA	T4	
auranofin	T5	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
BINOSTO	T4	
colchicine oral capsule	T4	QL (62 EA per 31 days)
colchicine oral tablet	T2	QL (62 EA per 31 days)
CUPRIMINE	T5	
CYLTEZO(CF)	T5	PA; QL (2 EA per 28 days)
CYLTEZO(CF) PEN	T5	PA; QL (2 EA per 28 days)
CYLTEZO(CF) PEN CROHN'S-UC-HS	T5	PA; QL (12 EA per 365 days)
CYLTEZO(CF) PEN PSORIASIS-UV	T5	PA; QL (8 EA per 365 days)
DEPEN TITRATABS	T5	
ENBREL MINI	T5	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)	T5	PA; QL (8 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (8 ML per 28 days)
EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	T5	PA; QL (2.34 ML per 28 days)
EVISTA	T3	
febuxostat	T4	PA
FORTEO	T5	PA; QL (2.4 ML per 28 days)
FOSAMAX ORAL TABLET 70 MG	T4	
FOSAMAX PLUS D	T4	
GLOPERBA	T4	QL (300 ML per 30 days)
HADLIMA	T5	PA; QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH	T5	PA; QL (1.6 ML per 28 days)
HADLIMA(CF)	T5	PA; QL (0.8 ML per 28 days)
HADLIMA(CF) PUSHTOUCH	T5	PA; QL (0.8 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
HULIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT	T5	PA; QL (2 EA per 28 days)
HULIO(CF) SUBCUTANEOUS SYRINGE KIT	T5	PA; QL (2 EA per 28 days)
HUMIRA PEN	T5	PA; QL (2 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) PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS	T5	PA; QL (6 EA per 365 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA; QL (6 EA per 365 days)
HYRIMOZ	T5	PA; QL (1.6 ML per 28 days)
HYRIMOZ PEN	T5	PA; QL (1.6 ML per 28 days)
HYRIMOZ PEN CROHN'S-UC STARTER	T5	PA; QL (4.8 ML per 365 days)
HYRIMOZ PEN PSORIASIS STARTER	T5	PA; QL (3.2 ML per 365 days)
HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML	T5	PA; QL (4.8 ML per 365 days)
HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML-40 MG/0.4 ML	T5	PA; QL (2.4 ML per 365 days)
HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 80 MG/0.8 ML	T5	PA; QL (1.6 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML	T5	PA; QL (0.2 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML	T5	PA; QL (0.4 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
ibandronate oral	T2	
IDACIO(CF)	T5	PA; QL (2 EA per 28 days)
IDACIO(CF) PEN CROHN-UC STARTR	T5	PA; QL (12 EA per 365 days)
IDACIO(CF) PEN PSORIASIS START	T5	PA; QL (8 EA per 365 days)
IDACIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT	T5	PA; QL (2 EA per 28 days)
KEVZARA	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
leflunomide	T2	

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

Drug Name	Drug Tier	Requirements/Limits
MITIGARE	T4	QL (62 EA per 31 days)
OLUMIANT	T5	PA; QL (31 EA per 31 days)
ORENCIA CLICKJECT	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	T5	PA; QL (2.8 ML per 28 days)
OTEZLA	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51)	T5	PA; QL (110 EA per 365 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
RIDAURA	T5	
RINVOQ LQ	T5	PA; QL (372 ML per 31 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	T5	PA; QL (31 EA per 31 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	T5	PA; QL (168 EA per 365 days)
risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg	T3	
risedronate oral tablet,delayed release (dr/ec)	T3	
SAVELLA	T4	PA
SIMLANDI(CF)	T5	PA; QL (2 EA per 28 days)
SIMLANDI(CF) AUTOINJECTOR	T5	PA; QL (2 EA per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
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 subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)	T5	PA; QL (2.48 ML per 28 days)
TYENNE AUTOINJECTOR	T5	PA; QL (3.6 ML per 28 days)
TYENNE SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
TYMLOS	T5	PA; QL (1.56 ML per 30 days)
ULORIC	T4	PA
XELJANZ ORAL SOLUTION	T5	PA; QL (310 ML per 31 days)
XELJANZ ORAL TABLET	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
YUFLYMA(CF)	T5	PA; QL (2 EA per 28 days)
YUFLYMA(CF) AI CROHN'S-UC-HS	T5	PA; QL (6 EA per 365 days)
YUFLYMA(CF) AUTOINJECTOR	T5	PA; QL (2 EA per 28 days)
YUSIMRY(CF) PEN	T5	PA; QL (1.6 ML per 28 days)
Obstetrics / Gynecology		
ACTIVELLA	T4	
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
ANGELIQ	T4	
ANNOVERA	T4	
APRI	T2	
ARANELLE (28)	T2	
ASHLYNA	T2	
AUBRA EQ	T2	
AVIANE	T2	
AZURETTE (28)	T2	
BALCOLTRA	T4	
BALZIVA (28)	T2	
BEYAZ	T4	
BIJUVA	T4	
BLISOVI 24 FE	T2	
BLISOVI FE 1.5/30 (28)	T2	
BRIELLYN	T2	

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

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

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

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

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

Drug Name	Drug Tier	Requirements/Limits
JUNEL FE 1.5/30 (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	
KYLEENA	T4	
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	
LARIN FE 1/20 (28)	T2	
LAYOLIS FE	T4	
LESSINA	T2	
LEVONEST (28)	T2	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg	T2	
levonorgestrel-ethinyl estrad oral tablet 90-20 mcg (28)	T4	
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month	T2	
levonorg-eth estrad triphasic	T2	
LEVORA-28	T2	
LILETTA	T3	
LO LOESTRIN FE	T4	
LOESTRIN 1.5/30 (21)	T4	
LOESTRIN 1/20 (21)	T4	
LOESTRIN FE 1.5/30 (28-DAY)	T4	
LOESTRIN FE 1/20 (28-DAY)	T4	
LORYNA (28)	T2	
LOW-OGESTREL (28)	T2	
LUTERA (28)	T2	
LYLEQ	T2	
LYLLANA	T2	

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

Drug Name	Drug Tier	Requirements/Limits
LYZA	T2	
MARLISSA (28)	T2	
medroxyprogesterone	T2	
MENOSTAR	T4	
MERZEE	T4	
metronidazole vaginal gel 0.75 % (37.5mg/5 gram)	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	
MIMVEY	T2	
MINIVELLE	T4	
MINZOYA	T4	
MIRENA	T4	
MYFEMBREE	T5	PA; QL (31 EA per 31 days)
NATAZIA	T4	
NECON 0.5/35 (28)	T2	
NEXPLANON	T3	
NEXTSTELLIS	T4	
NIKKI (28)	T2	
NORA-BE	T2	
norelgestromin-ethin.estradiol	T2	
noreth-ethinyl estradiol-iron oral tablet,chewable 0.4mg-35mcg(21) and 75 mg (7)	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 capsule	T4	
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1-20(5)/1-30(7) /1mg-35mcg (9)	T2	

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

Drug Name	Drug Tier	Requirements/Limits
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 1/35 (28)	T2	
NYLIA 7/7/7 (28)	T2	
OCELLA	T2	
ORIAHNN	T5	PA; QL (56 EA per 28 days)
OSPHENA	T4	PA; QL (31 EA per 31 days)
PHEXXI	T4	
PIMTREA (28)	T2	
PORTIA 28	T2	
PREMARIN ORAL	T4	
PREMARIN VAGINAL	T3	
PREMPHASE	T4	
PREMPRO	T4	
progesterone micronized	T2	
PROMETRIUM	T4	
PROVERA	T4	
RECLIPSEN (28)	T2	
RIVELSA	T4	
SAFYRAL	T4	
SETLAKIN	T2	
SHAROBEL	T2	
SKYLA	T4	
SPRINTEC (28)	T2	
SRONYX	T2	
SYEDA	T2	
TARINA 24 FE	T2	
TARINA FE 1-20 EQ (28)	T2	
terconazole	T2	
TILIA FE	T2	

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

Drug Name	Drug Tier	Requirements/Limits
tranexamic acid oral	T2	
TRI-ESTARYLLA	T2	
TRI-LEGEST FE	T2	
TRI-LO-ESTARYLLA	T2	
TRI-LO-SPRINTEC	T2	
TRI-MILI	T2	
TRI-SPRINTEC (28)	T2	
TRIVORA (28)	T2	
TRI-VYLIBRA	T2	
TRI-VYLIBRA LO	T2	
TURQOZ (28)	T2	
TYDEMY	T2	
VAGIFEM	T4	
VANDAZOLE	T3	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VEOZAH	T4	PA; QL (31 EA per 31 days)
VESTURA (28)	T2	
VIENVA	T2	
VIVELLE-DOT	T4	
VYFEMLA (28)	T2	
VYLIBRA	T2	
WYMZYA FE	T2	
XACIATO	T4	
XARAH FE	T2	
XULANE	T2	
YASMIN (28)	T4	
YAZ (28)	T4	
YUVAFEM	T4	
ZAFEMY	T2	
ZOVIA 1-35 (28)	T2	
Ophthalmology		
acetazolamide	T2	
ACULAR	T4	
ACULAR LS	T4	
ACUVAIL (PF)	T4	

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

Drug Name	Drug Tier	Requirements/Limits
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.15 %	T4	
ALREX	T4	
apraclonidine	T2	
atropine ophthalmic (eye) drops 1 %	T2	
AZASITE	T4	
azelastine ophthalmic (eye)	T2	
AZOPT	T4	
bacitracin ophthalmic (eye)	T2	
bacitracin-polymyxin b	T2	
bepotastine besilate	T4	PA
BEPREVE	T4	PA
BESIVANCE	T4	
betaxolol ophthalmic (eye)	T2	
BETIMOL	T4	
BETOPTIC S	T4	
bimatoprost ophthalmic (eye)	T2	
brimonidine ophthalmic (eye) drops 0.1 %	T3	
brimonidine ophthalmic (eye) drops 0.15 %, 0.2 %	T2	
brimonidine-timolol	T3	
brinzolamide	T4	
bromfenac ophthalmic (eye) drops 0.07 %, 0.075 %	T4	
bromfenac ophthalmic (eye) drops 0.09 %	T2	
BROMSITE	T4	
carteolol	T2	
CEQUA	T4	ST; QL (60 EA per 30 days)
CILOXAN OPHTHALMIC (EYE) OINTMENT	T3	
ciprofloxacin hcl ophthalmic (eye)	T1	
COMBIGAN	T3	
COSOPT	T4	
COSOPT (PF)	T4	
cromolyn ophthalmic (eye)	T2	

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Drug Name	Drug Tier	Requirements/Limits
cyclosporine ophthalmic (eye)	T3	QL (60 EA per 30 days)
CYSTADROPS	T5	PA; QL (20 ML per 28 days)
CYSTARAN	T5	PA; QL (60 ML per 28 days)
dexamethasone sodium phosphate ophthalmic (eye)	T2	
diclofenac sodium ophthalmic (eye)	T1	
difluprednate	T4	
dorzolamide	T2	
dorzolamide-timolol	T2	
dorzolamide-timolol (pf) ophthalmic (eye) dropperette	T4	
DUREZOL	T4	
epinastine	T2	
erythromycin ophthalmic (eye)	T2	
EYSUVIS	T3	QL (8.3 ML per 30 days)
FLAREX	T4	
fluorometholone	T2	
flurbiprofen sodium	T2	
FML FORTE	T4	
FML LIQUIFILM	T4	
gatifloxacin	T3	
gentamicin ophthalmic (eye) drops	T1	
ILEVRO	T3	
INVELTYS	T4	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	T4	
ISTALOL	T4	
IYUZEH (PF)	T4	ST; QL (30 EA per 30 days)
ketorolac ophthalmic (eye)	T2	
latanoprost	T1	
levobunolol ophthalmic (eye) drops 0.5 %	T1	
LOTEMAX	T4	
LOTEMAX SM	T4	
loteprednol etabonate	T4	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
MAXIDEX	T4	

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

Drug Name	Drug Tier	Requirements/Limits
MAXITROL	T4	
methazolamide	T2	
MIEBO (PF)	T4	ST; QL (9 ML per 30 days)
moxifloxacin ophthalmic (eye) drops	T3	
NATACYN	T4	
neomycin-bacitracin-poly-hc	T2	
neomycin-bacitracin-polymyxin	T2	
neomycin-polymyxin b-dexameth	T2	
neomycin-polymyxin-gramicidin	T2	
neomycin-polymyxin-hc ophthalmic (eye)	T2	
NEO-POLYCIN	T2	
NEO-POLYCIN HC	T2	
NEVANAC	T4	
OCUFLOX	T4	
ofloxacin ophthalmic (eye)	T2	
OXERVATE	T5	PA; QL (112 ML per 56 days)
PHOSPHOLINE IODIDE	T5	PA; QL (5 ML per 25 days)
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	T2	
POLYCIN	T2	
polymyxin b sulf-trimethoprim	T1	
PRED FORTE	T4	
PRED MILD	T4	
prednisolone acetate	T1	
prednisolone sodium phosphate ophthalmic (eye)	T2	
PROLENSA	T3	
RESTASIS	T3	QL (60 EA per 30 days)
RESTASIS MULTIDOSE	T3	QL (5.5 ML per 27 days)
RHOPRESSA	T3	ST
ROCKLATAN	T3	ST
SIMBRINZA	T4	
sulfacetamide sodium ophthalmic (eye) drops	T2	
sulfacetamide sodium ophthalmic (eye) ointment	T1	
sulfacetamide-prednisolone	T2	
tafluprost (pf)	T4	
timolol	T4	

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

Drug Name	Drug Tier	Requirements/Limits
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	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
tobramycin ophthalmic (eye)	T1	
tobramycin-dexamethasone	T2	
TOBREX OPHTHALMIC (EYE) OINTMENT	T3	
TRAVATAN Z	T4	
travoprost	T3	
trifluridine	T2	
TYRVAYA	T4	ST; QL (8.4 ML per 30 days)
VERKAZIA	T5	PA; QL (120 EA per 30 days)
VEVYE	T4	ST; QL (2 ML per 50 days)
VIGAMOX	T4	
VUITY	T4	PA; QL (5 ML per 25 days)
VYZULTA	T4	ST; QL (5 ML per 31 days)
XALATAN	T4	
XDEMVY	T5	PA; QL (10 ML per 42 days)
XIIDRA	T3	QL (60 EA per 30 days)
ZERVIATE	T4	PA
ZIOPTAN (PF)	T4	ST
ZIRGAN	T4	ST
ZYLET	T4	
Respiratory And Allergy		
acetylcysteine	T2	PA-BvD
ADCIRCA	T5	PA; QL (62 EA per 31 days)
ADEMPAS	T5	PA; QL (93 EA per 31 days)
ADVAIR DISKUS	T4	ST; QL (60 EA per 30 days)
ADVAIR HFA	T3	QL (12 GM per 30 days)
AIRDUO RESPICLICK	T4	QL (1 EA per 30 days)
AIRSUPRA	T4	ST; QL (32.1 GM per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
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)
ALYFTREK ORAL TABLET 10-50-125 MG	T5	PA; QL (56 EA per 28 days)
ALYFTREK ORAL TABLET 4-20-50 MG	T5	PA; QL (84 EA per 28 days)
ALYQ	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
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	T4	ST
azelastine-fluticasone	T4	QL (23 GM per 30 days)
BERINERT INTRAVENOUS KIT	T5	PA
BEVESPI AEROSPHERE	T4	QL (10.7 GM per 30 days)
bosentan oral tablet	T5	PA; QL (62 EA per 31 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BREYNA	T3	QL (10.3 GM per 30 days)
BREZTRI AEROSPHERE	T3	QL (10.7 GM per 30 days)
BRONCHITOL	T5	PA; QL (600 EA per 30 days)
BROVANA	T4	PA-BvD
budesonide inhalation	T4	PA-BvD
budesonide-formoterol	T3	QL (10.2 GM per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
carbinoxamine maleate oral liquid	T4	PA
carbinoxamine maleate oral tablet	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	PA
clemastine oral tablet	T2	
COMBIVENT RESPIMAT	T3	QL (4 GM per 30 days)
cromolyn inhalation	T4	PA-BvD
cyproheptadine	T2	PA
DALIRESP	T4	QL (31 EA per 31 days)
desloratadine	T2	QL (31 EA per 31 days)
DUAKLIR PRESSAIR	T4	QL (1 EA per 30 days)
DULERA	T3	QL (13 GM per 30 days)
DYMISTA	T4	ST; QL (23 GM per 30 days)
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	T5	PA; QL (93 EA per 31 days)
FASENRA PEN	T5	PA; QL (1 ML per 56 days)
FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	T5	PA; QL (0.5 ML per 56 days)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	T5	PA; QL (1 ML per 56 days)
FIRAZYR	T5	PA; QL (18 ML per 30 days)
flunisolide	T2	QL (50 ML per 25 days)
fluticasone furoate-vilanterol	T4	ST; QL (60 EA per 30 days)
fluticasone propionate inhalation blister with device 100 mcg/actuation, 50 mcg/actuation	T4	ST; QL (60 EA per 30 days)
fluticasone propionate inhalation blister with device 250 mcg/actuation	T4	ST; QL (240 EA per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation	T4	ST; QL (12 GM per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation	T4	ST; QL (24 GM per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation	T4	ST; QL (10.6 GM per 30 days)
fluticasone propionate nasal	T1	QL (16 GM per 30 days)
fluticasone propion-salmeterol inhalation aerosol powdr breath activated	T3	QL (1 EA per 30 days)
fluticasone propion-salmeterol inhalation blister with device	T3	QL (60 EA per 30 days)
fluticasone propion-salmeterol inhalation hfa aerosol inhaler	T4	QL (12 GM per 30 days)
formoterol fumarate	T4	PA-BvD
HAEGARDA	T5	PA
hydroxyzine hcl oral solution 10 mg/5 ml	T2	PA
hydroxyzine hcl oral tablet	T2	PA
hydroxyzine pamoate	T2	PA
icatibant	T5	PA; QL (18 ML per 30 days)
INCRUSE ELLIPTA	T4	ST; QL (30 EA per 30 days)
ipratropium bromide inhalation	T1	PA-BvD
ipratropium-albuterol	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 5.8 MG, 50 MG, 75 MG	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL GRANULES IN PACKET 25 MG	T5	PA; QL (62 EA per 31 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
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	T4	QL (310 ML per 31 days)
levocetirizine oral tablet	T1	QL (31 EA per 31 days)
mometasone nasal	T3	QL (34 GM per 30 days)
montelukast	T2	QL (31 EA per 31 days)
NEFFY	T4	ST
NUCALA SUBCUTANEOUS AUTO-INJECTOR	T5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN	T5	PA; QL (3 EA per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.4 ML per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
OFEV	T5	PA; QL (62 EA per 31 days)
OHTUVAYRE	T5	PA; QL (150 ML per 30 days)
OMNARIS	T4	QL (12.5 GM per 30 days)
OPSUMIT	T5	PA; QL (31 EA per 31 days)
OPSYNVI	T5	PA; QL (31 EA per 31 days)
ORKAMBI ORAL GRANULES IN PACKET	T5	PA; QL (62 EA per 31 days)
ORKAMBI ORAL TABLET	T5	PA; QL (124 EA per 31 days)
ORLADEYO	T5	PA; QL (31 EA per 31 days)
PERFOROMIST	T4	PA-BvD
pirfenidone oral capsule	T5	PA; QL (279 EA per 31 days)
pirfenidone oral tablet	T5	PA; QL (93 EA per 31 days)
PROAIR RESPICLICK	T4	ST; QL (2 EA per 30 days)
promethazine oral	T2	PA
promethazine rectal suppository 12.5 mg, 25 mg	T2	
PROMETHEGAN RECTAL SUPPOSITORY 25 MG, 50 MG	T2	
PULMICORT	T4	PA-BvD
PULMICORT FLEXHALER	T4	QL (1 EA per 30 days)
PULMOZYME	T5	PA
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION	T4	QL (6.8 GM per 30 days)
QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION	T4	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	T3	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	T3	QL (21.2 GM per 30 days)
REVATIO ORAL TABLET	T5	PA; QL (372 EA per 31 days)
roflumilast oral tablet 250 mcg	T4	QL (31 EA per 31 days)
roflumilast oral tablet 500 mcg	T3	QL (31 EA per 31 days)
RUCONEST	T5	PA
RYALTRIS	T4	ST; QL (29 GM per 30 days)
RYCLORA	T4	
RYVENT	T4	PA
SAJAZIR	T5	PA; QL (18 ML per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
SEREVENT DISKUS	T3	QL (60 EA per 30 days)
sildenafil (pulm.hypertension) oral suspension for reconstitution	T5	PA; QL (784 ML per 31 days)
sildenafil (pulm.hypertension) oral tablet	T3	PA; QL (372 EA per 31 days)
SINGULAIR	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	T3	QL (4 GM per 30 days)
SYMBICORT	T4	ST; QL (10.2 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
tadalafil (pulm. hypertension)	T5	PA; QL (62 EA per 31 days)
TADLIQ	T5	PA; QL (310 ML per 31 days)
TAKHZYRO SUBCUTANEOUS SOLUTION	T5	PA; QL (4 ML per 28 days)
TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (2 ML per 28 days)
TAKHZYRO SUBCUTANEOUS SYRINGE 300 MG/2 ML (150 MG/ML)	T5	PA; QL (4 ML per 28 days)
terbutaline oral	T2	
THEO-24	T4	
theophylline oral solution	T2	
theophylline oral tablet extended release 12 hr	T2	
theophylline oral tablet extended release 24 hr	T2	
tiotropium bromide	T4	QL (30 EA per 30 days)
TRACLEER ORAL TABLET	T5	PA; QL (62 EA per 31 days)
TRACLEER ORAL TABLET FOR SUSPENSION	T5	PA; QL (124 EA per 31 days)
TRELEGY ELLIPTA	T3	QL (60 EA per 30 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	T5	PA; QL (56 EA per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	T5	PA; QL (84 EA per 28 days)
TUDORZA PRESSAIR	T4	ST; QL (1 EA per 30 days)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 32 MCG, 48 MCG, 64 MCG	T5	PA

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

Drug Name	Drug Tier	Requirements/Limits
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16(112)-32(112) -48(28) MCG	T5	PA; QL (504 EA per 365 days)
umeclidinium-vilanterol	T4	ST; QL (60 EA per 30 days)
VENTOLIN HFA	T3	QL (36 GM per 30 days)
WINREVAIR	T5	PA
WIXELA INHUB	T3	QL (60 EA per 30 days)
XHANCE	T4	PA; QL (32 ML per 30 days)
XOLAIR	T5	PA
XOPENEX HFA	T4	ST; QL (30 GM per 30 days)
YUPELRI	T5	PA-BvD
zafirlukast oral tablet 10 mg	T4	QL (93 EA per 31 days)
zafirlukast oral tablet 20 mg	T4	QL (62 EA per 31 days)
zileuton	T5	PA; QL (124 EA per 31 days)
ZYFLO	T5	PA; QL (124 EA per 31 days)
Urologicals		
alfuzosin	T2	QL (31 EA per 31 days)
AVODART	T4	QL (31 EA per 31 days)
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg	T2	
bethanechol chloride oral tablet 50 mg	T3	
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T3	
darifenacin	T3	QL (31 EA per 31 days)
DETROL ORAL TABLET 2 MG	T4	QL (62 EA per 31 days)
dutasteride	T2	QL (31 EA per 31 days)
dutasteride-tamsulosin	T3	QL (31 EA per 31 days)
ELMIRON	T4	
fesoterodine	T3	QL (31 EA per 31 days)
finasteride oral tablet 5 mg	T2	
flavoxate	T2	
GEMTESA	T4	QL (31 EA per 31 days)
JALYN	T5	QL (31 EA per 31 days)
mirabegron	T4	ST; QL (31 EA per 31 days)
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON	T3	QL (300 ML per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	T3	QL (31 EA per 31 days)
oxybutynin chloride oral syrup	T2	
oxybutynin chloride oral tablet 5 mg	T2	
oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg	T2	QL (31 EA per 31 days)
oxybutynin chloride oral tablet extended release 24hr 15 mg	T3	QL (62 EA per 31 days)
OXYTROL	T4	QL (8 EA per 28 days)
potassium citrate oral tablet extended release	T2	
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET	T5	PA
PROSCAR	T4	
RAPAFLO	T4	
RIVFLOZA SUBCUTANEOUS SOLUTION	T5	PA; QL (1 ML per 28 days)
RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML	T5	PA; QL (0.8 ML per 28 days)
RIVFLOZA SUBCUTANEOUS SYRINGE 160 MG/ML	T5	PA; QL (1 ML per 28 days)
silodosin	T4	
solifenacin	T3	QL (31 EA per 31 days)
tadalafil oral tablet 2.5 mg	T4	PA; QL (62 EA per 31 days)
tadalafil oral tablet 5 mg	T4	PA; QL (31 EA per 31 days)
tamsulosin	T1	
tolterodine oral capsule,extended release 24hr	T3	QL (31 EA per 31 days)
tolterodine oral tablet	T3	QL (62 EA per 31 days)
TOVIAZ	T4	QL (31 EA per 31 days)
trospium oral capsule,extended release 24hr	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	
UROXATRAL	T4	QL (31 EA per 31 days)
VESICARE	T4	QL (31 EA per 31 days)
VESICARE LS	T4	QL (310 ML per 31 days)
Vitamins, Hematinics / Electrolytes		
AQNEURSA	T5	PA; QL (62 EA per 31 days)
CLINIMIX 5%/D15W SULFITE FREE	T4	PA-BvD

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

Drug Name	Drug Tier	Requirements/Limits
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
electrolyte-148	T4	PA-BvD
fluoride (sodium) oral tablet	T2	
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	T4	PA-BvD
ISOLYTE S PH 7.4	T3	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T4	PA-BvD
KLOR-CON	T4	
KLOR-CON 10	T3	
KLOR-CON 8	T3	
KLOR-CON M10	T1	
KLOR-CON M15	T1	
KLOR-CON M20	T1	
magnesium sulfate injection	T2	
NUTRILIPID	T4	PA-BvD
PLASMA-LYTE A	T4	PA-BvD
PLENAMINE	T3	PA-BvD
potassium chlorid-d5-0.45%nacl	T2	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	T2	
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l	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	

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

Drug Name	Drug Tier	Requirements/Limits
potassium chloride oral packet	T2	
potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq	T1	
potassium chloride oral tablet extended release 15 meq	T4	
potassium chloride oral tablet,er particles/crystals	T1	
potassium chloride-0.45 % nacl	T2	
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
PROSOL 20 %	T4	PA-BvD
sodium chloride 0.45 % intravenous	T2	
sodium chloride 3 % hypertonic	T2	
sodium chloride 5 % hypertonic	T2	
TPN ELECTROLYTES	T4	
TRAVASOL 10 %	T3	PA-BvD
TROPHAMINE 10 %	T4	PA-BvD

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

Index of Drugs

Acitretin

Products Affected

- *acitretin*

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

Actemra

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Part A covered for Covid-19 in hospitalized patients
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 therapeutic failure 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 therapeutic failure or intolerance to one immunosuppressant (e.g., mycophenolate mofetil, corticosteroids, 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	
Part B Prerequisite	No

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). 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. 2. and 3.) must be met. 1) Prescriber attestation that the member cannot use corticosteroids (e.g. IV methylprednisolone, high dose oral corticosteroids) due to unsatisfactory response, intolerance (e.g. severe anaphylaxis) or experienced a severe adverse event to corticosteroids (e.g. psychosis). 2) If the reauthorization is for the treatment of multiple sclerosis, a rheumatic disorder, dermatologic disease, or nephrotic syndrome, the prescriber attests that H.P. Acthar is being used for a new acute exacerbation and not on a routine basis to prevent an exacerbation as supported by Compendia. 3) If the reauthorization is for treatment of multiple sclerosis, a rheumatic disorder, or collagen disease, the member continues to receive maintenance therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Gout, Epileptic Aphasia
Part B Prerequisite	No

Acthar SelfJect

Products Affected

- **ACTHAR SELFJECT**

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

PA Criteria	Criteria Details
Other Criteria	For reauthorization, the following (1. 2. and 3.) must be met. 1) Prescriber attestation that the member cannot use corticosteroids (e.g. IV methylprednisolone, high dose oral corticosteroids) due to unsatisfactory response, intolerance (e.g. severe anaphylaxis) or experienced a severe adverse event to corticosteroids (e.g. psychosis). 2) If the reauthorization is for the treatment of multiple sclerosis, a rheumatic disorder, dermatologic disease, or nephrotic syndrome, the prescriber attests that H.P. Acthar is being used for a new acute exacerbation and not on a routine basis to prevent an exacerbation as supported by Compendia. 3) If the reauthorization is for treatment of multiple sclerosis, a rheumatic disorder, or collagen disease, the member continues to receive maintenance therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Gout, Epileptic Aphasia
Part B Prerequisite	No

Actimmune

Products Affected

- **ACTIMMUNE**

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

Adalimumab

Products Affected

- **ABRILADA(CF)**
- **ABRILADA(CF) PEN**
- *adalimumab-aacf subcutaneous pen injector kit*
- *adalimumab-aacf subcutaneous syringe kit*
- **ADALIMUMAB-AACF(CF) PEN CROHNS**
- **ADALIMUMAB-AACF(CF) PEN PS-UV**
- *adalimumab-aaty*
- *adalimumab-adaz subcutaneous pen injector 40 mg/0.4 ml, 80 mg/0.8 ml*
- *adalimumab-adaz subcutaneous syringe 10 mg/0.1 ml, 20 mg/0.2 ml, 40 mg/0.4 ml*
- *adalimumab-adbm*
- **ADALIMUMAB-ADBM(CF) PEN CROHNS**
- **ADALIMUMAB-ADBM(CF) PEN PS-UV**
- *adalimumab-fkjp subcutaneous pen injector kit*
- *adalimumab-fkjp subcutaneous syringe kit*
- *adalimumab-ryvk*
- **AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML, 40 MG/0.8 ML, 80 MG/0.8 ML**
- **AMJEVITA(CF) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML, 20 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.4 ML, 40 MG/0.8 ML**
- **HADLIMA**
- **HADLIMA PUSHTOUCH**
- **HADLIMA(CF)**
- **HADLIMA(CF) PUSHTOUCH**
- **HULIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT**
- **HULIO(CF) SUBCUTANEOUS SYRINGE KIT**
- **HYRIMOZ**
- **HYRIMOZ PEN**
- **HYRIMOZ PEN CROHN'S-UC STARTER**
- **HYRIMOZ PEN PSORIASIS STARTER**
- **HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML, 80 MG/0.8 ML- 40 MG/0.4 ML**
- **HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML, 80 MG/0.8 ML**
- **HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML**
- **IDACIO(CF)**
- **IDACIO(CF) PEN CROHN-UC STARTR**
- **IDACIO(CF) PEN PSORIASIS START**
- **IDACIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT**
- **SIMLANDI(CF)**
- **SIMLANDI(CF) AUTOINJECTOR**
- **YUSIMRY(CF) PEN**

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For uveitis, inadequate response or intolerance to 1 immunosuppressant or corticosteroid, or all are contraindicated.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, and Ankylosing Spondylitis or less than 12 years of age for Hidradenitis Suppurative or Less than 6 years of age for Crohn's disease or Less than 5 years of age for Ulcerative Colitis or less than 2 years of age for Juvenile Idiopathic Arthritis and Uveitis
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Intolerance to 2 of the following preferred adalimumab products is required: Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis therapy without concomitant methotrexate, doses above plan quantity limit will be approved aligned with recommended weekly dosing regimen. For pediatric ulcerative colitis and hidradenitis suppurativa, doses above plan quantity limit will be approved to align with recommended dosing regimen. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Adbry

Products Affected

- **ADBRY**

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

ADHD Drugs

Products Affected

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

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

Adlarity

Products Affected

- **ADLARITY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- one of the following (1 or 2): 1) therapeutic failure or intolerance to donepezil tablets, 2) Unable to take daily oral donepezil due to impaired memory.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Afinitor

Products Affected

- **AFINITOR**
- **AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG**
- *everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg*

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

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

Agamree

Products Affected

- **AGAMREE**

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

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 migraine frequency
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 migraine frequency
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Akeega

Products Affected

- **AKEEGA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- All of the following: 1) BRCA mutations, 2) Comcomitant therapy with prednisone, 3) Concomitant therapy with a gonadotropin-releasing hormone analog or a bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Alecensa

Products Affected

- **ALECENSA**

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

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	
Part B Prerequisite	No

Alpha1-Proteinase Inhibitors

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of panacinar emphysema AND documentation of a decline in forced expiratory volume in 1 second (fev1) despite medical therapy (bronchodilators, corticosteroids) 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	
Part B Prerequisite	No

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Alyftrek

Products Affected

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

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 vanzacaftor/tezacaftor/deutivacaftor based on clinical and/or in vitro assay.
Age Restrictions	
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	
Part B Prerequisite	No

Amitiza

Products Affected

- **AMITIZA**

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

Amlodipine Liquid

Products Affected

- **KATERZIA**
- **NORLIQVA**

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

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	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	
Part B Prerequisite	No

Anabolic Steroids

Products Affected

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

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

Ancobon

Products Affected

- **ANCOBON**

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

Apokyn

Products Affected

- **APOKYN**
- *apomorphine*

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- experiencing off episodes despite the use of oral carbidopa/levodopa -AND- Therapeutic failure, intolerance, or contraindication to one of the following generic products: pramipexole, ropinirole, entacapone, selegiline or rasagiline
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Aqneursa

Products Affected

- **AQNEURSA**

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

Arikayce

Products Affected

- **ARIKAYCE**

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

ATTR-CM drugs

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitantly with transthyretin-lowering agents
Required Medical Information	Documentation of cardiomyopathy of 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 -AND- For Attruby (acoramidis), ATTR-CM type is wild-type or variant -AND- For Vyndaqel (tafamidis meglumine) and Vyndamax (tafamidis), ATTR-CM type is wild-type or hereditary.
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	
Part B Prerequisite	No

Atypical Antipsychotics

Products Affected

- **ABILIFY ORAL TABLET**
- *aripiprazole oral solution*
- *aripiprazole oral tablet,disintegrating*

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 therapeutic failure, contraindication or intolerance to one other generic antidepressant in addition to the antidepressant currently being used for the treatment of MDD (e.g. SSRI, SNRI, NDRIs, TCA, MAOI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Aubagio

Products Affected

- **AUBAGIO**
- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with 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	For brand Aubagio, therapeutic failure or intolerance to generic teriflunomide is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Augtyro

Products Affected

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

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

Austedo

Products Affected

- **AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG**
- **AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG**
- **AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG**

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

Auvelity

Products Affected

- **AUVELITY**

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

Ayvakit

Products Affected

- **AYVAKIT**

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

Baclofen Solution

Products Affected

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

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

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) -AND- Therapeutic failure or intolerance to generic dimethyl fumarate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Balversa

Products Affected

- **BALVERSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) FGFR3 mutation status as detected by an FDA approved test 2) disease progression on or after at least on prior line of systemic therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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- therapeutic failure or intolerance of a previous antiepileptic therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Banzel, therapeutic failure or intolerance to generic rufinamide is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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- 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- 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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For SLE reauthorization, attestation of disease stability or improvement -AND- attestation the member will continue to receive standard of care therapy with corticosteroids, antimalarials, or immunosuppressives. For active LN reauthorization, attestation of disease stability or improvement -AND- attestation the member will continue to receive standard of care therapy with mycophenolate or azathioprine. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.

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

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	
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	
Part B Prerequisite	No

Besremi

Products Affected

- **BESREMI**

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

Bimzelx

Products Affected

- **BIMZELX**
- **BIMZELX AUTOINJECTOR**

PA Criteria	Criteria Details
Exclusion Criteria	
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) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 nonsteroidal anti-inflammatory drugs (NSAIDs) or all are contraindicated. For ankylosing spondylitis, inadequate response or intolerance to 1 NSAID or all are contraindicated.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For plaque psoriasis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Otezla, Stelara SC, Enbrel and Skyrizi SC. For Psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cosentyx, Enbrel, a preferred adalimumab product, Xeljanz/Xeljanz XR, Otezla, Stelara SC, Rinvoq, and Skyrizi SC. For non-radiographic axial spondyloarthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cimzia, Rinvoq, Cosentyx. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For hidradenitis suppurativa, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. Must follow recommended dosing guidelines based upon weight. 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	
Part B Prerequisite	No

Bonjesta

Products Affected

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

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

Bosulif

Products Affected

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

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

Braftovi

Products Affected

- **BRAFTOVI**

PA Criteria	Criteria Details
Exclusion Criteria	Use in wild-type BRAF melanoma or wild-type BRAF CRC
Required Medical Information	Documentation of diagnosis. For metastatic colorectal cancer (mCRC) and using in combination with cetuximab, all of the following (1-3): 1) BRAF V600E mutation status 2) using in combination with cetuximab 3) member has received prior therapy for CRC. For mCRC and using in combination with cetuximab and modified FOLFOX6, all of the following (4-5): 4) BRAF V600E mutation status, as detected by an FDA-approved test 5) using in combination with cetuximab and modified FOLFOX6. For unresectable or metastatic melanoma, all of the following (6-7): 6) BRAF V600E or V600K mutation status 7) using in combination with binimetinib. For metastatic non-small cell lung cancer, all of the following (8-9): 8) BRAF V600E mutation status 9) using in combination with binimetinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of increase in FEV1
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Brukinsa

Products Affected

- **BRUKINSA**

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

Buphenyl

Products Affected

- **BUPHENYL**
- *sodium phenylbutyrate*

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

Bylvay

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of pruritis with progressive familial intrahepatic cholestasis or cholestatic pruritus with Alagille syndrome -AND- The member does not have cirrhosis, portal hypertension, or history of hepatic decompensation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial, 12 months reauthorization
Other Criteria	For reauthorization, attestation of improvement in pruritis -AND- attestation that the member has not progressed to any of the following (1-3): 1) portal hypertension, 2) cirrhosis, or 3) experienced a hepatic decompensation event.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Cabometyx

Products Affected

- **CABOMETYX**

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

Calquence

Products Affected

- **CALQUENCE**
- **CALQUENCE (ACALABRUTINIB MAL)**

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

Camzyos

Products Affected

- **CAMZYOS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy -AND- Left ventricular ejection fraction of greater than or equal to 55% -AND- Valsalva left ventricular outflow tract peak gradient of greater than or equal to 50 mmHg at rest or after provocation -AND- Therapeutic failure or intolerance to one of the following (1 or 2) or contraindication to all: 1) Non-vasodilating beta blocker (e.g. metoprolol) 2) non-dihydropyridine calcium channel blocker (e.g. diltiazem) -AND- Not currently treated with and attestation Camzyos will not be used concomitantly with disopyramide, ranolazine, or combination therapy of beta-blocker and calcium channel blocker
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, prescriber attestation of no NYHA class worsening -AND- Not currently treated with and attestation Camzyos will not be used concomitantly with disopyramide, ranolazine, or combination therapy of beta-blocker and calcium channel blocker
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Caplyta

Products Affected

- **CAPLYTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- therapeutic failure, intolerance, or contraindication to one other generic atypical antipsychotic (e.g. quetiapine).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Caprelsa

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Carbaglu

Products Affected

- **CARBAGLU**
- *carglumic acid*

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

Carbinoxamine

Products Affected

- *carbinoxamine maleate oral liquid*
- *carbinoxamine maleate oral tablet*
- **RYVENT**

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

Cayston

Products Affected

- **CAYSTON**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of decrease in sputum density of pseudomonas aeruginosa, increase in FEV1 or decrease in number of hospitalizations or pulmonary exacerbations
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cerdelga

Products Affected

- **CERDELGA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of type 1 Gaucher disease confirmed by the following A. or B. A) With one of the following symptoms (1, 2, 3, 4, or, 5): 1)Hepatomegaly. 2)Splenomegaly. 3)Bone disease (i.e. osteonecrosis, osteopenia, secondary pathologic fractures, bone infarct). 4)Bone marrow complications as defined by anemia with hemoglobin less than or equal to 11.5 g/dL for females or 12.5 g/dL for males or thrombocytopenia with platelet count less than or equal to 120,000/mm*3. 5)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). -OR- B) Attestation of deficiency in glucocerebrosidase activity in peripheral leukocytes or genetic testing confirms mutant alleles -AND- Documentation of CYP2D6 metabolizer status (e.g. intermediate metabolizer).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CF drugs

Products Affected

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

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

Chenodal

Products Affected

- **CHENODAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of radiolucent gallstones AND an inadequate response or intolerance 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. For reauthorization, attestation of partial dissolution of gallstones
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cholbam

Products Affected

- **CHOLBAM**

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

Cialis

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of benign prostatic hyperplasia (BPH) and trial/failure of 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	
Part B Prerequisite	No

Cibinqo

Products Affected

- **CIBINQO**

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

Cimzia

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide) or all nonbiologic DMARDs are contraindicated. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) or all are contraindicated. For non-radiographic axial spondyloarthritis, inadequate response or intolerance to two nonsteroidal anti-inflammatory drugs (NSAIDs) or all are contraindicated. For moderate to severe psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- all nonbiologic DMARDs are contraindicated -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity, or at high risk of disabling joint damage.
Age Restrictions	Deny if less than 2 years of age for juvenile idiopathic arthritis or less than 18 years of age for all other indications.
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred biologic products: a preferred adalimumab product, Stelara , Rinvoq, and Skyrizi SC. For Rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Actemra SC, Xeljanz/Xeljanz XR and Rinvoq. For plaque psoriasis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Otezla, Stelara SC, Skyrizi SC, and Enbrel. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For Psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cosentyx, Enbrel, a preferred adalimumab product, Xeljanz/Xeljanz XR, Otezla, Stelara SC, Rinvoq, and Skyrizi SC. For Juvenile Idiopathic Arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Rinvoz/Rinvoq LQ, Xeljanx/Xeljanz solution and Actemra SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. 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	
Part B Prerequisite	No

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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Citalopram Capsule

Products Affected

- *citalopram oral capsule*

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

Clemastine Syrup

Products Affected

- *clemastine oral syrup*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of allergic rhinitis or mild, uncomplicated allergic skin manifestations of urticaria and angioedema -AND- Therapeutic failure, contraindication or intolerance to one generic antihistamine product -AND- Therapeutic failure or intolerance to generic clemastine fumarate tablets or an inability to swallow tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cobenfy

Products Affected

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

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

Cometriq

Products Affected

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

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

Copiktra

Products Affected

- **COPIKTRA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- member is no longer responding or is intolerant to at least 2 prior therapies for chronic lymphocytic leukemia and small lymphocytic leukemia.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Corlanor

Products Affected

- **CORLANOR ORAL SOLUTION**
- **CORLANOR ORAL TABLET 5 MG, 7.5 MG**
- *ivabradine oral tablet 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- All of the following: 1) Normal sinus rhythm, 2) Resting heart rate greater than or equal to 70 beats per minute, 3) Left ventricular ejection fraction less than or equal to 35 percent, when applicable, 4) In adult patients (greater than or equal to 18 years), concurrent use, therapeutic failure, or intolerance to the maximum tolerated dose of one beta-blocker used for treatment of heart failure (i.e. 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. For brand Corlanor tablets, when being utilized for the same medically accepted indication, trial and failure of generic ivabradine tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cosentyx

Products Affected

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

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

Cotellic

Products Affected

- **COTELLIC**

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

Crenessity

Products Affected

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

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

Cresemba

Products Affected

- **CRESEMBA ORAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of invasive aspergillosis infection -AND- therapeutic failure, contraindication, or intolerance to voriconazole -OR- Documentation of invasive mucormycosis infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of presence of continued indicators of active disease (e.g. histopathology, fungal culture).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Ctexli

Products Affected

- **CTEXLI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of cerebrotendinous xanthomatosis (CTX) confirmed by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months for initial approval with an additional 12 months upon renewal
Other Criteria	Pending CMS Review
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cuvrior

Products Affected

- **CUVRIOR**

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

Cysteamine Ophthalmic Drops

Products Affected

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

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

Danziten

Products Affected

- **DANZITEN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For Ph+ chronic myeloid leukemia (CML), member's CML is in the chronic or accelerated phase and the member is no longer responding to or is intolerant to imatinib -OR- member is newly diagnosed in the chronic phase.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Daraprim

Products Affected

- **DARAPRIM**
- *pyrimethamine*

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

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Daybue

Products Affected

- **DAYBUE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Rett syndrome confirmed by all of the following (1 thru 4): 1) Partial or complete loss of acquired purposeful hand skills, 2) Partial or complete loss of acquired spoken language, 3) Gait abnormalities: impaired or absence of ability, 4) Stereotypic hand movements such as hand wringing/squeezing, clapping/tapping, mouthing, and washing/rubbing automatisms
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Daytrana

Products Affected

- **DAYTRANA**
- *methylphenidate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial/failure or intolerance to 2 of the following generic medications: methylphenidate, atomoxetine, or dextroamphetamine/amphetamine.
Age Restrictions	Deny if less than 6 years of age or greater than 17 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Daytrana, trial/failure of generic methylphenidate patch is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Deferasirox

Products Affected

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

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

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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation supporting reduction in seizure frequency
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Dihydroergotamine

Products Affected

- *dihydroergotamine nasal*
- **TRUDHESA**

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

Dojolvi

Products Affected

- **DOJOLVI**

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

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	
Part B Prerequisite	No

Doxepin Cream

Products Affected

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

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

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 tablets/capsules. For fibromyalgia, members must also have widespread bilateral pain above and below the waist for greater than 3 months duration -AND- At least 1 fibromyalgia-related symptom (e.g., cognitive impairment, fatigue, sleep disturbance, neurologic symptoms, exercise intolerance).
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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Duexis2

Products Affected

- *ibuprofen-famotidine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) Trial/failure of ibuprofen used in combination with famotidine. -AND- 2) Trial/failure of one additional generic formulary NSAID (other than ibuprofen) used in combination with another 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	
Part B Prerequisite	No

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 dipropionate 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	
Part B Prerequisite	No

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	Moderate to severe atopic dermatitis: trial/failure or intolerance to 1 topical corticosteroid or, if 2 yrs or older, topical calcineurin inhibitor (e.g. tacrolimus, pimecrolimus) -OR- severe atopic dermatitis and incapable of applying topical therapies due to the extent of body surface area involvement or topical therapies are contraindicated due to severely damaged skin. Moderate-to-severe asthma: history of at least 2 asthma exacerbations requiring oral or injectable corticosteroids in past 12mos or at least 1 asthma exacerbation requiring hospitalization in past 12mos -AND- blood eosinophils of at least 150cells/uL or current daily or alternate-day oral corticosteroid (OCS) therapy -AND- inadequate symptom control despite regular treatment w/ medium- or high-dose inhaled corticosteroids (ICS) and at least 1 add'l asthma controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline) w/ or w/o OCS, unless intolerant or contraindicated to all -AND- will continue treatment with a medium- or high-dose ICS and at least 1 add'l asthma controller medication w/ or w/o OCS. Chronic rhinosinusitis with nasal polyposis: trial/ failure, intolerance or contraindication to intra-nasal corticosteroid and 14 day course of OCS. Eosinophilic esophagitis: esophageal eosinophil count of at least 15eos/hpf on esophageal biopsy -AND- clinical symptoms of esophageal dysfunction. Prurigo nodularis. COPD: blood eosinophils of at least 300cells/uL or current daily or alternate-day OCS therapy -AND- inadequate symptom control despite regular treatment for at least 3 months with LAMA, LABA, and ICS, unless intolerant or contraindicated to all. Chronic Spontaneous Urticaria: trial/failure, contraindication or intolerance to 1 second-generation non-sedating H1 antihistamine at the maximum recommended dose (e.g. cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine).
Age Restrictions	

PA Criteria	Criteria Details
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 atopic dermatitis reauthorization, attestation of positive clinical response to therapy. For asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of severe asthma exacerbations, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For CRSwNP reauthorization, attestation of decrease in nasal polyp score or reduction in nasal congestion/obstruction severity score. For EoE reauthorization, attestation of histological remission (less than 15 eos/hpf) on esophageal biopsy or reduced severity or frequency of clinical symptoms of esophageal dysfunction. For prurigo nodularis reauthorization, attestation of reduction in itch or number of nodules or lesions from baseline. For COPD reauthorization, attestation of one of the following is required (1-4): 1) reduction in COPD symptoms, 2) improvement in exercise tolerance, 3) delayed disease progression, or 4) reduction in the number of COPD exacerbations. For CSU reauthorization, improved CSU symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Duvyzat

Products Affected

- **DUVYZAT**

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

Ebglyss

Products Affected

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

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

EGFR Tyrosine Kinase Inhibitors

Products Affected

- *erlotinib*
- **GILOTRIF**

PA Criteria	Criteria Details
Exclusion Criteria	Afatinib products: tumors with resistant EGFR mutations. Erlotinib products: use in NSCLC tumors with mutations other than those in FDA-approved indications. Use in combination with platinum based chemotherapy.
Required Medical Information	For afatinib, documentation of metastatic non-small cell lung cancer (NSCLC) -AND- one of the following, as detected by an FDA-approved test (1-3): 1) disease harbors EGFR exon 19 deletions 2) disease harbors EGFR exon 21 (L858R) substitution mutation 3) disease harbors non-resistant EGFR mutation (i.e., S768I, L861Q, G719X) -OR- documentation of squamous metastatic NSCLC and member has experienced progression on platinum-based chemotherapy. For erlotinib, documentation of metastatic NSCLC -AND- one of the following, as detected by an FDA-approved test (1-2): 1) disease harbors EGFR exon 19 deletions 2) disease harbors EGFR exon 21 (L858R) substitution mutations -OR- documentation of locally advanced, unresectable or metastatic pancreatic cancer -AND- all of the following (1-2): 1) using erlotinib as first-line therapy 2) using in combination with gemcitabine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	For reauthorization, continued antiretroviral therapy for HIV infection -AND- reduction in visceral adipose tissue from baseline (e.g. reduction of minimum waist circumference, waist to hip ratio, or BMI) are required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Elyxyb

Products Affected

- **ELYXYB**

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

Emflaza

Products Affected

- *deflazacort*
- **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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Emflaza tablets and 5 years of age or older, therapeutic failure or intolerance to generic deflazacort tablets is required. For brand Emflaza suspension and 5 years of age or older, therapeutic failure or intolerance to generic deflazacort tablets or inability to swallow tablets is required, and therapeutic failure or intolerance to generic deflazacort suspension. For generic deflazacort suspension and 5 years of age or older, therapeutic failure or intolerance to generic deflazacort tablets or inability to swallow tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

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 of episodic migraine prevention, attestation of reduction in migraine frequency is required. For reauthorization of cluster headache, 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	
Part B Prerequisite	No

Enbrel

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For 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) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis and Ankylosing Spondylitis or less than 2 years of age for Juvenile Idiopathic Arthritis and Psoriatic 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	
Part B Prerequisite	No

Endari

Products Affected

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

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 concurrent use, therapeutic failure, contraindication, or intolerance to hydroxyurea.
Age Restrictions	Deny if less than 5 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Endari, initial authorization requires documentation of trial and failure of generic prescription L-glutamine and reauthorization requires failure of generic prescription L-glutamine if not previously trialed. 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	
Part B Prerequisite	No

Enspryng

Products Affected

- **ENSPRYNG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of neuromyelitis optica spectrum disorder (NMOSD) -AND- Attestation of anti-aquaporin-4 (AQP4) antibody positive -AND- Not used in combination with another monoclonal antibody used for the treatment of NMOSD.
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 NMOSD relapses. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Entresto Sprinkle

Products Affected

- **ENTRESTO SPRINKLE**

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

Entyvio

Products Affected

- **ENTYVIO PEN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation of clinical response or remission following at least 2 doses of IV Entyvio at least 6 weeks before initiating therapy with Entyvio SC.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For moderate to severe ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products is required: a preferred adalimumab product, Rinvoq, Xeljanz/Xeljanz XR, and Stelara SC. For moderate to severe active Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq, Skyrizi SC, and Stelara SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Epclusa

Products Affected

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

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

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

Eprontia

Products Affected

- **EPRONTIA**

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

Ergotamine

Products Affected

- **ERGOMAR**
- *ergotamine-caffeine*

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

Erivedge

Products Affected

- **ERIVEDGE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- if disease is locally advanced all of the following: 1) disease has recurred following surgery, or is not a candidate for surgery, 2) is not a candidate for radiation.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Erleada

Products Affected

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

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

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	
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	
Part B Prerequisite	No

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	
Part B Prerequisite	No

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- Postmenopausal woman at high risk for fracture, meeting one of the following (1. thru 3.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Covered under Part B for patients eligible for home health services when provider certifies that patient sustained bone fracture related to post-menopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug. A cumulative lifetime approval of romosozumab will be limited to a coverage duration of 12 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Evrysdi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of spinal muscular atrophy (SMA) -AND- Baseline motor function test results (e.g. MFM, CHOP, HINE, RULM, HFMSE, 6MWT) -AND- Not using concomitantly with Spinraza (nusinersen) -AND- Molecular genetic testing of 5q SMA showing Homozygous gene deletion, Homozygous conversion mutation or Compound heterozygote -AND- No history of gene replacement therapy to treat of SMA or experienced a decline in clinical status following gene replacement therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For reauthorization, attestation of stable or clinically significant improvement in SMA-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) -AND- Not using concomitantly with Spinraza (nusinersen) -AND- No history of gene replacement therapy to treat of SMA or experienced a decline in clinical status following gene replacement therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fabhalta

Products Affected

- **FABHALTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For paroxysmal nocturnal hemoglobinuria (PNH), meets one of the following (1 or 2): 1) PNH mutant clones confirmed by flow cytometry, or 2) glycosylphosphatidylinositol-anchored proteins (GPI-AP)-deficient polymorphonuclear cells (PMNs) confirmed by flow cytometry -AND- meets one of the following (3-6): 3) anemia secondary to PNH (e.g. hemoglobin less than 10.5 g/dL with symptoms of anemia), 4) elevated lactate dehydrogenase (LDH) greater than or equal to 1.5 times the upper limit of normal, 5) history of a thromboembolic event, or 6) clinical findings of systemic complications (e.g. fatigue, hemoglobinuria, abdominal pain, dyspnea, dysphagia, erectile dysfunction, history of blood cell transfusion due to PNH) -AND- will not be used in combination with another complement inhibitor for PNH (e.g. Soliris (eculizumab), Ultomiris (ravulizumab), Empaveli (pegcetacoplan)) unless initially cross-titrating. For diagnosis of primary immunoglobulin A nephrology (IgAN) confirmed by biopsy, member is at risk for rapid disease progression evidenced by one of the following (7 or 8): 7) Urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g or 8) Proteinuria greater than or equal to 1 g/day -AND- has experienced therapeutic failure, contraindication, or intolerance to a maximally tolerated dose of one of the following (a or b): a) Angiotensin converting enzyme (ACE) inhibitor, b) Angiotensin receptor blocker (ARB) -AND- experienced therapeutic failure, contraindication, or intolerance to one of the following (c or d): c) Filspari (sparsentan) or d) Tarpeyo (budesonide). For Complement 3 Glomerulopathy (C3G) confirmed by biopsy, meets all of the following (13-14): 13) UPCR greater than or equal to 1.0 g/g, 14) currently therapy of the member should be on the maximally tolerated dose of one of the following (e or f): e) ACE-inhibitor, f) ARB.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization of PNH, attestation of positive clinical response defined as one of the following (1-3): 1) hemoglobin stabilization or increase from baseline, 2) decrease in transfusions from baseline, or 3) decrease in LDH levels from baseline or reduction of hemolysis -AND- will not be used in combination with another complement inhibitor for PNH (e.g. Soliris (eculizumab), Ultomiris (ravulizumab), Empaveli (pegcetacoplan)). For reauthorization of IgAN, reduction in urine protein-to-creatinine ratio (UPCR) or proteinuria from baseline. For reauthorization of C3G, reduction in UPCR from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fanapt

Products Affected

- **FANAPT ORAL TABLET**
- **FANAPT ORAL TABLETS,DOSE PACK**

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

Fasenra

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of severe asthma and all of the following (1-4): 1) history of at least 2 asthma exacerbations requiring oral or injectable corticosteroid treatment in past 12 mos or at least 1 asthma exacerbation requiring hospitalization in past 12 mos 2) blood eosinophils greater than or equal to 150cells/uL within the past 6 weeks or greater than or equal to 300cells/uL within the past 12 mos in without other potential causes of eosinophilia (e.g. hypereosinophilic syndromes, neoplastic disease, known suspected parasitic infection) 3) inadequate symptom control despite regular treatment with medium or high dose inhaled corticosteroid (ICS) and at least 1 add'l asthma controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline), with or without oral corticosteroids (OCS), unless intolerant or contraindicated to all 4) will continue treatment with medium or high dose ICS and at least 1 add'l asthma controller medication, with or without OCS -OR- Documentation of eosinophilic granulomatosis with polyangiitis (EGPA) and all of the following (5-6): 5) history of relapsing or refractory disease 6) will be receiving standard of care while on Fasenra therapy with glucocorticoid treatment (e.g. prednisone or prednisolone), with or without immunosuppressive therapy (e.g. cyclosporine, leflunomide, azathioprine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For severe asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of severe asthma exacerbation, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For EPGA reauthorization, attestation of one of the following is required (5-8): 5) reduction in the frequency and/or severity of relapses, 6) reduction or discontinuation of doses of corticosteroids and/or immunosuppressant, 7) disease remission, or 8) reduction in severity or frequency of EGPA-related symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fecal Microbiota Products

Products Affected

- **VOWST**

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

Ferriprox

Products Affected

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

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

Fetzima

Products Affected

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

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

Filspari

Products Affected

- **FILSPARI**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with renin-angiotensin system inhibitors (i.e., ACE inhibitors, ARBs, aliskiren) or endothelin receptor antagonists (e.g., Letairis, Opsumit, Tracleer)
Required Medical Information	Documentation of primary immunoglobulin A nephropathy confirmed by biopsy -AND- Risk for rapid disease progression, evidenced by proteinuria greater than or equal to 0.5 g/day -AND- Therapeutic failure, contraindication, or intolerance to an angiotensin converting enzyme inhibitor or an angiotensin receptor blocker
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, reduction in proteinuria from baseline is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Filsuvez

Products Affected

- **FILSUVEZ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of dystrophic epidermolysis bullosa (DEB) or junctional epidermolysis bullosa (JEB) -AND- at least one open wound.
Age Restrictions	Deny if less than 6 months of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of improvement in targeted wound(s) -AND- member requires additional courses of treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fintepla

Products Affected

- **FINTEPLA**

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

Firazyr

Products Affected

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

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	
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	
Part B Prerequisite	No

Firdapse

Products Affected

- **FIRDAPSE**

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	
Part B Prerequisite	No

Firmagon

Products Affected

- **FIRMAGON KIT W DILUENT SYRINGE**

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

Flector

Products Affected

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

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

Forteo

Products Affected

- **FORTEO**
- *teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)*

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) T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 40 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. For brand Forteo, trial and failure of teriparatide is required. Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Forteo/teriparatide will be limited to a coverage duration of 24 months in the absence of provider attestation that the member remains at or has returned to having a high risk for fracture
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fotivda

Products Affected

- **FOTIVDA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- member has received at least two prior systemic therapies.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fruzaqla

Products Affected

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

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

Fulvicin PG

Products Affected

- *griseofulvin ultramicrosize oral tablet 165 mg*

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

Furoscix

Products Affected

- **FUROSCIX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- medication regimen includes an oral loop diuretic (e.g. furosemide, bumetanide, torsemide) -AND- treatment with oral diuretics will replace the use of Furoscix as soon as practical.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gabarone

Products Affected

- **GABARONE ORAL TABLET 100 MG, 400 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	Intolerance to generic immediate release gabapentin tablets or capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 -AND- Will not be used concomitantly with enzyme replacement therapy (ERT) e.g. Fabrazyme.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gattex

Products Affected

- **GATTEX 30-VIAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of short bowel syndrome (SBS) having less than 200 cm of functional small bowel -AND- Dependence on parenteral/intravenous nutrition -AND- weight of at least 10 kg.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, continued dependence on parenteral nutrition/intravenous nutritional support -AND- attestation of increase in weight from baseline or decrease in intravenous parenteral nutrition requirements from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gavreto

Products Affected

- **GAVRETO**

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

Gilenya

Products Affected

- *fingolimod*
- **GILENYA**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as teriflunomide, 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	Brand Gilenya requires therapeutic failure or intolerance to generic fingolimod. For Brand Gilenya 0.25mg, failure of generic is not required if age is between 10-17 years old and weight is less than or equal to 40kg.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gimoti

Products Affected

- **GIMOTI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute or recurrent diabetic gastroparesis -AND- Attestation of no signs or symptoms of tardive dyskinesia -AND- Therapeutic failure or intolerance to generic metoclopramide (tablets, orally disintegrating tablets, or solution) or not a candidate for oral dosage forms -AND- If over 65 years of age, member was titrated to a stable does of metoclopramide tablets or solution at 10mg four times a day before switching to Gimoti therapy.
Age Restrictions	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 administration -AND- Attestation of no signs or symptoms of tardive dyskinesia -AND- Attestation that extended therapy with Gimoti outweighs risk of developing tardive dyskinesia.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Glatiramer

Products Affected

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

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

Gleevec

Products Affected

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

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Gleostine

Products Affected

- **GLEOSTINE**

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

GLP1

Products Affected

- *liraglutide*
- **MOUNJARO**
- **OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)**
- **RYBELSUS**
- **TRULICITY**
- **VICTOZA 3-PAK**

PA Criteria	Criteria Details
Exclusion Criteria	Obesity or use for weight loss
Required Medical Information	Documentation of diabetes mellitus type 2
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	When used for the same age and indication, for Byetta, Victoza, and liraglutide, therapeutic failure or intolerance to two, or contraindication to all of the following: Mounjaro, Ozempic, Rybelsus, or Trulicity.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Glycate

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- using as an adjunctive treatment for peptic ulcer disease -AND- Therapeutic failure or intolerance to both generic glycopyrrolate 1mg tablet AND 2 mg tablet
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of positive clinical response to therapy -AND- Additional courses of therapy are required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gocovri

Products Affected

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

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

Gomekli

Products Affected

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

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

Gralise

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of postherpetic neuralgia (PHN) -AND- Trial and failure or intolerance to generic immediate-release 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	
Part B Prerequisite	No

Grastek

Products Affected

- **GRASTEK**

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

Growth Hormone

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis, growth chart, bone age, growth velocity, response to stimulation test, when applicable to meet standard diagnostic criteria. Additionally for growth failure due to chronic kidney disease, glomerular filtration rate is less than 89ml/min per 1.73m*2. For HIV wasting and cachexia, Concurrent use of antiretroviral therapy -AND- weight loss of at least 10 percent from baseline. For short bowel syndrome, receiving management for short bowel syndrome, including specialized nutritional support -AND- less than 200 cm of functional small bowel.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of growth velocity and bone age, as applicable to meet standard continuation of therapy guidelines. For reauthorization of HIV wasting and cachexia, attestation of increase in weight from start of therapy. For reauthorization of short bowel syndrome, continued dependence on parenteral nutrition/intravenous nutritional support -AND- attestation of increase in weight from baseline or decrease in intravenous parenteral nutrition requirements from baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Harvoni

Products Affected

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

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

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Hetlioz

Products Affected

- **HETLIOZ**

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

PA Criteria	Criteria Details
Part B Prerequisite	No

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	
Part B Prerequisite	No

High-risk meds

Products Affected

- *amitriptyline*
- *amitriptyline-chlordiazepoxide*
- **ANAFRANIL**
- *benztropine oral*
- *carisoprodol*
- *chlorzoxazone*
- *clomipramine*
- *cyproheptadine*
- *doxepin oral capsule*
- *doxepin oral concentrate*
- *doxepin oral tablet*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate*
- *imipramine hcl*
- *imipramine pamoate*
- *metaxalone oral tablet 400 mg, 800 mg*
- **NORGESIC**
- **NORGESIC FORTE**
- *orphenadrine citrate oral*
- *orphenadrine-asa-caffeine oral tablet 25-385-30 mg*
- *perphenazine-amitriptyline*
- *promethazine oral*
- **SILENOR**
- **SOMA**
- *trimipramine*

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 target tricyclic antidepressants (TCAs), in addition to criteria 1 through 3 above, trial and failure or documentation of intolerance or contraindication to at least 2 non-high risk alternative drugs for the same indication, if available, is required (e.g. SSRIs and SNRIs). If using a TCA for a medically-accepted indication not shared by the safer alternatives listed, then no trial of alternatives is required.
Age Restrictions	Automatic approval if less than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doxepin doses less than or equal to 6 mg per day will receive automatic approval.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

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	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Seizure disorders
Part B Prerequisite	No

Homozygous FH

Products Affected

- **JUXTAPID**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of homozygous familial hypercholesterolemia (HoFH) supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene -OR- untreated LDL-C greater than 400mg/dL or TC greater than 500mg/dl with cutaneous or tendon xanthoma before age 10 yrs or HeFH in both parents -AND- The member has a current LDL-C greater than 100mg/dL despite use of maximally tolerated statin OR statin intolerance -AND- The member will continue to receive concurrent lipid-lowering therapies for the treatment of HoFH
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Patients must have a trial/failure or contraindication to the preferred product Repatha. For reauthorization, documentation showing an LDL-C reduction on Juxtapid therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 pramipexole or ropinirole -AND- trial and failure of an additional dopaminergic agent, clonidine or pregabalin -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	
Part B Prerequisite	No

Humira

Products Affected

- **CYLTEZO(CF)**
- **CYLTEZO(CF) PEN**
- **CYLTEZO(CF) PEN CROHN'S-UC-HS**
- **CYLTEZO(CF) PEN PSORIASIS-UV**
- **HUMIRA PEN**
- **HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML**
- **HUMIRA(CF)**
- **HUMIRA(CF) PEN**
- **HUMIRA(CF) PEN CROHNS-UC-HS**
- **HUMIRA(CF) PEN PSOR-UV-ADOL HS**
- **YUFLYMA(CF)**
- **YUFLYMA(CF) AI CROHN'S-UC-HS**
- **YUFLYMA(CF) AUTOINJECTOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For uveitis, inadequate response or intolerance to 1 immunosuppressant or corticosteroid, or all are contraindicated.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, and Ankylosing Spondylitis or less than 12 years of age for Hidradenitis Suppurative or Less than 6 years of age for Crohn's disease or Less than 5 years of age for Ulcerative Colitis or less than 2 years of age for Juvenile Idiopathic Arthritis and Uveitis
Prescriber Restrictions	
Coverage Duration	Plan Year

PA Criteria	Criteria Details
Other Criteria	For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis therapy without concomitant methotrexate, doses above plan quantity limit will be approved aligned with recommended weekly dosing regimen. For pediatric ulcerative colitis and hidradenitis suppurativa, doses above plan quantity limit will be approved to align with recommended dosing regimen. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit. To clarify, these criteria are applicable to Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Hyftor

Products Affected

- **HYFTOR**

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

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 -OR- 2) documentation of use with fulvestrant in patients with disease progression following endocrine therapy. Documentation of endocrine-resistant, locally advanced or metastatic breast cancer -AND- all of the following (3-6): 3) disease is HR-positive, HER2-negative 4) disease is PIK3CA-mutated, as detected by an FDA-approved test 5) the member is using in combination with inavolisib and fulvestrant 6) the member has experienced recurrence on or after completing adjuvant endocrine therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ibsrela

Products Affected

- **IBSRELA**

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

Iclusig

Products Affected

- **ICLUSIG**

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

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IG

Products Affected

- **BIVIGAM**
- **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/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/contraindication to those standard therapies. 3) For B-cell CLL, associated with recurrent bacterial infections OR with Associated Hypogammaglobulinemia defined as IgG level less than 600mg/dL or evidence of a specific antibody deficiency. 4) For Bone Marrow Transplantation, the member is 20 years of age or older and within the first 100 days after transplantation. 5) For Dermatomyositis/Polymyositis, trial and failure, intolerance, or contraindication to standard fist line therapy (i.e. corticosteroids or immunosuppressants). 6) For Pediatric HIV, the patient is less than 13 y.o. who have entry CD4 lymphocyte count greater than or equal to 200/mcl and IgG less than 400mg/dL OR recurrent bacterial infections. 7) 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. 8) 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.
Age Restrictions	

PA Criteria	Criteria Details
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, Polymyositis, Bone Marrow Transplant, Pediatric HIV, Guillain-Barre syndrome, Autoimmune Mucocutaneous Blistering Diseases
Part B Prerequisite	No

Ilumya

Products Affected

- **ILUMYA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For psoriasis, patients must have therapeutic failure or intolerance to 2 of the preferred products: Cosentyx, a preferred adalimumab product, Otezla, Stelara, Enbrel and Skyrizi. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. 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	
Part B Prerequisite	No

Imbruvica

Products Affected

- **IMBRUVICA ORAL CAPSULE 140 MG, 280 MG, 420 MG 70 MG**
- **IMBRUVICA ORAL SUSPENSION**
- **IMBRUVICA ORAL TABLET 140 MG,**

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

Imkeldi

Products Affected

- **IMKELDI**

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

PA Criteria	Criteria Details
Part B Prerequisite	No

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	
Part B Prerequisite	No

Increlex

Products Affected

- **INCRELEX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of severe primary IGF-1 deficiency and all of the following: 1) Normal or elevated response (greater than 10 ng/ml) to two (2) of the following standard growth hormone stimulation tests: arginine, clonidine, glucagon, insulin, levodopa, propranolol. 2) Serum IGF-1 concentration that is less than or equal to three (3) standard deviations below the normal value based on laboratory reference range. 3) Height less than or equal to three (3) standard deviations below normal (at or below the third percentile for gender and age). 4) Member has open epiphyses. -OR- Documentation of diagnosis of growth hormone deficiency caused by gene deletion and all of the following: 1) Growth velocity at least 2 standard deviations below the age-appropriate mean or height at least 2.25 standard deviations below the age-appropriate mean. 2) Subnormal response (less than 10 ng/mL) to two (2) of the following standard growth hormone stimulation tests: arginine, clonidine, glucagon, insulin, levodopa, propranolol. 3) Development of neutralizing antibodies to growth hormone product(s). 4) Member has open epiphyses.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation member has a growth velocity of at least 2 cm/year -AND- member has open epiphyses.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Ingrezza

Products Affected

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

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

Inlyta

Products Affected

- **INLYTA**

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

Inqovi

Products Affected

- **INQOVI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation chronic myelomonocytic leukemia. Documentation of 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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Inrebic

Products Affected

- **INREBIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate-2 or high-risk myelofibrosis per an accepted risk stratification tool for myelofibrosis (e.g., International Prognostic Scoring System [IPSS]) -AND- If a new start, baseline platelet count of greater than or equal to 50x10*9/L
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Baseline platelet count to be provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Insulin Supplies

Products Affected

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

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

Interferon Alfa

Products Affected

- **PEGASYS**

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

Interferon Beta

Products Affected

- **AVONEX INTRAMUSCULAR PEN INJECTOR KIT**
- **AVONEX INTRAMUSCULAR SYRINGE KIT**
- **BETASERON SUBCUTANEOUS KIT**
- **PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML**
- **PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML**
- **REBIF (WITH ALBUMIN)**
- **REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8MCG/0.2ML-22 MCG/0.5ML (6)**
- **REBIF TITRATION PACK**

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

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	
Part B Prerequisite	No

Intrarosa

Products Affected

- **INTRAROSA**

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

IPF Agents

Products Affected

- **ESBRIET ORAL CAPSULE**
- **ESBRIET ORAL TABLET**
- **OFEV**
- *pirfenidone oral capsule*
- *pirfenidone oral tablet*

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	For brand Esbriet, documentation of failure on generic pirfenidone tablets is required.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Iqirvo

Products Affected

- **IQIRVO**

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

Iressa

Products Affected

- *gefitinib*
- **IRESSA**

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

Itovebi

Products Affected

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

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

Itraconazole

Products Affected

- *itraconazole*
- **SPORANOX ORAL CAPSULE**

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	
Part B Prerequisite	No

Ivermectin Oral

Products Affected

- *ivermectin oral tablet 3 mg*
- **STROMECTOL**

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

Iwilfin

Products Affected

- **IWILFIN**

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

Jakafi

Products Affected

- **JAKAFI**

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

Jaypirca

Products Affected

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

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

Joenja

Products Affected

- **JOENJA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of activated phosphoinositide 3-kinase delta syndrome (APDS) with genetic confirmation of variant in PIK3CD or PIK3R1 gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Journavx

Products Affected

- **JOURNAVX**

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

Jynarque

Products Affected

- **JYNARQUE ORAL TABLET**
- **JYNARQUE ORAL TABLETS, SEQUENTIAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of rapidly progressing autosomal dominant polycystic kidney disease defined by one of the following: 1.) Historical decline in eGFR greater than or equal to 5mL/min/1.73 m*2 within a 12 month period. 2.) Decline in eGFR of greater than or equal to 2.5mL/min/1.73m*2 over a period of 5 years. 3.) 5% increase in total kidney volume per year by 3 repeat CT or MRI. 4.) Average kidney length greater than 16.5cm. 5.) Family history of end-stage renal disease before age 58. 6.) Mayo imaging classification of 1C, 1D, or 1E. 7.) Kidney bleeds.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, prescriber attestation of slowed decline of kidney function
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kalydeco

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
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	
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	
Part B Prerequisite	No

Kerendia

Products Affected

- **KERENDIA**

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

Kesimpta

Products Affected

- **KESIMPTA PEN**

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

Keveyis

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of one of the following: 1. Primary hyperkalemic periodic paralysis 2. Primary hypokalemic periodic paralysis 3. Related variants of primary periodic paralysis
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	2 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation the number of muscle weakness attacks per week has decreased from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kevzara

Products Affected

- **KEVZARA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For polymyalgia rheumatica (PMR), one of the following (1-3): 1) inadequate response to corticosteroids, 2) intolerance to corticosteroid taper, or 3) used in combination with corticosteroid tapering course. For juvenile idiopathic arthritis, weight greater than or equal to 63 kg -AND- one of the following (4-5): 4) inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide), or 5) requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	Deny if less than 18 years of age for rheumatoid arthritis and polymyalgia rheumatica.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR. For juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Rinvoz/Rinvoq LQ, Xeljanx/Xeljanz solution and Actemra SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Kineret

Products Affected

- **KINERET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For 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 therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kisqali

Products Affected

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

Klisyri

Products Affected

- **KLISYRI (250 MG)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of actinic keratosis of the face or scalp -AND- Therapeutic failure or intolerance to 1 of the following 1) generic topical imiquimod 5% cream 2) generic fluorouracil 5% topical cream 3) generic fluorouracil topical solution
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation that the member has previously experienced complete or partial clearance of actinic keratosis lesions with Klisyri -AND- additional course of therapy is required for recurrence of actinic keratosis -AND- member is restarting therapy at least 60 days after cessation of an initial Klisyri 5-day course.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Korlym

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hyperglycemia secondary to hypercortisolism in patients with endogenous Cushing's syndrome -AND- Patient is not a candidate for surgery or where surgery has failed -AND- one of the following (1 or 2): 1) Diagnosis of diabetes with trial and failure, intolerance, or contraindication to one previous therapy for Type 2 Diabetes (e.g. metformin, sulfonylureas, insulin) or using in addition to a therapy for Type 2 diabetes. 2) Glucose intolerance
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Korlym, a trial and failure of generic mifepristone is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 or older than 17 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Krazati

Products Affected

- **KRAZATI**

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

Kuvan

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of PKU -AND- documented baseline Phe level greater than 6 mg/dL -AND- clinical documentation of current weight -AND- sapropterin dihydrochloride dose does not exceed 20 mg/kg/day
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, initial therapy has resulted in decrease in phenylalanine levels from baseline or current phenylalanine levels within the range of 120-360 micromol/L -AND- clinical documentation of current weight is required -AND- sapropterin dihydrochloride dose does not exceed 20 mg/kg/day. For brand Kuvan, a trial and failure of generic sapropterin dihydrochloride is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Prescriber Restrictions	
Coverage Duration	2 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Latuda

Products Affected

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

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

Lazcluze

Products Affected

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

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

Lenvima

Products Affected

- **LENVIMA**

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

PA Criteria	Criteria Details
Part B Prerequisite	No

Leukine

Products Affected

- **LEUKINE INJECTION RECON SOLN**

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

Leukotriene Modifiers

Products Affected

- *zileuton*
- **ZYFLO**

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

Lidoderm

Products Affected

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

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

Litfulo

Products Affected

- **LITFULO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For severe alopecia areata, therapeutic failure/intolerance to an intralesional corticosteroid or high potency topical corticosteroid, or contraindication to all.
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	
Part B Prerequisite	No

Livdelzi

Products Affected

- **LIVDELZI**

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

Livmarli

Products Affected

- **LIVMARLI ORAL SOLUTION 19 MG/ML, 9.5 MG/ML**

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

Livtencity

Products Affected

- **LIVTENCITY**

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of CMV prophylaxis.
Required Medical Information	Documentation of refractory cytomegalovirus infection or disease as evidenced by antigenemia or polymerase chain reaction (PCR) test -AND- all of the following (1-3): 1) member weighs at least 35 kg, 2) member is a recipient of hematopoietic stem cell transplant -OR- solid organ transplant. 3) member has experienced therapeutic failure to one of the following: ganciclovir, valganciclovir, cidofovir, or foscarnet.
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of a previous reduction in CMV DNA level -AND- documentation of one of the following (1-3): 1) new onset symptomatic CMV infection, 2) virologic relapse with treatment-emergent maribavir resistance or 3) continued antiviral treatment is required to achieve virologic clearance.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lodoco

Products Affected

- **LODOCO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of established atherosclerotic disease (e.g., ASCVD, experienced CV event) or multiple risk factors for cardiovascular disease (e.g., high cholesterol, high blood pressure, obesity, diabetes, smoking) -AND- being used to reduce the risk of myocardial infarction, stroke, coronary revascularization, or cardiovascular death -AND- trial and failure of maximally tolerated statin or documentation of statin intolerance.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Lonsurf

Products Affected

- **LONSURF**

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

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lotronex

Products Affected

- *alosetron oral tablet 0.5 mg, 1 mg*
- **LOTRONEX ORAL TABLET 0.5 MG, 1 MG**

PA Criteria	Criteria Details
Exclusion Criteria	For irritable bowel syndrome (IBS): Exclude if male gender
Required Medical Information	Documentation of chronic severe diarrhea-predominant IBS -AND- trial and failure or intolerance to one anti-diarrheal (e.g. loperamide), anti-spasmodic, or tricyclic antidepressant, or contraindication to all
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 weeks initial authorization, 12 months reauthorization
Other Criteria	For brand Lotronex, initial authorization requires documentation of trial and failure of generic alosetron and reauthorization requires failure of generic alosetron if not previously trialed. For reauthorization, attestation that symptoms of IBS continue to persist AND positive clinical response.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lovaza

Products Affected

- **LOVAZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For hypertriglyceridemia, triglycerides greater than or equal to 500mg/dL indicating severe hypertriglyceridemia -AND- Therapeutic failure or intolerance to a prescription, generic omega 3 acid ethyl ester capsules
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, reduction in triglyceride levels from baseline for hypertriglyceridemia
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lumakras

Products Affected

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

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

Lumryz

Products Affected

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

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 18 years or older and 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	

PA Criteria	Criteria Details
Part B Prerequisite	No

Lupkynis

Products Affected

- **LUPKYNIS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of active lupus nephritis -AND- Documented positive ANA titer (greater than or equal to 1:80) or anti-dsDNA greater than or equal to 30 IU/mL -AND- Trial, contraindication, 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 -AND- Member will continue to receive concomitant standard of care treatment with corticosteroids (e.g. prednisone) and one of the following (1,2): 1) mycophenolic acid analog (e.g. mycophenolate mofetil), 2) azathioprine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lupron Depot Ped

Products Affected

- **LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG**
- **LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)**
- **LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of central precocious puberty -AND- advancement of bone age is beyond chronological age -AND- Basal luteinizing hormone (LH) level greater than 0.2-0.3 IU/L or leuprolide-stimulating LH level greater than 3.3-5 IU/L
Age Restrictions	Deny if greater than 8 years of age for females or greater than 9 years of age for males unless there is medical necessity for treatment of central precocious puberty
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive clinical response to therapy defined as pre-pubertal slowing/decline, normalization of FSH, normalization LH, normalization of bone age, normalization of bone age, normalization of estradiol level or normalization of testosterone level
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lybalvi

Products Affected

- **LYBALVI**

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

Lynparza

Products Affected

- **LYNPARZA**

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

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

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 partial-onset 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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lytgobi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following (1-2): 1) disease harbors FGFR2 fusions or other rearrangements 2) member has experienced therapeutic failure or intolerance to at least one prior therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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.
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)
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	
Part B Prerequisite	No

Mavyret

Products Affected

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

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

Mayzent

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use 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- Testing for CYP2C9 variants has confirmed member does not have CYP2C9*3/*3 genotype
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Megace

Products Affected

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

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

Mekinist

Products Affected

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

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

Mektovi

Products Affected

- **MEKTOVI**

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

Methamphetamine

Products Affected

- *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	
Part B Prerequisite	No

Metronidazole

Products Affected

- *metronidazole oral tablet 125 mg*

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

Metyrosine

Products Affected

- **DEMSER**
- *metyrosine*

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

Miplyffa

Products Affected

- **MIPLYFFA**

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Aqneursa (levacetylleucine) -AND- Miplyffa (arimoclomal)
Required Medical Information	Documentation of diagnosis -AND- neurological symptoms of Niemann-Pick Disease Type C (e.g., ataxia, dysarthria, dysphagia, cognitive impairment, seizures) -AND- concurrent use with miglustat.
Age Restrictions	Deny if less than 2 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	
Part B Prerequisite	No

Motegrity

Products Affected

- **MOTEGRITY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic idiopathic constipation -AND- Therapeutic failure, contraindication or intolerance to generic prucalopride.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Motpoly XR

Products Affected

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

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

MTX Injection

Products Affected

- **OTREXUP (PF)**
- **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. For rheumatoid arthritis and juvenile idiopathic arthritis, disease is classified as severe and active -AND- therapeutic failure or intolerance to first-line therapy (e.g., nonsteroidal anti-inflammatory drug [NSAID]). For psoriasis, disease is classified as severe, recalcitrant, and disabling -AND- therapeutic failure or intolerance to at least one (1) other standard psoriasis therapy (e.g., cyclosporine)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Myalept

Products Affected

- **MYALEPT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of congenital or acquired generalized lipodystrophy -AND- Leptin levels less than 8 ng/mL for males or less than 12 ng/mL for females -AND- the member has a diagnosis of diabetes or fasting insulin levels greater than 30uU/mL or fasting hypertriglyceridemia greater than 200mg/dL -AND- Therapeutic failure to one previous diabetes therapy (e.g. metformin, insulin) or hypertriglyceridemia therapy (e.g. statin, fibrate)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, decrease in HbA1c from baseline, decrease in fasting plasma glucose from baseline or decrease in fasting triglycerides from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Myasthenia Gravis

Products Affected

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

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

Mycapssa

Products Affected

- **MYCAPSSA**

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

Myfembree

Products Affected

- **MYFEMBREE**

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

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Namenda

Products Affected

- **NAMENDA TITRATION PAK**

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	
Part B Prerequisite	No

Namzaric

Products Affected

- *memantine-donepezil*
- **NAMZARIC**

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

Nayzilam

Products Affected

- **NAYZILAM**

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

Nemluvio

Products Affected

- **NEMLUVIO**

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

Nerlynx

Products Affected

- **NERLYNX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of early-stage, HER2-positive breast cancer -AND- meets all of the following: 1)member has received adjuvant trastuzumab-based therapy 2) member is using neratinib as a single agent. Documentation of advanced HER-2 positive, or metastatic HER2-positive breast cancer and meets all of the following 1) using neratinib in combination with capecitabine 2) member has received two or more prior anti-HER2 based regimens in the metastatic setting.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nexavar

Products Affected

- **NEXAVAR**
- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For locally recurrent or metastatic, progressive, differentiated thyroid carcinoma, refractory to radioactive iodine treatment
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Nexavar, documentation of trial and failure of generic sorafenib is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nexletol

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For HeFH, diagnosis supported by presence of causal mutation of FH by genetic testing OR untreated LDL-C greater than or equal to 190 mg/dL or untreated LDL-C greater than or equal to 160 mg/dL before 20 years of age with physical signs of FH (e.g. xanthomas, xanthelasma) OR diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or definite Simon Broome register criteria, or definite on the Make Early Diagnosis to Prevent Early Deaths tool -AND- LDL-C greater than 100 mg/dL -AND- Attestation of use in combination with other LDL-C lowering therapies or concomitant LDL-C lowering therapy is not possible -AND- Therapeutic failure to a maximally tolerated statin or documentation of statin intolerance -AND- Therapeutic failure, intolerance or contraindication to ezetimibe. For Hyperlipidemia with ASCVD or Hyperlipidemia with attestation of high risk for CVD, LDL-C greater than 70 mg/dL -AND- Therapeutic failure to a maximally tolerated statin or documentation of statin intolerance -AND- Therapeutic failure, intolerance or contraindication to ezetimibe. For Primary Hyperlipidemia not associated with ASCVD or HeFH, LDL-C greater than 70 mg/dL -AND- Attestation of use in combination with other LDL-C lowering therapies or concomitant LDL-C lowering therapy is not possible -AND- Therapeutic failure to a maximally tolerated statin or documentation of statin intolerance -AND- Therapeutic failure, intolerance or contraindication to ezetimibe.
Age Restrictions	
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 from baseline -AND- for HeFH and Primary Hyperlipidemia (not associated with ASCVD or HeFH), attestation of continued use in combination with other LDL-C lowering therapies or concomitant LDL-C lowering therapy is not possible. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statin which resolved upon discontinuation of statin or documentation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ninlaro

Products Affected

- **NINLARO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of multiple myeloma -AND- previous treatment with at least 1 prior therapy -AND- used in combination with lenalidomide and dexamethasone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nitisinone

Products Affected

- *nitisinone*
- **NITYR**
- **ORFADIN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hereditary tyrosinemia type 1 (HT-1) confirmed by biochemical or genetic testing -AND- dietary restriction of tyrosine and phenylalanine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Nityr and Brand Orfadin capsule, documentation of failure on generic nitisinone capsules is required. For Orfadin suspension, documentation of failure on generic nitisinone capsules or an inability to swallow capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Northera

Products Affected

- *droxidopa oral capsule 100 mg, 200 mg, 300 mg*
- **NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
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	3 months
Other Criteria	For brand Northera, initial authorization requires documentation of trial and failure of generic droxidopa and reauthorization requires failure of generic droxidopa if not previously trialed. For reauthorization, attestation of increase from baseline of systolic or diastolic blood pressure upon standing -OR- attestation of decrease from baseline of neurogenic orthostatic hypotension symptoms upon standing (e.g., dizziness, feeling faint, etc.).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nourianz

Products Affected

- **NOURIANZ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease experiencing off episodes -AND- Used as adjunct to levodopa/carbidopa -AND- trial/failure, contraindication or intolerance to one of the following generic products: ropinirole, pramipexole, entacapone, selegiline, or rasagiline
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nubeqa

Products Affected

- **NUBEQA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of non-metastatic castration-resistant prostate cancer -AND- one of the following (1-2): 1) using in combination with a GnRH analog 2) member has had a bilateral orchiectomy. Documentation of metastatic hormone-sensitive prostate cancer -AND- will be using in combination with docetaxel -AND- one of the following (1-2): 1) using in combination with a GnRH analog 2) member has had a bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nucala

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of severe asthma and all of the following (1-4): 1) history of at least 2 asthma exacerbations requiring oral or injectable corticosteroid treatment in past 12 mos or at least 1 asthma exacerbation requiring hospitalization in past 12 mos 2) Blood eosinophils greater than or equal to 150cells/uL within past 6 wks or greater than or equal to 300cells/uL within past 12 mos without other potential causes of eosinophilia (e.g. hypereosinophilic syndromes, neoplastic disease, known suspected parasitic infection) 3) inadequate symptom control despite regular treatment with medium or high dose inhaled corticosteroid (ICS) and at least 1 add'l asthma controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline), with or without oral corticosteroids (OCS) 4) will continue treatment with medium or high dose ICS and at least 1 add'l asthma controller medication, with or without OCS -OR- Documentation of eosinophilic granulomatosis with polyangiitis (EGPA) with history of relapsing or refractory disease and will be receiving concomitant glucocorticoid treatment with or without immunosuppressive therapy -OR- Diagnosis of hypereosinophilic syndrome (HES) without identifiable non-hematologic secondary cause for greater than or equal to 6 mos and both of the following (5-6): 5) At least 2 HES flares (HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy) within past 12 mos 6) Stable on HES therapy for at least 4 wks (chronic or episodic OCS, immunosuppressive or cytotoxic therapy) -OR- Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) and trial/failure, contraindication, or intolerance to intranasal corticosteroid.
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	For Severe Asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of severe asthma exacerbation, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For EGPA reauthorization, attestation of one of the following is required (5-8): 5) reduction in frequency and/or severity of relapses, 6) reduction or discontinuation of corticosteroids and/or immunosuppressant, 7) disease remission, or 8) reduction in severity or frequency of EGPA-related symptoms. For HES reauthorization, attestation of one of the following is required (9-10): 9) reduction in frequency of HES flares, or 10) maintenance or reduction in background HES therapy requirements. For CRSwNP reauthorization, attestation of one of the following is required (11-12): 11) decrease in nasal polyp score, or 12) reduction in nasal congestion/obstruction severity score.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nuedexta

Products Affected

- **NUEDEXTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation supporting improvement in symptoms is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nuplazid

Products Affected

- **NUPLAZID**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hallucinations and delusions associated with Parkinson's disease psychosis
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nurtec

Products Affected

- **NURTEC ODT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For Episodic Migraine Prevention, defined as 4-14 migraine days 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 acute treatment of migraine with or without aura, trial and failure of one generic triptan.
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 of episodic migraine prevention, attestation of reduction in migraine frequency. For reauthorization of acute treatment of migraine, attestation of reduction in migraine symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nuvigil

Products Affected

- *armodafinil*
- **NUVIGIL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of shift work sleep disorder (SWSD) substantiated by excessive sleepiness or insomnia that is temporarily associated with a recurring work schedule that overlaps the usual time for sleep -AND- Symptoms are accompanied by a reduction of total sleep time -AND- Symptoms experienced for at least 3 months -AND- Sleep log or actigraphy monitoring for at least 14 days including both work and free days -AND- Sleep disturbance is not better explained by another current sleep disorder, medical or neurological disorder, mental disorder, medication use, or substance use disorder. 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 or equal to 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than or equal to 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

PA Criteria	Criteria Details
Other Criteria	For reauthorization, provider attestation of improvement in daytime sleepiness is required. For brand Nuvigil, documentation of failure on modafinil (generic Provigil).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ocaliva

Products Affected

- **OCALIVA**

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

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- therapeutic failure or cannot be treated with surgical resection, pituitary irradiation or bromocriptine mesylate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization of acromegaly, decreased or normalized IGF-1 from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Odactra

Products Affected

- **ODACTRA**

PA Criteria	Criteria Details
Exclusion Criteria	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy
Required Medical Information	Documentation of allergic rhinitis due to house dust mites -AND- allergic rhinitis with or without conjunctivitis has been confirmed by skin testing for licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to D. pteronyssinus or D. Farina -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
Age Restrictions	Deny if less than 5 years of age or greater than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector. For reauthorization, attestation of improved allergy symptoms is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ogsiveo

Products Affected

- **OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of progressing desmoid tumor(s) requiring systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ohtuvayre

Products Affected

- **OHTUVAYRE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of chronic obstructive pulmonary disease (COPD) -AND- Inadequate symptom control despite regular treatment for at least 3 months of at least two maintenance COPD controllers (e.g. LABA/LAMA, LAMA/LABA/ICS), or intolerance/contraindication to these agents.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Ohtuvayre covered under Part B when using via nebulizer in the home setting.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ojemda

Products Affected

- **OJEMDA ORAL SUSPENSION FOR RECONSTITUTION**
- **OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4), 500 MG/WEEK (100 MG X 5), 600 MG/WEEK (100 MG X 6)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory pediatric low-grade glioma -AND- one of the following (1-2): 1) BRAF fusion or rearrangement, or 2) BRAF V600K mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ojjaara

Products Affected

- **OJJAARA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis -AND- attestation of anemia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Olpruva

Products Affected

- **OLPRUVA ORAL PELLETS IN PACKET 2 GRAM, 3 GRAM, 4 GRAM, 5 GRAM, 6 GRAM, 6.67 GRAM**

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of acute hyperammonemia in urea cycle disorders
Required Medical Information	Documentation of chronic management of urea cycle disorders involving deficiencies of carbamylphosphate synthetase, argininosuccinic acid synthetase, or ornithine transcarbamylase -AND- use as an adjunctive therapy to dietary management.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure of generic sodium phenylbutyrate is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Olumiant

Products Affected

- **OLUMIANT**

PA Criteria	Criteria Details
Exclusion Criteria	Part A covered for Covid-19 in hospitalized patients
Required Medical Information	Documentation of diagnosis. For moderate to severely active rheumatoid arthritis an inadequate response or intolerance to at least one non-biologic DMARD (e.g., methotrexate, leflunomide). For severe alopecia areata, inadequate response or intolerance to an intralesional corticosteroid or high potency topical corticosteroid, or contraindication to all.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis and Alopecia Areata
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR, with at least 1 being a tumor necrosis factor blocker. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Omvoh

Products Affected

- **OMVOH PEN SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 300MG/3ML(100MG /ML-200 MG/2ML)**
- **OMVOH SUBCUTANEOUS SYRINGE 100 MG/ML, 300MG/3ML(100MG /ML-200 MG/2ML)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation of receiving or currently undergoing 3 doses of IV Omvoh within 3 months of initiating therapy with Omvoh SC.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For moderate to severe ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq, Xeljanz/Xeljanz XR, Skyrizi SC and Stelara SC. For moderate to severe active Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq, Skyrizi SC, and Stelara SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Onapgo

Products Affected

- **ONAPGO**

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

Onfi

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- **ONFI ORAL SUSPENSION**
- **ONFI ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- therapeutic failure or intolerance of a previous antiepileptic therapy
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ongentys

Products Affected

- **ONGENTYS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease experiencing off episodes -AND- Used as adjunct to levodopa/carbidopa -AND- trial/failure, contraindication or intolerance to the following (1. and 2.): 1) entacapone 2) one of the following generic products: rasagiline, pramipexole, ropinirole, selegiline
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Onyda XR

Products Affected

- **ONYDA XR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of ADHD -AND- trial/failure, intolerance or contraindication to a stimulant
Age Restrictions	Deny if less than 6 years of age or greater than 17 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Inability to swallow tablets or capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ophthalmic Antihistamines

Products Affected

- *bepotastine besilate*
- **BEPREVE**
- **ZERVIATE**

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

Opipza

Products Affected

- **OPIPZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- 1 of the following (1-2): 1) intolerance to generic aripiprazole tablets, 2) inability to swallow oral tablets. If medication is being used for major depressive disorder, documentation of adjunctive therapy and therapeutic failure, contraindication or intolerance to one other generic antidepressant in addition to the antidepressant currently being used for the treatment of MDD (e.g. SSRI, SNRI, NDRIs, TCA, MAOI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Opzelura

Products Affected

- **OPZELURA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-4): 1) mild to moderate atopic dermatitis (AD), 2) attestation of up to 20 percent of body surface area (excluding scalp) with AD involvement, 3) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- documentation of facial or anogenital involvement, 4) trial & failure, intolerance, or contraindication to topical generic tacrolimus or topical generic pimecrolimus -OR- Documentation of all of the following (5-7): 5) Nonsegmental vitiligo, 6) body surface area with vitiligo involvement does not exceed 10%, 7) trial & failure or intolerance to at least 1 generic, formulary high or ultrahigh potency topical corticosteroid -OR- vitiligo with facial or anogenital involvement
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	Initial authorization: 8 weeks for AD, 24 weeks for vitiligo. Reauthorization: 12 months
Other Criteria	For reauthorization, attestation of positive clinical response to therapy for atopic dermatitis -OR- meaningful repigmentation of affected areas for vitiligo
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Orencia

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For 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 or less than 2 years of age for Juvenile Idiopathic Arthritis and Psoriatic Arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients over 18 years of age must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Cosentyx, Xeljanz/Xeljanz XR, Otezla and Stelara SC, Rinvoq, and Skyrizi SC. For juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Xeljanx/Xeljanz solution and Actemra SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Orgovyx

Products Affected

- **ORGOVYX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced prostate cancer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Oriahnn

Products Affected

- **ORIAHNN**

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of severe hepatic impairment or osteoporosis.
Required Medical Information	Documentation of premenopausal woman with uterine leiomyomas -AND- Experiencing heavy menstrual bleeding -AND- For women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or with out estrogen and progestin does not exceed 24 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 18 months reauthorization
Other Criteria	For reauthorization, attestation of continued experience of heavy menstrual bleeding -AND- Attestation of decrease in menstrual blood loss -AND- for women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or without estrogen and progestin does not exceed 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Orilissa

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of severe hepatic impairment or osteoporosis.
Required Medical Information	Documentation of premenopausal woman with diagnosis of endometriosis with moderate to severe pain -AND- For women of childbearing age, attestation of not pregnant -AND- Inadequate response, failure or contraindication to 2 standard of care treatments (e.g. NSAIDS, combined hormonal contraceptives, progestin, GnRH agonist, Danazol) -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or with out estrogen and progestin does not exceed 24 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 18 months reauthorization
Other Criteria	For reauthorization, Orilissa is continued to be used for pain associated with endometriosis -AND- attestation of reduction in pain -AND- For women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or without estrogen and progestin does not exceed 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Orkambi

Products Affected

- **ORKAMBI ORAL GRANULES IN PACKET**
- **ORKAMBI ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis and homozygous F508del mutation
Age Restrictions	
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	
Part B Prerequisite	No

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 attacks of hereditary angioedema (HAE) type I & II with the following (1-3): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. For the prophylactic treatment of attacks of hereditary angioedema (HAE) type III with the following (4-7): 4) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 5) Documentation of family history of HAE or FXII mutation 6) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 7) Medications known to cause angioedema have been evaluated and discontinued.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Orserdu

Products Affected

- **ORSERDU ORAL TABLET 345 MG, 86 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following (1-4): 1) member is male or a postmenopausal female 2) tumor status is ER-positive, HER2-negative 3) an ESR1 gene mutation is present in the tumor 4) member has experienced disease progression on or after an endocrine based regimen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Osphena

Products Affected

- **OSPHENA**

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

OTEZLA

Products Affected

- **OTEZLA** **(47)**
- **OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For plaque psoriasis, all of the following (1-2): 1) if the member is greater than or equal to 6 years of age and less than 18 years, weight is greater than or equal to 20 kg and member has moderate-to-severe disease -AND- 2) inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For oral ulcers associated with Behcet's Disease, inadequate response or intolerance to one systemic therapy for prevention of recurrent oral ulcers
Age Restrictions	Deny if less than 6 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Palynziq

Products Affected

- **PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML, 2.5 MG/0.5 ML, 20 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of phenylketonuria -AND- all of the following criteria (1-3): 1) Baseline Phe level greater than 600 micromoles/L, 2) Failure or intolerance to existing management (i.e. sapropterin dihydrochloride), 3) Has a prescription for epinephrine agent unless contraindicated.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of reduction in baseline pretreatment Phe levels -OR- blood Phe levels are less than or equal to 600 micromoles/L -OR- attestation that additional therapy with Palynziq is needed to allow adequate trial of maximum dose of 60mg per day for 16 weeks or member is not currently on 60mg per day dose.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Panretin

Products Affected

- **PANRETIN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous lesions in patients with AIDS-related Kaposi Sarcoma (KS) who are not receiving systemic therapy for KS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Pemazyre

Products Affected

- **PEMAZYRE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of unresectable locally advanced cholangiocarcinoma or metastatic cholangiocarcinoma -AND- all of the following (1-2): 1) disease harbors FGFR2 fusion or other rearrangement as detected by an FDA-approved test 2) member has experienced therapeutic failure or intolerance to at least on prior therapy. Documentation of relapsed or refractory myeloid/lymphoid neoplasms -AND- disease harbors an FGFR1 rearrangement.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Pheburane

Products Affected

- **PHEBURANE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- therapeutic failure or intolerence to generic sodium phenylbutyrate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Phenoxybenzamine

Products Affected

- **DIBENZYLINE**
- *phenoxybenzamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of excessive sweating and hypertension associated with pheochromocytoma supported by one of the following (1. or 2.): 1. Elevated metanephrines in plasma or urine. 2. Tumor evidence from CT scan or MRI
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Phospholine Iodide

Products Affected

- **PHOSPHOLINE IODIDE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For diagnosis of elevated intraocular pressure (IOP), the following criteria apply (1 and 2): therapeutic failure or intolerance to generic latanoprost, 2) therapeutic failure, contraindication, or intolerance to one generic ophthalmic alternative that lowers IOP (a. through f.): a) prostaglandin analog, b) ophthalmic beta-blocker, c) alpha-adrenergic agonist, d) carbonic anhydrase inhibitor, e) ophthalmic cholinergic agonist, f) combination products of these classes
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Piqray

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) HR-positive, HER2-negative tumor status, 2) PIK3CA mutation positive as detected by an FDA-approved test, 3) disease progression on or after an endocrine-based regimen, 4) Concomitant therapy with fulvestrant
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Posaconazole Powder Packet

Products Affected

- **NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For aspergillus or candida infection prophylaxis, high risk of developing invasive Aspergillosis or Candidiasis infection due to being severely immunocompromised (e.g., hematopoietic stem cell transplant recipients with graft versus host disease, those with hematologic malignancies with prolonged neutropenia from chemotherapy) -AND- weight less than or equal to 40 kg.
Age Restrictions	Deny if less than 2 years of age or greater than 17 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Posaconazole Suspension

Products Affected

- **NOXAFIL ORAL SUSPENSION**
- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For aspergillus or candida infection prophylaxis, high risk of developing invasive Aspergillosis or Candidiasis infection due to being severely immunocompromised (e.g., hematopoietic stem cell transplant recipients with graft versus host disease, those with hematologic malignancies with prolonged neutropenia from chemotherapy). For oropharyngeal candidiasis treatment, trial/failure or intolerance to generic fluconazole or generic itraconazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of failure on generic posaconazole delayed-release tablets or an inability to swallow tablets is required when being utilized for the same FDA approved indication. For brand Noxafil oral suspension, therapeutic failure or intolerance to generic posaconazole oral suspension is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Posaconazole Tablet

Products Affected

- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For aspergillus or candida infection prophylaxis, high risk of developing invasive Aspergillosis or Candidiasis infection due to being severely immunocompromised (e.g., hematopoietic stem cell transplant recipients with graft versus host disease, those with hematologic malignancies with prolonged neutropenia from chemotherapy) -AND- weight greater than 40 kg. For invasive aspergillosis infection, trial/failure or contraindication to voriconazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Praluent

Products Affected

- **PRALUENT PEN**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with another PCSK9 inhibitor or siRNA directed to PCSK9.
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 definite on Simon Broome register, or definite on the Make Early Diagnosis to Prevent Early Deaths tool AND LDL-C greater than 100 mg/dL if 18 and older or LDL-C greater than 130 if 17 and younger despite use of maximally tolerated statin or statin intolerance. If 17 and younger will continue to receive concurrent lipid-lowering therapies. 3.Hypercholesterolemia ASCVD or Primary Hyperlipidemia AND LDL-C greater than 70 mg/dL despite use of maximally tolerated statin or statin intolerance
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization

PA Criteria	Criteria Details
Other Criteria	For HoFH and Hypercholesterolemia with ASCVD, patients must have a trial/failure or contraindication to the preferred product Repatha . For HeFH and 10 years and older, patients must have a trial/failure or contraindication to the preferred product Repatha. For reauthorization, documentation showing an LDL-C reduction on Praluent therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Prescription Drug Combo

Products Affected

- *acetaminophen-codeine oral solution 120-12 mg/5 ml*
- *acetaminophen-codeine oral tablet*
- **ALPRAZOLAM INTENSOL**
- *alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg*
- *alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- **AMBIEN**
- **AMBIEN CR**
- **ASCOMP WITH CODEINE**
- **ATIVAN ORAL TABLET 0.5 MG, 1 MG, 2 MG**
- **BELBUCA**
- *buprenorphine*
- *butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg*
- **BUTRANS**
- *chlordiazepoxide hcl*
- *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- *clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg*
- *codeine sulfate*
- *codeine-butalbital-asa-caff*
- **CONZIP**
- **DEMEROL (PF) INJECTION SYRINGE 25 MG/ML**
- **DEMEROL INJECTION**
- **DIAZEPAM INTENSOL**
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*
- *diazepam oral tablet*
- **DILAUDID ORAL LIQUID**
- **DILAUDID ORAL TABLET 2 MG, 4 MG, 8 MG**
- **EDLUAR**
- **ENDOCET**
- *estazolam*
- *eszopiclone*
- *fentanyl*
- **FIORICET WITH CODEINE**
- *flurazepam*
- **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 10-325 mg/15 ml, 7.5-325 mg/15 ml*
- *hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg*
- *hydrocodone-ibuprofen*
- *hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml*
- *hydromorphone oral liquid*
- *hydromorphone oral tablet 2 mg, 4 mg, 8 mg*
- *hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg*
- **HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG**
- **KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG**
- *levorphanol tartrate*
- **LORAZEPAM INTENSOL**
- *lorazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- **LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1 MG, 1.5 MG, 2 MG, 3 MG**
- **LUNESTA**
- *meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*
- *meperidine oral solution*
- *meperidine oral tablet 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 15 MG, 30 MG, 60 MG**
- **NALOCET**
- **NUCYNTA**
- **NUCYNTA ER**
- *oxazepam*
- *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*
- *oxycodone-acetaminophen oral solution 5-325 mg/5 ml*
- *oxycodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg*
- **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 SOLUTION**
- **PROLATE ORAL TABLET**
- **RESTORIL**
- **ROXICODONE ORAL TABLET 15 MG, 30 MG**
- **ROXYBOND**
- *temazepam*
- *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, 25 mg, 50 mg, 75 mg*
- *tramadol oral tablet extended release 24 hr*
- *tramadol-acetaminophen*
- *triazolam*
- **VALIUM**
- **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**
- *zaleplon oral capsule 10 mg, 5 mg*
- *zolpidem*

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	For concomitant use of an opiate agonist and substance abuse therapy, documentation that the member has 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, attestations that non-opiate therapies (e.g. NSAIDs) and non-benzodiazepine therapies (e.g. SSRI, SNRI) have been considered, 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, sedative-hypnotics) attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For long acting (e.g. extended release) opioid medications, the following apply (1-5). 1)Pain is severe enough to require daily, around-the-clock, long-term opioid treatment. 2)Patient is not opioid naive. 3)Attestation that non-opiate alternative therapies have been explored (e.g. NSAIDs). 4)Attestation that controlled substance Rx history has been reviewed in the state Prescription Drug Monitoring Program. 5)Attestation of counseling on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Opiate tx for pain+subs. abuse, approve opiate x 1mo. All other combos and dx 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 with a centrally acting skeletal muscle relaxant (e.g., carisoprodol) OR a gabapentinoid OR a sedative-hypnotic. Benzodiazepines (e.g. triazolam, alprazolam) will receive automatic approval if no recent claims for an opiate agonist with a centrally acting skeletal muscle relaxant (e.g. carisoprodol). Sedative-hypnotics (e.g. zolpidem) will receive automatic approval if no recent claims for an opiate agonist. Infusible opiate agonists will be covered under Part B when administered via infusion pump.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Pretomanid

Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. Criteria will be applied consistent with current ATS/CDC/ERS/IDSA Clinical Practice Guideline (Saukkonen JJ, Duarte R, Munsiff S, et al. Updates on the Treatment of Drug-Susceptible and Drug-Resistant Tuberculosis: An Official ATS/CDC/ERS/IDSA Clinical Practice Guideline. Am J Respir Crit Care Med 2025:211 (2):15-33.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of disease improvement -AND- member requires additional antimicrobial therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Prevymis Oral Pellets

Products Affected

- **PREVYMIS ORAL PELLETS IN PACKET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	Deny if less than 6 months of age with HSCT. Deny if less than 12 years of age with kidney transplant.
Prescriber Restrictions	
Coverage Duration	7 months
Other Criteria	One of the following is required (1-2): 1) inability to swallow tablets, 2) unable to use Prevymis (letermovir) tablets due to body weight dosing limitations.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Prolia

Products Affected

- **PROLIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -And- For osteoporosis at high risk for fracture, meeting one of the following (1. thru 4.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 (i.e. osteopenia) -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 40 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For osteoporosis and osteopenia, documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Covered under Part B for patients eligible for home health services when provider certifies that patient sustained bone fracture related to post-menopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Provigil

Products Affected

- *modafinil*
- **PROVIGIL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of shift work sleep disorder (SWSD) substantiated by excessive sleepiness or insomnia that is temporarily associated with a recurring work schedule that overlaps the usual time for sleep -AND- Symptoms are accompanied by a reduction of total sleep time -AND- Symptoms experienced for at least 3 months -AND- Sleep log or actigraphy monitoring for at least 14 days including both work and free days -AND- Sleep disturbance is not better explained by another current sleep disorder, medical or neurological disorder, mental disorder, medication use, or substance use disorder. 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 or equal to 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than or equal to 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

PA Criteria	Criteria Details
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.
Off Label Uses	Fatigue associated with Multiple Sclerosis (MS)
Part B Prerequisite	No

Prucalopride

Products Affected

- *prucalopride*

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

Pulmonary Arterial Hypertension

Products Affected

- **ADCIRCA**
- **ADEMPAS**
- **ALYQ**
- *ambrisentan*
- *bosentan oral tablet*
- **LETAIRIS**
- **OPSUMIT**
- **OPSYNVI**
- **ORENITRAM MONTH 1 TITRATION KT**
- **ORENITRAM MONTH 2 TITRATION KT**
- **ORENITRAM MONTH 3 TITRATION KT**
- **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG**
- **REVATIO ORAL TABLET**
- *sildenafil (pulm.hypertension) oral suspension for reconstitution*
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*
- **TADLIQ**
- **TRACLEER ORAL TABLET**
- **TRACLEER ORAL TABLET FOR SUSPENSION**
- **TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 48 MCG, 64 MCG**
- **UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**
- **UPTRAVI ORAL TABLETS,DOSE PACK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization (RHC), defined as a mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than or equal to 3 Wood units -AND- WHO Group. For bosentan and sildenafil (i.e. Revatio) in pediatric individuals, an exception to RHC will be allowed when the risk of RHC outweighs the benefit -AND- prescriber attests alternative studies have been completed (i.e. CT, MRI or specified test ruling out other causes of pulmonary hypertension). For Adempas, additional diagnosis of CTEPH as documented by right heart catheterization and V/Q scan substantiating mPAP greater than 20 mmHg at rest and PWP less than or equal to 15 mmHg and documented presence of occlusive thrombi within the pulmonary arteries will be approved.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Adcirca, trial and failure of generic tadalafil or Alyq is required. For brand Letairis, trial and failure of generic ambrisentan is required. For brand Revatio, trial and failure of generic sildenafil is required. For brand Tracleer 62.5mg and 125mg, trial and failure of generic bosentan is required. For brand Tadliq, trial and failure of generic tadalafil or Alyq - OR- Inability to swallow tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Pulmozyme

Products Affected

- **PULMOZYME**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis -AND- Used in conjunction with standard therapies for management of cystic fibrosis to improve pulmonary function.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Inhalation solutions covered under Part B when administered in the home setting using a covered nebulizer (i.e. DME). For reauthorization, attestation of increase in FEV1 or decrease in number of hospitalizations or pulmonary exacerbations.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Purified Cortrophin Gel

Products Affected

- **CORTROPHIN GEL INJECTION**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Covered for the following indications: 1. Acute exacerbations of multiple sclerosis (MS) for patients receiving concurrent immunomodulator therapy 2. Rheumatic disorders for patients receiving maintenance therapy 3. Collagen diseases for members receiving maintenance therapy 4. Dermatologic diseases, if using for severe psoriasis, then the member is concurrently receiving maintenance therapy 5. Allergic states (i.e. serum sickness and transfusion reaction due to serum protein reaction), if using for atopic dermatitis, then the member is concurrently receiving maintenance therapy 6. Ophthalmic diseases 7. Respiratory diseases 8. Gout and unable to take first-line therapies. 9. Pediatric acquired epileptic aphasia. 10. Proteinuria in nephrotic syndrome and trial/failure or contraindication to two therapies from any of the following different classes: corticosteroids (e.g., cortisone or dexamethasone), calcineurin inhibitors (e.g., cyclosporine or tacrolimus, per DRUGDEX). For covered indications 1 through 9, limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (i.e. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month

PA Criteria	Criteria Details
Other Criteria	For reauthorization, the following (1. 2. and 3.) must be met. 1) Prescriber attestation that the member cannot use corticosteroids (e.g. IV methylprednisolone, high dose oral corticosteroids) due to unsatisfactory response, intolerance (e.g. severe anaphylaxis) or experienced a severe adverse event to corticosteroids (e.g. psychosis). 2) If the reauthorization is for the treatment of multiple sclerosis, a rheumatic disorder, dermatologic disease, or nephrotic syndrome, the prescriber attests that Cortrophin is being used for a new acute exacerbation and not on a routine basis to prevent an exacerbation as supported by Compendia. 3) If the reauthorization is for treatment of multiple sclerosis, a rheumatic disorder, or collagen disease, the member continues to receive maintenance therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Epileptic Aphasia
Part B Prerequisite	No

Pyrukynd

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hemolytic anemia with pyruvate kinase deficiency, as supported by one of the following (1-2): 1) mutations in the PKLR gene, 2) reduced activity of the pyruvate kinase enzyme.
Age Restrictions	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 increase in hemoglobin level from baseline -OR- decrease in transfusion burden from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Qelbree

Products Affected

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

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

Qinlock

Products Affected

- **QINLOCK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced gastrointestinal stromal tumor -AND- Prior treatment with imatinib and 2 other kinase inhibitors.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Quinine

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	Treatment or prevention of leg cramps
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	10 days
Other Criteria	Doses for duration greater than 10 days will not be approved
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Qulipta

Products Affected

- **QULIPTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, of which 8 or more are migraine days. The following criteria will apply (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound (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 migraine frequency
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Radicava ORS

Products Affected

- **RADICAVA ORS STARTER KIT SUSP**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of amyotrophic lateral sclerosis (ALS) -AND- Therapeutic failure, intolerance, or contraindication to riluzole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of experiencing stability or improvement of symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ravicti

Products Affected

- **RAVICTI**

PA Criteria	Criteria Details
Exclusion Criteria	Urea cycle disorders due to N-acetylglutamate synthetase deficiency, Treatment of acute hyperammonemia in urea cycle disorders
Required Medical Information	Documentation of chronic management of a urea cycle disorders (UCDs)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	For reauthorization, one of the following (1-2): 1) documentation of decrease in ulcer(s) size without complete ulcer(s) closure -OR- 2) documentation of new lower extremity diabetic neuropathic ulcer(s) that extends into the subcutaneous tissue or beyond with an adequate blood supply, attestation of being used as an adjunct to standard ulcer care practices, and attestation of a wound care plan.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Relistor

Products Affected

- **RELISTOR ORAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation (OIC) due to any of the following (1-2): 1) chronic non-cancer pain, or 2) chronic pain related to prior cancer or its treatment who do not require frequent (e.g. weekly) opioid dosage escalation -AND- documentation of opioid medication use -AND- trial and failure, contraindication, or intolerance to 2 of the following (3-5): 3) Laxatives, 4) lubiprostone, 5) Movantik
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Relistor SC

Products Affected

- **RELISTOR SUBCUTANEOUS SOLUTION**
- **RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation (OIC) due to any of the following (1-3): 1) chronic non-cancer pain, 2) advanced illness or active cancer in palliative care or 3) chronic pain related to prior cancer or its treatments who do not require frequent (e.g., weekly) opioid dosage escalation -AND- documentation of opioid medication use -AND- trial and failure, contraindication, or intolerance to 2 of the following (4 to 6): 4) Laxatives 5) lubiprostone 6) Movantik.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Repatha

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with another PCSK9 inhibitor or siRNA directed to PCSK9.
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 definite on Simon Broome register, or definite on the Make Early Diagnosis to Prevent Early Deaths tool, AND LDL-C greater than 100 mg/dL if 18 and older or LDL-C greater than 130 if 17 and younger despite use of maximally tolerated statin or statin intolerance. If 17 and younger will continue to receive concurrent lipid-lowering therapies. 3.Hypercholesterolemia ASCVD or Primary Hyperlipidemia AND LDL-C greater than 70 mg/dL despite use of maximally tolerated statin or statin intolerance
Age Restrictions	
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 Repatha therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Retevmo

Products Affected

- **RETEVMO ORAL CAPSULE 40 MG, 80 MG**
- **RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic non-small cell lung cancer -AND- disease is classified as RET gene fusion as detected by an FDA approved test. Documentation of advanced or metastatic medullary thyroid cancer -AND- disease is classified as RET mutation as detected by an FDA approved test. Documentation of advanced or metastatic thyroid cancer -AND- all of the following (1-2): 1) disease is classified as RET gene fusion as detected by an FDA approved test 2) if radioactive iodine is appropriate for the member, the member is radioactive iodine-refractory. Documentation of locally advanced or metastatic solid tumor(s) -AND- disease harbors a RET gene fusion, as detected by an FDA-approved test -AND- one of the following (1-2): 1) the member has no satisfactory alternative treatments 2) the member's tumors have progressed following prior systemic treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Revlimid

Products Affected

- *lenalidomide*
- **REVLIMID**

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of chronic lymphocytic leukemia outside of a controlled clinical trial
Required Medical Information	Diagnosis of multiple myeloma in combination with dexamethasone -OR- diagnosis of multiple myeloma, as maintenance following autologous hematopoietic stem cell transplant (auto-HSCT) -OR- diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities -OR- diagnosis of mantle cell lymphoma (MCL) in which disease has relapsed or progressed after two prior therapies, one of which included bortezomib -OR- diagnosis of follicular lymphoma in combination with a rituximab product after previous treatment -OR- diagnosis of marginal zone lymphoma in combination with a rituximab product after previous treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Revlimid, documentation of trial and failure of generic lenalidomide is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Revuforj

Products Affected

- **REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rexulti

Products Affected

- **REXULTI ORAL TABLET**

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

Reyvow

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute migraine headaches with or without aura -AND- Therapeutic failure, contraindication or intolerance to one generic triptan
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in migraine symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rezdiffra

Products Affected

- **REZDIFFRA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in conjunction with diet and exercise. Diagnosis of NASH confirmed by a liver biopsy or non-invasive tests (NITs) performed within the previous 6 months indicating F2 or F3 fibrosis -AND- member does not have any evidence of cirrhosis, hepatic decompensation, or hepatocellular carcinoma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of continued use in conjunction with diet and exercise -AND- member has experienced stabilization of fibrosis as demonstrated by NIT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rezlidhia

Products Affected

- **REZLIDHIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA approved test
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rezurock

Products Affected

- **REZUROCK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic graft-versus-host disease (cGVHD) -AND- therapeutic failure or intolerance to 2 lines of systemic therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Riluzole

Products Affected

- **TIGLUTIK**

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

Rinvoq

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe active rheumatoid arthritis, an inadequate response or intolerance to at least one non-biologic DMARD (e.g., leflunomide, methotrexate) or all non-biologic DMARDs are contraindicated. For moderate to severe refractory atopic dermatitis whose disease is not adequately controlled with other systemic drug products, documentation of one of the following (1 or 2): 1) trial & failure, or intolerance to at least one topical corticosteroid -OR- topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus) 2) The member has severe atopic dermatitis and is incapable of applying topical therapies due to the extent of body surface area involvement or topical therapies are contraindicated due to severely damaged skin. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For Non-radiographic Axial Spondyloarthritis, trial & failure or intolerance to two nonsteroidal anti-inflammatory drugs (NSAIDs) or contraindication to all. For juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or all non-biologic DMARDs are contraindicated or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For diagnoses in which tumor necrosis factor (TNF) blockers are also indicated (e.g., Rheumatoid Arthritis, Psoriatic Arthritis), the member has experienced therapeutic failure or intolerance to at least 1 TNF blocker.

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

Rinvoq LQ

Products Affected

- **RINVOQ LQ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or all non-biologic DMARDs are contraindicated or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	For PsA, deny if 18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	The member has experienced therapeutic failure or intolerance to at least 1 tumor necrosis factor (TNF) blocker.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rivfloza

Products Affected

- **RIVFLOZA SUBCUTANEOUS SOLUTION**
- **RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML, 160 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3): 1) genetically confirmed diagnosis of primary hyperoxaluria type 1 (PH1), 2) relatively preserved kidney function (e.g., eGFR greater than or equal to 30 mL/min/1.73 m2), and 3) at least two elevated urinary oxalate levels greater than 1.5 times the upper reference limit.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, continued preserved kidney function (e.g., eGFR greater than or equal to 30 mL/min/1.73 m2) -AND- reduction in urinary oxalate levels from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Romvimza

Products Affected

- **ROMVIMZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic tenosynovial giant cell tumor -AND- attestation that surgical resection may cause one of the following (1-2): 1) worsening functional limitation, 2) severe morbidity
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rozlytrek

Products Affected

- **ROZLYTREK ORAL CAPSULE 100 MG, 200 MG**
- **ROZLYTREK ORAL PELLETS IN PACKET**

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

Rubraca

Products Affected

- **RUBRACA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, all of the following (1-2): 1) Disease harbors a deleterious BRCA mutation (germline or somatic) 2) member is in complete or partial response to platinum-based chemotherapy. For metastatic castration-resistant prostate cancer, all of the following (1-3): 1) disease harbors a deleterious BRCA mutation (germline and/or somatic) 2) member has been treated with androgen receptor-directed therapy and taxane-based chemotherapy 3) member is concurrently receiving a gonadotropin-releasing hormone (GnRH) analog or member has had a bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 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 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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For 18 years of age or older, therapeutic failure, intolerance or contraindication to icatibant.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Rydapt

Products Affected

- **RYDAPT**

PA Criteria	Criteria Details
Exclusion Criteria	Use as single agent induction therapy for AML
Required Medical Information	Documentation of diagnosis. For a new diagnosis of acute myeloid leukemia, member is using in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy regimens and member is FLT3 mutation positive as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sabril

Products Affected

- **SABRIL**
- *vigabatrin*
- **VIGADRONE**
- **VIGPODER**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of refractory complex partial seizures -AND- documentation of adjunctive therapy -AND- therapeutic failure or intolerance to at least two alternative treatments (e.g. carbamazepine, lamotrigine, levetiracetam, oxcarbazepine, tiagabine) -OR- documentation of use as monotherapy in treatment of infantile spasms
Age Restrictions	Deny if less than 2 years of age in treatment of refractory complex partial seizures -OR- if less than 1 month old and greater than 2 years of age in treatment of infantile spasms
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Sabril, trial and failure of generic vigabatrin is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Samsca

Products Affected

- **SAMSCA**
- *tolvaptan*

PA Criteria	Criteria Details
Exclusion Criteria	
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 brand Samsca, initial authorization requires a trial and failure of generic tolvaptan and reauthorization requires failure of generic tolvaptan if not previously trialed. 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	
Part B Prerequisite	No

Saphris

Products Affected

- *asenapine maleate*
- **SAPHRIS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis - AND - trial and failure of one of the following: olanzapine, quetiapine, or risperidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Brand Saphris, trial and failure of generic asenapine sublingual tablets
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Scemblix

Products Affected

- **SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- one of the following (1-3): 1) the member is newly-diagnosed, 2) member has been previously treated for Ph+ CML in chronic phase, 3) disease is positive for the T3151 mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Secuado

Products Affected

- **SECUADO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure of generic asenapine sublingual tablets -AND- trial/failure or intolerance to 1 of the following or all are contraindicated (1-3): 1) olanzapine, 2) quetiapine, 3) risperidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sertraline Capsule

Products Affected

- *sertraline oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder or obsessive-compulsive disorder -AND- Sertraline 100mg or sertraline 125mg has been received for greater than or equal to 7 days -AND- Therapeutic failure or intolerance to generic sertraline immediate release tablets -AND- Therapeutic failure, intolerance or contraindication to at least one other antidepressant (e.g. SNRI, SSRI, TCA, MAOI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Seysara

Products Affected

- **SEYSARA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of inflammatory lesions of non-nodular moderate to severe acne -AND- trial and failure or intolerance of at least 1 generic topical acne medication (e.g. adapalene, clindamycin, sulfacetamide, erythromycin) -AND- trial and failure or intolerance of at least 1 generic oral acne antibiotic (e.g. minocycline, azithromycin, trimethoprim)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Siliq

Products Affected

- **SILIQ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For psoriasis, patients must have therapeutic failure or intolerance to 2 preferred products: a preferred adalimumab product, Cosentyx, Otezla, Stelara SC, Enbrel, and Skyrizi SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. For 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	
Part B Prerequisite	No

Simponi

Products Affected

- **SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML**
- **SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. Simponi 50mg: For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide) and Simponi will be used in combination with methotrexate. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). Diagnosis of psoriatic arthritis Simponi 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 therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Cosentyx, Xeljanz/Xeljanz XR, Otezla, Stelara SC, Rinvoq, and Skyrizi SC. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For ulcerative colitis, patients must have therapeutic failure or intolerance to the preferred products: a preferred adalimumab product, Stelara SC, Rinvoq, and Xeljanz/Xeljanz XR. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. For ulcerative colitis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.

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

Sirturo

Products Affected

- **SIRTURO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. Criteria will be applied consistent with the current ATS/CDC/ERS/IDSA Clinical Practice Guideline for the Treatment of Drug-Susceptible and Drug-Resistant Tuberculosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of disease improvement -AND- member requires additional antimicrobial therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Skyclarys

Products Affected

- **SKYCLARYS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Friedreichs ataxia confirmed by genetic testing (i.e., FXN gene mutation).
Age Restrictions	Deny if less than 16 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Skyrizi

Products Affected

- **SKYRIZI SUBCUTANEOUS PEN INJECTOR**
- **SKYRIZI SUBCUTANEOUS SYRINGE**
- **SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For Crohns disease, attestation of receiving or currently undergoing IV administration of Skyrizi within 3 months of initiating therapy with Skyrizi SC. For moderate to severe ulcerative colitis, attestation of receiving or currently undergoing IV administration of Skyrizi within 3 months of initiating therapy with Skyrizi SC.
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	
Part B Prerequisite	No

Skytrofa

Products Affected

- **SKYTROFA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis, growth chart, bone age, growth velocity, response to stimulation test, when applicable to meet standard diagnostic criteria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation member has a growth velocity of at least 2 cm/year -AND- member has open epiphyses.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sogroya

Products Affected

- **SOGROYA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis, growth chart, bone age, growth velocity, response to stimulation test, when applicable to meet standard diagnostic criteria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation member has a growth velocity of at least 2 cm/year -AND- member has open epiphyses.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sohonos

Products Affected

- **SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	Deny if female and less than 8 years of age -OR- if male and less than 10 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of reduction in volume of new heterotopic ossification from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Solaraze

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure, intolerance, or contraindication to one of the following (1 or 2): 1) topical fluorouracil solution or fluorouracil 5% cream 2) topical imiquimod 5% cream
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of 30 day washout period since optimal therapeutic effect may not be evident until 30 days following cessation of therapy AND attestation of previous response to diclofenac sodium 3% topical gel therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Somavert

Products Affected

- **SOMAVERT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For acromegaly, high pretreatment insulin-like growth factor-1 (IGF-1) based on laboratory reference range -AND- inadequate or partial response to surgery or radiotherapy or not a candidate for surgery or radiotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization of acromegaly, decreased or normalized IGF-1 from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sotyktu

Products Affected

- **SOTYKTU**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Otezla, Stelara, Enbrel and Skyrizi. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sovaldi

Products Affected

- **SOVALDI**

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

Spevigo SC

Products Affected

- **SPEVIGO SUBCUTANEOUS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of generalized pustular psoriasis (GPP) -AND- Previous GPP flares have been experienced -AND- A flare is not currently being experienced -AND- Prevetion for future GPP flares is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sprycel

Products Affected

- *dasatinib*
- **SPRYCEL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For adults with Ph+ chronic myeloid leukemia, the member is newly diagnosed in the chronic phase -OR- the member is in chronic, accelerated, or myeloid or lymphoid blast phase and has resistance or intolerance to prior therapy including imatinib. For adults with Ph+ acute lymphocytic leukemia, member has had resistance or intolerance to prior therapy. For pediatric patients with Ph+ CML, the member is in the chronic phase. For pediatric patients with Ph+ acute lymphoblastic leukemia, the member is newly diagnosed and will be using in combination with chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Sprycel, documentation of trial and failure of generic dasatinib is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Statin Liquid

Products Affected

- **ATORVALIQ**
- **FLOLIPID**

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

Stelara

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
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) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For Crohn's Disease, attestation of receiving or currently undergoing a single induction dose of IV Stelara within 2 months of initiating therapy with Stelara SC. For Ulcerative colitis, attestation of receiving or currently undergoing a single induction dose of IV Stelara within 2 months of initiating therapy with Stelara SC
Age Restrictions	Deny if less than 18 years of age for Crohn's Disease and Ulcerative Colitis or less than 6 years of age for Plaque Psoriasis and Psoriatic Arthritis
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Must follow recommended dosing guidelines based upon weight. Subcutaneous 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	
Part B Prerequisite	No

Steroidogenesis Inhibitors

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- patient is not a candidate for pituitary surgery or surgery has not been curative
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of decrease in urinary free cortisol levels from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sucraid

Products Affected

- **SUCRAID**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of congenital-sucrase-isomaltase deficiency (CSID) supported by one of the following (1 or 2): 1) small bowel biopsy with disaccharidase assay showing absent or reduced sucrase activity, reduced or normal isomaltase activity, reduced maltase activity, and reduced or normal lactase activity. 2) sucrase deficiency evidenced by sucrose breath hydrogen test or carbon-sucrose breath test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	

PA Criteria	Criteria Details
Part B Prerequisite	No

Sutent

Products Affected

- *sunitinib malate*
- **SUTENT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For gastrointestinal stromal tumor (GIST), the member has experienced therapeutic failure, intolerance, or contraindication to imatinib. For a high risk of recurrent renal cell carcinoma, member has had a nephrectomy and sunitinib is to be used as adjuvant treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Sutent, documentation of trial and failure of generic sunitinib is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Sympazan

Products Affected

- **SYMPAZAN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- therapeutic failure or intolerance of a previous antiepileptic therapy -AND- unable to tolerate generic clobazam
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Symproic

Products Affected

- **SYMPROIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation (OIC) due to any of the following (1-2): 1) chronic non-cancer pain, or 2) chronic pain related to prior cancer or its treatments who do not require frequent (e.g., weekly) opioid dosage escalation -AND- documentation of opioid medication use -AND- trial and failure, contraindication, or intolerance to at least 2 of the following (3-5): 3) Laxatives, 4) lubiprostone, 5) Movantik
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Synarel

Products Affected

- **SYNAREL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For central precocious puberty (CPP), advancement of bone age is beyond chronological age -AND- Basal luteinizing hormone (LH) level greater than 0.2-0.3IU/L or leuprolide-stimulating LH level greater than 3.3-5 IU/L. For female with endometriosis, attestation of not pregnant if of childbearing age -AND- Therapeutic failure, contraindication or intolerance to 2 of the following standard of care treatments: NSAIDs, combination hormonal contraceptive, progestin (i.e. medroxyprogesterone injection), GnRH agonist (i.e. Leuprolide) or danazol
Age Restrictions	Deny if greater than 8 years of age for females or greater than 9 years of age for males unless there is medical necessity for treatment of central precocious puberty. Deny if less than 18 years of age for endometriosis.
Prescriber Restrictions	
Coverage Duration	Endometriosis: 6 months, CPP: 6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization for CPP, attestation of pubertal development slowing from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tabrecta

Products Affected

- **TABRECTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer with MET exon 14 skipping mutation as detected by an FDA approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tafinlar

Products Affected

- **TAFINLAR ORAL CAPSULE**
- **TAFINLAR ORAL TABLET FOR SUSPENSION**

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

Tagrisso

Products Affected

- **TAGRISSO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of non-small cell lung cancer (NSCLC) and one of the following (1-5): 1) Adjuvant therapy after tumor resection -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test 2) Locally advanced disease -AND- using as first-line therapy -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test -AND- used in combination with pemetrexed and platinum-based chemotherapy, 3) Metastatic disease -AND- using as first-line therapy -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test -AND- used with or without combination therapy of pemetrexed and platinum-based chemotherapy, 4) Metastatic disease -AND- disease harbors EGFR T790M mutations, as detected by an FDA-approved test -AND- has progressed on or after EGFR TKI therapy, 5) Locally advanced, unresectable (stage III) disease -AND- disease has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy -AND- disease harbors EGFR exon 19 deletions or EGFR exon 21 L858R mutations, as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Takhzyro

Products Affected

- **TAKHZYRO SUBCUTANEOUS SOLUTION (150 MG/ML)**
- **TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML**

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

PA Criteria	Criteria Details
Part B Prerequisite	No

Talicia

Products Affected

- **TALICIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of H. Pylori infection confirmed by invasive techniques (e.g. endoscopic) or non-invasive techniques (e.g. urea breath test, stool antigen) -AND- Clarithromycin allergy, prior exposure to macrolide therapy or previous treatment using all the components of a first line therapy (1-3) failed to eradicate H. Pylori infection: 1. Lansoprazole or omeprazole 2. Amoxicillin or metronidazole 3. Clarithromycin -AND- Previous treatment with Pylera and omeprazole failed to eradicate H. Pylori infections or an allergy, intolerance, or contraindication to any component of Pylera.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Taltz

Products Affected

- **TALTZ AUTOINJECTOR**
- **TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML, 40 MG/0.5 ML, 80 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs.
Age Restrictions	Deny if less than 18 years of age for Psoriatic Arthritis, Ankylosing Spondylitis and non-radiographic axial spondyloarthritis or less than 6 years of age for Plaque Psoriasis
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cosentyx, Enbrel, a preferred adalimumab product, Xeljanz/Xeljanz XR, Otezla, Stelara SC, Rinvoq, and Skyrizi SC. For plaque psoriasis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Cosentyx, Otezla, Stelara SC, Skyrizi SC, and Enbrel. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Enbrel, Cosentyx, Rinvoq, and Xeljanz/Xeljanz XR. For non-radiographic axial spondyloarthritis patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cimzia, Rinvoq, Cosentyx. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Talzenna

Products Affected

- **TALZENNA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of deleterious or suspected deleterious gBRCAm, HER2-negative locally advanced or metastatic breast cancer as a single agent -OR- Documentation of HRR gene-mutated metastatic castration-resistant prostate cancer in combination with enzalutamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Targretin

Products Affected

- *bexarotene oral*
- *bexarotene topical*
- **TARGRETIN ORAL**
- **TARGRETIN TOPICAL**

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	For brand Targretin, documentation of trial and failure of generic bexarotene is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tarpeyo

Products Affected

- **TARPEYO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy -AND- At risk of disease progression as evidenced by proteinuria greater than or equal to 1.0 g/day -AND- One of the following (1 or 2): 1) Used in combination with an angiotensin-converting enzyme inhibitor (ACE-I) or an angiotensin II receptor blocker (ARB), or 2) Intolerance or contraindication to one ACE-I and one ARB.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	10 months
Other Criteria	For reauthorizations, documentation of primary immunoglobulin A nephropathy (IgAN) -AND- member requires re-continuation of therapy with Tarpeyo -AND- At risk of disease progression -AND- One of the following (1 or 2): 1) Used in combination with an angiotensin-converting enzyme inhibitor (ACE-I) or an angiotensin II receptor blocker (ARB), or 2) Intolerance or contraindication to one ACE-I and one ARB.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tascenso ODT

Products Affected

- **TASCENSO ODT**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as teriflunomide, interferons, Copaxone, Tysabri
Required Medical Information	Documentation of a relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- Inability to swallow capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tasigna

Products Affected

- **TASIGNA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For adult patients with Ph+ chronic myeloid leukemia (CML), member's CML is in the chronic or accelerated phase and the member is no longer responding to or is intolerant to imatinib -OR- member is newly diagnosed in the chronic phase. For pediatric patients, one of the following (1-2): 1) member has chronic phase or accelerated phase Ph+ CML and is is resistant or intolerant to prior tyrosine kinase inhibitor therapy 2) member is newly diagnosed with Ph+ CML in the chronic phase.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tasimelteon

Products Affected

- *tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Non-24 Sleep-Wake disorder in patient that is totally blind -AND- evidenced by all the following (1 through 4): 1) history of insomnia, excessive daytime sleepiness, or both alternating with asymptomatic episodes 2) symptoms persistent for at least 3 months 3) daily sleep logs for at least 1 month demonstrating a sleep/wake pattern that delays each day 4) sleep disturbances are not better explained by another current disorder or medication/substance use
Age Restrictions	Deny if less than 18 years of age
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
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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) insufficient 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	
Part B Prerequisite	No

Tavneos

Products Affected

- **TAVNEOS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of severe active granulomatosis with polyangiitis or severe active microscopic polyangiitis -AND- Prescriber attests to positive test for anti-PR3 or positive test for anti-MPO -AND- Member will continue to receive concomitant standard of care treatment with systemic glucocorticoids (e.g. prednisone) and immunosuppressives (e.g. mycophenolate mofetil, azathioprine).
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 therapeutic response defined by disease stability or disease improvement -AND- Member will continue to receive concomitant standard of care treatment with glucocorticoids (e.g. prednisone) and immunosuppressives (e.g. mycophenolate mofetil, azathioprine).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tazarotene

Products Affected

- **ARAZLO**
- **FABIOR**
- *tazarotene topical foam*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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	
Part B Prerequisite	No

Tazorac

Products Affected

- *tazarotene topical cream*
- *tazarotene topical gel*
- **TAZORAC TOPICAL CREAM**
- **TAZORAC TOPICAL GEL**

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	
Part B Prerequisite	No

Tazverik

Products Affected

- **TAZVERIK**

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

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	For brand Tecfidera, documentation of failure on generic dimethyl fumarate
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tepmetko

Products Affected

- **TEPMETKO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer with a MET exon 14 skipping alteration
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Testosterone (androgens)

Products Affected

- **AVEED**
- **DEPO-TESTOSTERONE**
- **JATENZO ORAL CAPSULE 158 MG, 198 MG, 237 MG**
- **TESTIM**
- *testosterone cypionate*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump*
- *testosterone transdermal gel in packet*
- *testosterone transdermal solution in metered pump w/app*
- **TLANDO**
- **UNDECATREX**
- **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 total testosterone level below the normal range for the laboratory -OR- a total testosterone level near the lower limit of the normal range with a low free testosterone level which is less than normal based upon the laboratory reference range -OR- the member is not producing any testosterone. Additional approvable indications include female patients with metastatic breast cancer (testosterone enanthate only), primary or secondary hypogonadism in males with testicular failure due to double orchidectomy, and delayed puberty in males (testosterone enanthate only).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	HIV Wasting
Part B Prerequisite	No

Tezruly

Products Affected

- **TEZRULY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis benign prostatic hyperplasia or hypertension -AND- Therapeutic failure to generic doxazosin, intolerance to generic doxazosin, or intolerance to generic terazosin -AND- Inability to swallow tablets and capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Thalomid

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Use as monotherapy for ENL treatment in the presence of moderate to severe neuritis
Required Medical Information	Documentation of multiple myeloma in combination with dexamethasone -OR- documentation for use in the treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) -OR- documentation of therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Thiola

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Confirmation of cystinuria by at least one 24-hour urine collection with measurement of urinary cysteine levels greater than 400 mg/day -AND- Attestation of failure of urine alkalization with potassium citrate (to achieve pH of 7.0).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For brand Thiola, brand Thiola EC, or Venxxiva, intolerance of generic tiopronin. For reauthorization, attestation of urine cystine concentration decreased from baseline -OR- decrease in production of cystine stones is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Thrombopoiesis Stimulating Agents

Products Affected

- **ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG**
- **PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG**
- **PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of persistent or 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 -OR- severe aplastic anemia who have had an insufficient response to immunosuppressive therapy -OR- For eltrombopag olamine only, 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. For Alvaiz (eltrombopag choline), therapeutic failure, contraindication, or intolerance to Promacta (eltrombopag olamine) is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tibsovo

Products Affected

- **TIBSOVO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- disease is IDH1 mutation positive as detected by an FDA-approved test. For newly-diagnosed acute myeloid leukemia, member is using as monotherapy or in combination with azacitidine -AND- member meets one of the following (1-5): 1) age is greater than or equal to 75 years of age 2) severe cardiac or pulmonary comorbidity 3) reduced renal function 4) hepatic impairment 5) or prescriber attestation that member is not a candidate for intensive induction therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tigan

Products Affected

- *trimethobenzamide oral*

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

Tolsura

Products Affected

- **TOLSURA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Unable to tolerate generic itraconazole capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation the member is still unable to tolerate generic itraconazole capsules
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Torpenz

Products Affected

- **TORPENZ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced, hormone receptor-positive, HER2-negative breast cancer -AND- member is a postmenopausal woman -AND- member is using Torpenz in combination with exemestane -AND- member has experienced therapeutic failure or intolerance to prior treatment with letrozole or anastrozole. Documentation of renal angiomyolipoma and tuberous sclerosis complex (TSC) -AND- the member does not require immediate surgery. Documentation of TSC with subependymal giant cell astrocytoma -AND- the member is not a candidate for curative surgical resection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Torpenz, documentation of failure on generic everolimus tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tremfya

Products Affected

- **TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML**
- **TREMFYA SUBCUTANEOUS AUTO-INJECTOR**
- **TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML, 200 MG/2 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For moderate to severe ulcerative colitis, attestation of receiving or currently undergoing 3 doses of IV Tremfya within 3 to 4 months of initiating therapy with Tremfya SC. For moderate to severe Crohn's disease, attestation of receiving or currently undergoing 3 doses of IV Tremfya within 3 to 4 months of initiating maintenance therapy with Tremfya SC or Tremfya SC is used for induction dosing.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For psoriasis, patients must have therapeutic failure or intolerance to 2 of the preferred products: Cosentyx, a preferred adalimumab product, Otezla, Stelara SC, Enbrel and Skyrizi SC. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the preferred products Cosentyx, a preferred adalimumab product, Otezla, Stelara SC, Enbrel, Rinvoq, Skyrizi SC, and Xeljanz/Xeljanz XR. For ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the preferred products: a preferred adalimumab product, Rinvoq, Skyrizi SC, Stelara SC and Xeljanz/Xeljanz XR. For moderate to severe active Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq, Skyrizi SC, and Stelara SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606. For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For CD, documentation that the maintenance dose is the lowest effective dose to maintain therapeutic response -AND- requests for the maintenance dose of 200mg every 4 weeks require attestation that the maintenance dose of 100mg every 8 weeks is unable to maintain therapeutic response.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tretinoin

Products Affected

- *adapalene topical cream*
- *adapalene topical gel 0.3 %*
- *adapalene topical swab*
- *adapalene-benzoyl peroxide*
- **AKLIEF**
- **ALTRENO**
- **ATRALIN**
- **CABTREO**
- *clindamycin-tretinoin*
- **DIFFERIN TOPICAL CREAM**
- **DIFFERIN TOPICAL GEL WITH PUMP**
- **EPIDUO FORTE**
- **EPIDUO TOPICAL GEL WITH PUMP**
- **RETIN-A**
- **RETIN-A MICRO**
- **RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %**
- *tretinoin*
- *tretinoin microspheres topical gel*
- *tretinoin microspheres topical gel with pump 0.08 %*
- **TWYNEO**
- **WINLEVI**
- **ZIANA**

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

Trientine

Products Affected

- *trientine oral capsule 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Wilson's Disease -AND- intolerant of penicillamine (e.g., generic penicillamine capsule or tablet).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Therapeutic failure or intolerance to generic trientine hydrochloride 250mg capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Trikafta

Products Affected

- **TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL**
- **TRIKAFTA ORAL TABLETS, SEQUENTIAL**

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	
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	
Part B Prerequisite	No

Trintellix

Products Affected

- **TRINTELLIX**

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

Trulance

Products Affected

- **TRULANCE**

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

Truqap

Products Affected

- **TRUQAP**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following (1-3): 1) HR mutation status, HER2 mutation status, and PIK3CA/AKT1/PTEN status 2) concomitant therapy with fulvestrant 3) disease progression on at least one endocrine-based regimen in the metastatic setting -OR- recurrence on or within 12 months of completing adjuvant therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tryngolza

Products Affected

- **TRYNGOLZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of familial chylomicronemia syndrome (FCS) confirmed by the following A. or B. A) genetic test demonstrating biallelic pathogenic variants in at least one gene causing FCS (e.g., LPL, GPIHBP1, APOA5, APOC2, LMF1), or B) genetic test results are inconclusive and one of the following (1-5): 1) FCS score greater than or equal to 10, 2) NAFCS score greater than or equal to 45, 3) history of pancreatitis, 4) history of eruptive xanthomas, 5) history of lipemia retinalis -AND- fasting triglyceride level greater than or equal to 750 mg/dL, which do not respond to standard lipid-lowering therapy -AND- will be used in combination with diet.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, the member has experienced improvement in triglycerides from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tryvio

Products Affected

- **TRYVIO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Resistant Hypertension -AND- Therapeutic failure, intolerance, or contraindication to maximally tolerated doses of all of the following (1-3): 1) thiazide diuretic, 2) ACE-I or ARB, 3) mineralocorticoid receptor antagonist.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of a reduction in blood pressure from baseline is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tukysa

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For advanced unresectable HER2-positive breast cancer or metastatic HER2-positive breast cancer, member will be using in combination with trastuzumab and capecitabine -AND- member has received one or more prior anti-HER2 based regimens in the metastatic setting. For RAS wild-type HER2-positive unresectable or metastatic colorectal cancer, member will be using in combination with trastuzumab -AND- member has experienced disease progression following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Turalio

Products Affected

- **TURALIO ORAL CAPSULE 125 MG**

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	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tyenne

Products Affected

- **TYENNE AUTOINJECTOR**
- **TYENNE SUBCUTANEOUS**

PA Criteria	Criteria Details
Exclusion Criteria	Part A covered for Covid-19 in hospitalized patients
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 therapeutic failure 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. Documentation of systemic juvenile idiopathic arthritis.
Age Restrictions	Deny if less than 18 years of age for 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	Therapeutic failure or intolerance to preferred Actemra.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tykerb

Products Affected

- *lapatinib*
- **TYKERB**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For advanced HER2-positive, or metastatic HER2-positive breast cancer, the member has received prior therapy with an anthracycline, a taxane, and trastuzumab -AND- will be using in combination with capecitabine. For HR+, metastatic breast cancer, the member is post-menopausal -AND- the member's cancer over expresses the HER2 receptor -AND- the member will be using lapatinib in combination with letrozole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Tykerb, trial and failure of generic lapatinib is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tymlos

Products Affected

- **TYMLOS**

PA Criteria	Criteria Details
Exclusion Criteria	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) 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 or intolerance to at least one oral bisphosphonate or all are contraindicated. Additional documentation of trial/failure, intolerance or contraindication to preferred parathyroid hormone analog teriparatide. Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Tymlos will be limited to a coverage duration of 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ubrelvy

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of acute treatment of migraine with or without aura -AND- trial and failure of one generic triptan.
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 migraine symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Uloric

Products Affected

- *febuxostat*
- **ULORIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of chronic management of hyperuricemia due to gout -And- trial/failure, intolerance or contraindication to allopurinol.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ustekinumab

Products Affected

- **OTULFI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **PYZCHIVA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **STEQEYMA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- *ustekinumab-ttwe subcutaneous syringe 45 mg/0.5 ml, 90 mg/ml*
- **WEZLANA SUBCUTANEOUS SOLUTION**
- **WEZLANA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**
- **YESINTEK SUBCUTANEOUS SOLUTION**
- **YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
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) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For Crohn's Disease or Ulcerative Colitis, attestation of receiving or currently undergoing a single induction dose of IV ustekinumab within 2 months of initiating therapy with ustekinumab SC.
Age Restrictions	Deny if less than 18 years of age for Crohn's Disease and Ulcerative Colitis. Deny if less than 6 years of age for Plaque Psoriasis and Psoriatic Arthritis.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Intolerance to preferred Stelara is required. Must follow recommended dosing guidelines based upon weight. Subcutaneous induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Valchlor

Products Affected

- **VALCHLOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received at least one prior skin-directed therapy (e.g. topical corticosteroids, topical chemotherapy, local radiation and topical retinoids).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Valtoco

Products Affected

- **VALTOCO**

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

Vancomycin

Products Affected

- **VANCOCIN ORAL CAPSULE 125 MG, 250 MG**
- *vancomycin oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For brand Vancocin, trial and failure of generic vancomycin capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vanflyta

Products Affected

- **VANFLYTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- disease is FLT3-ITD-positive as detected by an FDA-approved test -AND- one of the following (1-3): 1) member is receiving induction therapy and is using Vanflyta in combination with standard cytarabine and anthracycline induction therapy 2) member is receiving consolidation therapy and is using Vanflyta in combination with standard cytarabine consolidation therapy 3) member is receiving maintenance therapy and is using Vanflyta as monotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vanrafia

Products Affected

- **VANRAFIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy -AND- At risk of disease progression as evidenced by proteinuria greater than or equal to 0.5 g/day -AND- One of the following (1 or 2): 1) Used in combination with an angiotensin-converting enzyme inhibitor (ACE-I) or an angiotensin II receptor blocker (ARB), or 2) Contraindication or intolerance to a maximally tolerated dose of an ACE-I or ARB.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, reduction in proteinuria from baseline is required -AND- One of the following (1 or 2): 1) Used in combination with an ACE-I or ARB, or 2) Contraindication or intolerance to an ACE-I or ARB.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Velsipity

Products Affected

- **VELSIPITY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- inadequate response or intolerance to one systemic therapy (e.g. corticosteroids, azathioprine, cyclophosphamide).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq, Xeljanz/Xeljanz XR and Stelara SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Veltassa

Products Affected

- **VELTASSA ORAL POWDER IN PACKET 1 GRAM, 16.8 GRAM, 25.2 GRAM, 8.4 GRAM**

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 12 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	
Part B Prerequisite	No

Venbysi XR

Products Affected

- *venlafaxine besylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- venlafaxine extended-release product at a total daily dose greater than or equal to 75 mg has been received for greater than or equal to 4 days.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Venclexta

Products Affected

- **VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG**
- **VENCLEXTA STARTING PACK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For newly-diagnosed AML, member is using in combination with azacitidine, decitabine, cytarabine -AND- age greater than or equal to 75 years or presence of at least one comorbidity that precludes use of intensive induction chemotherapy (i.e. severe cardiac or pulmonary comorbidity, reduced renal function, hepatic impairment, or physician attestation) is required.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Veozah

Products Affected

- **VEOZAH**

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

Verkazia

Products Affected

- **VERKAZIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- therapeutic failure or intolerance to 2 of the following medication classes or all are contraindicated: 1) generic ophthalmic antihistamines (e.g., olopatadine), 2) generic ophthalmic mast cell stabilizers (e.g., cromolyn sodium), 3) Generic ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Verquvo

Products Affected

- **VERQUVO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of heart failure (NYHA Class II to IV) -AND- Left ventricular ejection fraction less than 45% -AND- Hospitalization for heart failure or received outpatient IV diuretics for heart failure -AND- Used in combination with a angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker or Entresto -AND- Used in combination with bisoprolol, carvedilol IR/ER or metoprolol succinate ER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Verzenio

Products Affected

- **VERZENIO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- disease is classified as HR-positive, HER2-negative. For early breast cancer that is at high risk of recurrence and is node-positive, all of the following (1-2): 1) used in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) 2) used as adjuvant treatment. For advanced or metastatic breast cancer, used as initial endocrine-based therapy and used in combination with an aromatase inhibitor -OR- used after documented disease progression following endocrine therapy and used in combination with fulvestrant -OR- used after documented disease progression and used following endocrine therapy and prior chemotherapy in the metastatic setting and will be used as monotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Viberzi

Products Affected

- **VIBERZI**

PA Criteria	Criteria Details
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Documentation of diarrhea predominant, irritable bowel syndrome (IBS-D) -AND- trial/failure or intolerance to one of the following medications for IBS-D or documentation of contraindication to all: antidiarrheal (e.g., loperamide), antispasmodic (e.g., dicyclomine, hyoscyamine), tricyclic antidepressant (e.g., amitriptyline, nortriptyline).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vigafyde

Products Affected

- **VIGAFYDE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of use as monotherapy in treatment of infantile spasms
Age Restrictions	Deny if less than 1 month old and greater than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure or intolerance to generic vigabatrin packets for oral solution is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Viibryd

Products Affected

- **VIIBRYD ORAL TABLET**
- *vilazodone*

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

Vijoice

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of severe manifestations of PIK3CA Related Overgrowth Spectrum (PROS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vimovo2

Products Affected

- *naproxen-esomeprazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) Trial/failure of naproxen used in combination with omeprazole. -AND- 2) Trial/failure of one additional generic formulary NSAID (other than naproxen) used in combination with another generic formulary PPI (other than omeprazole).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vitrakvi

Products Affected

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

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

Vivjoa

Products Affected

- **VIVJOA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of recurrent vulvovaginal candidiasis defined as at least 3 episodes of vulvovaginal candidiasis in less than one year -AND Documentation the member is NOT of reproductive potential defined as postmenopausal or another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy) -AND- the member has experienced therapeutic failure, contraindication, or intolerance to a six-month maintenance course of oral fluconazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vivlodex

Products Affected

- *meloxicam submicronized*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure or intolerance to generic meloxicam tablets and one additional generic NSAID
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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, as detected by an FDA-approved test (1 or 2): 1) Epidermal growth factor (EGFR) exon 19 deletions, 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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vonjo

Products Affected

- **VONJO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis -AND- attestation of a platelet count of less than 50 x 10*9/L.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Voquezna

Products Affected

- **VOQUEZNA ORAL TABLET 10 MG, 20 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For healing of erosive esophagitis (EE) and relief of heartburn associated with EE, therapeutic failure, contraindication, or intolerance to omeprazole and pantoprazole. For maintenance of EE healing and relief of heartburn associated with EE, therapeutic failure, contraindication, or intolerance to omeprazole and pantoprazole. For relief of heartburn associated with non-erosive gasteroesophageal reflux disease (GERD), therapeutic failure, contraindication, or intolerance to omeprazole and pantoprazole. For treatment of H. pylori infection, used in combination with amoxicillin -OR- amoxicillin and clarithromycin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	H.pylori tx: 14 days. EE healing: 8 wks. EE Maintenance: 6 mo. Non-erosive GERD: 4 wks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Voquezna Combo Pak

Products Affected

- **VOQUEZNA DUAL PAK**
- **VOQUEZNA TRIPLE PAK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Voranigo

Products Affected

- **VORANIGO ORAL TABLET 10 MG, 40 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following (1-3): 1) grade 2 astrocytoma or grade 2 oligodendroglioma, 2) disease harbors a susceptible isocitrate dehydrogenase (IDH)-1 or IDH-2 mutation, 3) will be used following surgery including biopsy, sub-total resection, or gross total resection.
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	
Part B Prerequisite	No

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. histopathology, positive cultures) is required
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vosevi

Products Affected

- **VOSEVI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member has a contraindication to or is otherwise not a candidate for one of the following regimens recommended by the AASLD/IDSA guidelines containing the following agents: sofosbuvir/velpatasvir (i.e. Epclusa authorized generic), Mavyret.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Votrient

Products Affected

- *pazopanib*
- **VOTRIENT**

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of adipocytic soft tissue sarcoma or gastrointestinal stromal tumor
Required Medical Information	Documentation of diagnosis. For advanced soft-tissue sarcoma, trial/failure of at least one prior chemotherapy regimen.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Votrient, documentation of trial and failure of generic pazopanib is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Voxzogo

Products Affected

- **VOXZOGO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of achondroplasia as evidenced by an FGFR3 gene mutation detected by genetic testing -AND- all of the following (1-2): 1) baseline annualized growth velocity (AGV), 2) attestation that the member's epiphyses have not closed.
Age Restrictions	Deny if greater than 17 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of increase in annualized growth velocity (AGV) from baseline and attestation that the member's epiphyses have not closed are required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Voydeya

Products Affected

- **VOYDEYA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) -AND- all of the following (1-3): 1) clinically significant extravascular hemolysis supported by hemoglobin less than or equal to 9.5gm/dL or absolute reticulocyte count (ARC) greater than or equal to 120x10*9/L, 2) attestation of history of ravulizumab or eculizumab use for the treatment of PNH for at least 6 months, 3) attestation of use concomitant use with ravulizumab or eculizumab.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of positive clinical response defined as one of the following (1-5): 1) increased or stabilized hemoglobin levels, 2) reduction in transfusions, 3) improvement in hemolysis, 4) decrease in LDH levels, or 5) increased reticulocyte levels.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vraylar

Products Affected

- **VRAYLAR ORAL CAPSULE**

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

Vtama

Products Affected

- **VTAMA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3). 1) Documentation of plaque psoriasis -AND- 2) trial and failure or intolerance to at least one generic, formulary medium, high, or ultrahigh potency topical corticosteroid (e.g. fluocinonide, triamcinolone, betamethasone) -OR- psoriasis on facial or intertriginous areas -AND- 3) trial and failure, contraindication, or intolerance to one generic, formulary vitamin D analog (e.g., calcipotriene, calcitriol) -OR- the member has psoriasis on the face -OR- Documentation of all of the following (4-6). 4) Atopic dermatitis, 5) trial and failure, intolerance, or contraindication to at least one generic formulary topical corticosteroid or documentation of facial or anogenital involvement, 6) trial and failure, intolerance, or contraindication to topical generic tacrolimus or topical generic pimecrolimus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vuity

Products Affected

- **VUITY**

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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) -AND- Therapeutic failure or intolerance to generic dimethyl fumarate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vykat XR

Products Affected

- **VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 25 MG, 75 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Prader-Willi Syndrome (PWS) confirmed by documentation of genetic analysis with identification of abnormal DNA methylation of chromosome 15q11.2-q13 -AND- Experiencing hyperphagia due to PWS diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of a decrease in hyperphagic and food-related behaviors is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Wainua

Products Affected

- **WAINUA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of polyneuropathy associated with hereditary TTR (hATTR) amyloidosis with mutation in TTR gene confirmed by genetic testing -AND- Neurologic examination shows clinical signs and symptoms of the disease (e.g. peripheral/autonomic neuropathy, motor disability, carpel tunnel, etc.) -AND- Attestation of peripheral neuropathy impairment score (NIS) of 10 or greater -AND- Not simultaneously utilizing other gene targeted therapy for polyneuropathy of hATTR
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of improvement of polyneuropathy from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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. 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	

PA Criteria	Criteria Details
Part B Prerequisite	No

Wegovy

Products Affected

- **WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML**

PA Criteria	Criteria Details
Exclusion Criteria	Treatment to reduce body weight and maintain weight reduction
Required Medical Information	Documentation of use in combination with reduced calorie diet and increased physical activity to reduce the risk of major adverse cardiovascular in adults with established cardiovascular disease and either obesity or overweight -AND- Baseline BMI is greater than or equal to 27 kg/m2 -AND- If diagnosis of atherosclerotic cardiovascular disease, attestation of use as part of a plan to manage cardiovascular risk factors -AND- if diagnosis of diabetes type 2, failure, contraindication or intolerance to a preferred GLP1 RA that is FDA approved for diabetes and cardiovascular risk reduction (e.g. Ozempic) -AND- Will not be used in combination with GLP1 RA or GLP1 RA combinations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of continued use is required of Wegovy therapy in combination with reduced calorie diet and increased physical activity for reduction of major adverse cardiovascular event risk -AND- If diagnosis of atherosclerotic cardiovascular disease, attestation of use as part of a plan to manage cardiovascular risk factors -AND- Requested dose is 1.7mg or 2.4mg weekly -AND- If diagnosis of diabetes type 2, failure, contraindication or intolerance to a preferred GLP1 RA that is FDA approved for diabetes and cardiovascular risk reduction.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Welireg

Products Affected

- **WELIREG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For von Hippel Lindau (VHL) syndrome, one of the following diagnoses not requiring immediate surgery (1, 2, or 3): 1) Renal cell carcinoma (RCC) 2) CNS hemangioblastoma 3) Pancreatic neuroendocrine tumor. For advanced RCC with a clear cell component, prior treatment with a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) -AND- a programmed death receptor-1 (PD-1) or a programmed death-ligand (PD-L1) inhibitor.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Winrevair

Products Affected

- **WINREVAIR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization (RHC), defined as a mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than or equal to 3 Wood units -AND- WHO Group -AND- Concomitant use of at least one of the following (1-4): 1) generic endothelin-1 receptor antagonist, 2) phosphodiesterase type 5 inhibitor, 3) soluble guanylate cyclase stimulator, 4) generic prostacyclin agent -AND- Background therapy with PAH-specific therapies will be continued while being treated with Winrevair.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xalkori

Products Affected

- **XALKORI ORAL CAPSULE**
- **XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For metastatic non-small cell lung cancer (NSCLC), disease is ALK-positive or ROS1-positive. For relapsed or refractory anaplastic large cell lymphoma (ALCL), disease is ALK-positive. For unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT), disease is ALK-positive.
Age Restrictions	Deny if less than 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	For crizotinib oral pellets and NSCLC, inability to swallow capsules is required. For crizotinib oral pellets and ALCL / IMT, inability to swallow oral capsules -OR- body surface area less than 1.34 m2 is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xcopri

Products Affected

- **XCOPRI**
- **XCOPRI MAINTENANCE PACK**
- **XCOPRI TITRATION PACK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of partial-onset seizures -AND- Therapeutic failure, intolerance or contraindication to 1 other anti-epileptic drug (e.g. carbamazepine, levetiracetam)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xdemvy

Products Affected

- **XDEMVY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis confirmed by identification of Demodex infection via microscopic examination of pulled eyelashes -OR- identification of collarettes via slit-lamp evaluation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xeljanz

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severely active rheumatoid arthritis and an inadequate response or intolerance to methotrexate. Xeljanz immediate release for juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID).
Age Restrictions	Deny if less than 18 years of age for rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, ankylosing spondylitis. For Xeljanz regular release tablet, deny if less than 2 years of age for juvenile idiopathic arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	The member has experienced inadequate response or intolerance to at least 1 tumor necrosis factor (TNF) blocker. Doses greater than 10 mg per day for Xeljanz and 11 mg per day for Xeljanz XR will not be approved for rheumatoid arthritis and psoriatic arthritis. Doses greater than 20mg per day for Xeljanz and 22 mg per day for Xeljanz XR will not be approved for ulcerative colitis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	The member has experienced therapeutic failure or intolerance to at least 1 tumor necrosis factor (TNF) blocker.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*
- **XENAZINE ORAL TABLET 12.5 MG, 25 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation that the beneficiary is not actively suicidal
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Xenazine, trial and failure of generic tetrabenazine is required. In patients with comorbid depression, attestation of adequate treatment for depression is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in average number of daily bowel movements -AND- the member will continue to use in combination with a somatostatin analog.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

Xhance

Products Affected

- **XHANCE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic rhinosinusitis with nasal polyps or chronic rhinosinusitis without nasal polyps -AND- Therapeutic failure, intolerance or contraindication 1 corticosteroid nasal sprays.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xifaxan

Products Affected

- **XIFAXAN ORAL TABLET 550 MG**

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

Xolair

Products Affected

- **XOLAIR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of the following (1-2): 1) Chronic Spontaneous Urticaria, 2) 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 the following (3-9): 3) moderate to severe persistent asthma, 4) a positive skin test or in vitro reactivity to a perennial aeroallergen, 5) Baseline IgE titer greater than or equal to 30 IU/mL, 6) documented pretreatment FEV1 less than 80% predicted in adults or less than 90% predicted in children and adolescents or FEV1 reversibility of at least 12% and 200mL after albuterol administration, 7) history of at least 2 asthma exacerbations requiring oral or injectable corticosteroid treatment in past 12 mos or at least 1 asthma exacerbation requiring hospitalization in past 12 mos, 8) inadequately controlled symptoms despite a 3-month trial of both of the following (a-b) a) medium-dose inhaled corticosteroid or systemic steroid b) a long-acting beta-agonist or leukotriene antagonist, 9) currently on 1 of the following (c, d, e): c) a long-acting beta2-agonist, d) leukotriene modifier, or e) theophylline. -OR- Documentation of the following (10-11): 10) chronic rhinosinusitis with nasal polyps (CRSwNP), 11) will use concomitantly with nasal corticosteroid maintenance treatment, -OR- Documentation of the following (12-17): 12) IgE mediated food allergy, 13) diagnosis confirmed by skin prick test or food-specific antibodies, 14) previous allergic reaction to food, 15) using for the reduction of allergic reactions (type 1), including anaphylaxis, 16) will be used in conjunction with food allergen avoidance, 17) member has a documented prescription for epinephrine.
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	For asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of asthma exacerbations, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For CSU reauthorization, improved CSU symptoms. For CRSwNP reauthorization, attestation of decrease in nasal polyp score or reduction in nasal congestion/obstruction severity score. For IgE-mediated food allergy reauthorization, member requires continuation of therapy and will continue food allergen avoidance.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xolremdi

Products Affected

- **XOLREMDI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of WHIM syndrome (warts, hypogammaglobulinemia, infections, myelokathexis).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of reduction in incidence of infections is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xospata

Products Affected

- **XOSPATA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- member is FLT3 mutation-positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xpovio

Products Affected

- **XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 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 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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xtandi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For castration-resistant prostate cancer and metastatic castration sensitive-prostate cancer, the member is using in combination with a GnRH analog or the member has had a bilateral orchiectomy. For non-metastatic castration-sensitive prostate cancer, the member has biochemical recurrence at high risk for metastasis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xyrem

Products Affected

- *sodium oxybate*
- **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	
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	
Part B Prerequisite	No

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 -AND- Sensitivity to sodium intake due to heart failure, hypertension or impaired renal function. If the member has a diagnosis of cataplexy, provision of baseline number of cataplexy episodes is required. -OR- (II) 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	
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	
Part B Prerequisite	No

Yonsa

Products Affected

- **YONSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- using in combination with methylprednisolone.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Yorvipath

Products Affected

- **YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML, 294 MCG/0.98 ML, 420 MCG/1.4 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of hypoparathyroidism -AND- albumin-corrected serum calcium greater than or equal to 7.8 mg/dL -AND- trial and failure of calcium -AND- trial and failure of an active form of vitamin D (e.g. calcitriol, alfacalcidol).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of an improvement in total serum calcium from baseline is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zavesca

Products Affected

- *miglustat*
- **YARGESA**
- **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 thrombocytopenia with platelet count less than or equal to 120,000/mm*3. or 5)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). -OR- B. Attestation of deficiency in glucocerebrosidase activity in peripheral leukocytes or genetic testing confirms mutant alleles. -OR- Documentation of Niemann-Pick Disease Type C (NPC) and all of the following (6-8): 6) diagnosis is molecularly confirmed, 7) neurological symptoms of NPC (e.g., ataxia, dysarthria, dysphagia, cognitive impairment, seizures), 8) will be given in combination with arimoclomal.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Attestation enzyme replacement therapy (e.g. Cerezyme, Elelyso, or VPRIV) is not a therapeutic option. For brand Zavesca, documentation of failure on generic miglustat.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Niemann-Pick Disease, type C
Part B Prerequisite	No

Zavzpret

Products Affected

- **ZAVZPRET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute migraine headaches with or without aura -AND- Therapeutic failure, contraindication or intolerance to one generic triptan -AND- Inability to swallow capsules/tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in migraine symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zejula

Products Affected

- **ZEJULA ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer, member is in complete or partial response to first-line platinum-based therapy. For recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer, all of the following (1-2): 1) disease harbors a deleterious or suspected deleterious germline BRCA mutation 2) member is in a complete or partial response to platinum-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zelboraf

Products Affected

- **ZELBORAF**

PA Criteria	Criteria Details
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	Documentation of diagnosis. For unresectable or metastatic melanoma and use in combination with cobimetinib, member has a BRAF V600E or V600K mutation. For unresectable or metastatic melanoma and use as monotherapy, member has a BRAF V600E mutation. For Erdheim-Chester Disease and use as monotherapy, member has a BRAF V600 mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 has a contraindication to or is otherwise not a candidate for one of the following regimens recommended by the AASLD/IDSA guidelines containing the following agents: sofosbuvir/velpatasvir (i.e. Epclusa authorized generic), Mavyret.
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zepbound

Products Affected

- **ZEPBOUND SUBCUTANEOUS PEN INJECTOR**

PA Criteria	Criteria Details
Exclusion Criteria	Treatment to reduce body weight and maintain weight reduction
Required Medical Information	Diagnosis of moderate to severe obstructive sleep apnea/hypopnea syndrome (OSAHS) -AND- Baseline polysomnography or recording time (without use of positive airway pressure (PAP) during testing) demonstrating an apnea/hypoapnea index (AHI) of greater than or equal to 15 events per hour -AND- A baseline AHI after optimization of guideline directed care -AND- Baseline BMI is greater than or equal to 30 kg/m2 -AND- Attestation of use in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity -AND- Attestation of use in combination with sleep hygiene modifications (e.g., sleep positioning to avoid a non-supine position, avoidance of alcohol and sedatives before bed) -AND- Will not be used in combination with GLP1 RA or GLP1 RA combinations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization

PA Criteria	Criteria Details
Other Criteria	For reauthorization, all of the following are required (1-9): 1) Diagnosis of moderate to severe obstructive sleep apnea/hypopnea syndrome (OSAHS) prior to initiation of Zepbound therapy, 2) Baseline polysomnography or recording time (without use of PAP during testing) prior to initiation of Zepbound therapy demonstrating an AHI of greater than or equal to 15 events per hour, 3) Attestation of a pre-Zepbound therapy baseline AHI from a polysomnography or recording time (without use of PAP during testing), 4) Attestation of decrease in baseline post-optimization of guideline directed care AHI after Zepbound initiation, 5) Attestation that additional Zepbound therapy is required to maintain the AHI decrease, 6) Attestation that baseline BMI was greater than or equal to 30 kg/m2 prior to initiation of Zepbound therapy, 7) Attestation of use in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity, 8) Attestation of use in combination with sleep hygiene modifications (e.g., sleep positioning to avoid a non-supine position, avoidance of alcohol and sedatives before bed), 9) the requested dose is 10mg, 12.5mg, or 15mg once weekly, or attestation that the member is titrating to a dose of 10mg once weekly.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zeposia

Products Affected

- **ZEPOSIA**
- **ZEPOSIA STARTER KIT (28-DAY)**
- **ZEPOSIA STARTER PACK (7-DAY)**

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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Ulcerative Colitis: 12 months, Multiple Sclerosis: 24 months
Other Criteria	For moderate to severe active ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq, Xeljanz/Xeljanz XR and Stelara SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zolinza

Products Affected

- **ZOLINZA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following 2 systemic therapies. Systemic therapies include bexarotene, interferon alpha, extracorporeal photochemotherapy, PUVA, single agent or combination chemotherapies (e.g. cyclophosphamide, vinblastine, romidepsin)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zolpidem Capsule

Products Affected

- *zolpidem*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of insomnia characterized by difficulties with sleep onset - AND- therapeutic failure or intolerance to 2 of the following (1-3): 1) eszopiclone, 2) zaleplon, 3) generic zolpidem tablets/zolpidem ER tablets. When 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	Deny if greater than 64 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zonisade

Products Affected

- **ZONISADE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of partial-onset seizures -AND- Documentation of adjunctive therapy -AND- Inability to swallow capsules -AND- Therapeutic failure/intolerance to 2 or contraindication to all of the following (1-6): 1) generic carbamazepine suspension/chewable tablet/extended-release capsule, 2) generic gabapentin capsules/solution, 3) generic lacosamide solution, 4) generic levetiracetam solution, 5) generic oxcarbazepine suspension, 6) generic pregabalin capsules/solution.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zoryve 0.15 Cream

Products Affected

- **ZORYVE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3). 1) Documentation of mild to moderate atopic dermatitis -AND- 2) therapeutic failure, contraindication or intolerance to one generic formulary topical corticosteroid -OR- documentation of facial or anogenital involvement -AND- 3) therapeutic failure, contraindication or intolerance to topical generic tacrolimus or topical generic pimecrolimus.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zoryve Cream

Products Affected

- **ZORYVE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3). 1) Documentation of plaque psoriasis -AND- 2) trial and failure or intolerance to at least one generic, formulary medium, high, or ultrahigh potency topical corticosteroid (e.g. fluocinonide, triamcinolone, betamethasone) -OR- psoriasis on facial or intertriginous areas -AND- 3) trial and failure, contraindication, or intolerance to one generic, formulary vitamin D analog (e.g., calcipotriene, calcitriol) -OR- the member has psoriasis on the face.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zoryve Foam

Products Affected

- **ZORYVE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3). 1) Documentation of seborrheic dermatitis -AND- 2) trial and failure or intolerance to at least one generic, formulary topical corticosteroid -OR- seborrheic dermatitis on facial or intertriginous areas -AND- 3) if the member is 12 years of age or older, trial and failure, contraindication, or intolerance to one generic, topical antifungal agent for seborrheic dermatitis (e.g., ketoconazole, ciclopirox).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ztalmy

Products Affected

- **ZTALMY**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizures associated with CDKL5 deficiency confirmed by genetic testing -AND- therapeutic failure or intolerance to 2 previous antiepileptic therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	Therapeutic failure, contraindication, or intolerance to generic lidocaine patch 5% is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zunveyl

Products Affected

- **ZUNVEYL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis - AND- therapeutic failure or intolerance to generic galantamine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zurzuvae

Products Affected

- **ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of moderate to severe postpartum depression -AND- less than or equal to 12 months postpartum.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 -AND- all of the following (1-2): 1) will be used in combination with rituximab 2) use of rituximab alone would be appropriate due to other due to other comorbidities.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zykadia

Products Affected

- **ZYKADIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- ALK mutations, as detected by an FDA approved test.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zymfentra

Products Affected

- **ZYMFENTRA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation of clinical response or remission following at least 3 doses of IV infliximab at least 10 weeks before initiating therapy with Zymfentra.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For moderate to severe active ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq, Xeljanz/Xeljanz XR, and Stelara SC. For moderate to severe active Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product, Rinvoq, Skyrizi SC, and Stelara SC. Please Note: preferred adalimumab products include Humira with NDC starting with 00074, Cyltezo with NDC starting 00597 and Yuflyma with NDC starting 72606.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zytiga

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- using in combination with prednisone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Zytiga, intolerance of generic abiraterone or Abirtega is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 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**
- **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**
- *dextroamphetamine-amphetamine er 12.5 mg capsule, 3 bead, ext rel 24hr*
- *dextroamphetamine-amphetamine er 25 mg capsule,3 bead,ext release 24hr*
- *dextroamphetamine-amphetamine er 37.5 mg capsule, 3 bead, ext rel 24hr*
- *dextroamphetamine-amphetamine er 50 mg capsule,3 bead,ext release 24hr*
- **DYANAVEL XR 10 MG TABLET, EXTENDED RELEASE**

- **DYANAVEL XR 15 MG TABLET, EXTENDED RELEASE**
- **DYANAVEL XR 2.5 MG/ML ORAL 24 HR EXTENDED RELEASE SUSPENSION**
- **DYANAVEL XR 20 MG TABLET, EXTENDED RELEASE**
- **DYANAVEL XR 5 MG TABLET, EXTENDED RELEASE**
- **FOCALIN 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**
- *lisdexamfetamine 10 mg capsule*
- *lisdexamfetamine 10 mg chewable tablet*
- *lisdexamfetamine 20 mg capsule*
- *lisdexamfetamine 20 mg chewable tablet*
- *lisdexamfetamine 30 mg capsule*
- *lisdexamfetamine 30 mg chewable tablet*
- *lisdexamfetamine 40 mg capsule*
- *lisdexamfetamine 40 mg chewable tablet*
- *lisdexamfetamine 50 mg capsule*
- *lisdexamfetamine 50 mg chewable tablet*
- *lisdexamfetamine 60 mg capsule*
- *lisdexamfetamine 60 mg chewable tablet*
- *lisdexamfetamine 70 mg capsule*
- **METADATE CD 10 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 20 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 30 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 40 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 50 MG CAPSULE,EXTENDED RELEASE**
- **METADATE CD 60 MG CAPSULE,EXTENDED RELEASE**
- **METHYLIN 10 MG/5 ML ORAL SOLUTION**
- **METHYLIN 5 MG/5 ML ORAL SOLUTION**
- *methylphenidate er 10 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 15 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 20 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 30 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 40 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 45 mg tablet,extended release 24 hr*
- *methylphenidate er 50 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 60 mg capsule,extended release (40-60) sprinkle*
- *methylphenidate er 63 mg tablet,extended*

release 24 hr

- *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 18 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 27 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 36 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 45 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 54 MG TABLET,EXTENDED RELEASE**
- **RELEXXII 63 MG TABLET,EXTENDED RELEASE**
- **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**
- **XELSTRYM 13.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**
- **XELSTRYM 18 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**
- **XELSTRYM 4.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**
- **XELSTRYM 9 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH**

Details

Criteria	Require a 1 month trial of 2 of the following generic ADHD medications (Step 1 drug) when being utilized for the same medically accepted indication: methylphenidate (i.e. generics of Concerta, Metadate CD, Methylin, Relexxii, Ritalin/Ritalin LA), atomoxetine, dextroamphetamine/amphetamine (i.e. generics of Adderall/Adderal XR), or dexmethylphenidate in the last 180 days.

Brand Albuterol

Products Affected

- **AIRSUPRA 90 MCG-80 MCG/ACTUATION HFA AEROSOL INHALER**
- *albuterol sulfate hfa 90 mcg/actuation aerosol inhaler (nda020983)*
- **PROAIR RESPICLICK 90 MCG/ACTUATION BREATH ACTIVATED**

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**
- **NEFFY 1 MG/SPRAY (0.1 ML) NASAL SPRAY**
- **NEFFY 2 MG/SPRAY (0.1 ML) NASAL SPRAY**

Details

Criteria	Require a trial of 2 of the following (Step 1 drug): generic epinephrine injection or Epipen 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**

Details

Criteria	Require a 1 month trial of generic celecoxib and 1 other formulary generic NSAID (Step 1 drugs) in the last 180 days

Clonidine ER

Products Affected

- *clonidine hcl er 0.17 mg tablet,extended release 24 hr*
- **NEXICLON XR 0.17 MG TABLET,EXTENDED RELEASE**

Details

Criteria	Require a 1 month trial of generic clonidine IR tablet (Step 1 drug) in the last 90 days

DPP4 Agents

Products Affected

- *alogliptin 12.5 mg tablet*
- *alogliptin 12.5 mg-metformin 1,000 mg tablet*
- *alogliptin 12.5 mg-metformin 500 mg tablet*
- *alogliptin 12.5 mg-pioglitazone 30 mg tablet*
- *alogliptin 25 mg tablet*
- *alogliptin 25 mg-pioglitazone 15 mg tablet*
- *alogliptin 25 mg-pioglitazone 30 mg tablet*
- *alogliptin 25 mg-pioglitazone 45 mg tablet*
- *alogliptin 6.25 mg tablet*
- *saxagliptin 2.5 mg tablet*
- *saxagliptin 2.5 mg-metformin er 1,000 mg tablet,extend release 24hr mp*
- *saxagliptin 5 mg tablet*
- *saxagliptin 5 mg-metformin er 1,000 mg tablet,extend release 24hr mp*
- *saxagliptin 5 mg-metformin er 500 mg tablet,extend release 24hr mp*
- *sitagliptin 100 mg tablet*
- *sitagliptin 25 mg tablet*
- *sitagliptin 50 mg tablet*
- *sitagliptin 50 mg-metformin 1,000 mg tablet*
- *sitagliptin 50 mg-metformin 500 mg tablet*
- **ZITUVIMET 50 MG-1,000 MG TABLET**
- **ZITUVIMET 50 MG-500 MG TABLET**
- **ZITUVIMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE**
- **ZITUVIMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE**
- **ZITUVIMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE**
- **ZITUVIO 100 MG TABLET**
- **ZITUVIO 25 MG TABLET**
- **ZITUVIO 50 MG TABLET**

Details

Criteria	Require a 1 month trial of a Januvia/Janumet/Janumet XR product and Tradjenta/Jentadueto/Jentadueto XR product in the last 180 days

DPP4-SGLT2 Combo

Products Affected

- **QTERN 10 MG-5 MG TABLET**
- **QTERN 5 MG-5 MG TABLET**
- **STEGLUJAN 15 MG-100 MG TABLET**
- **STEGLUJAN 5 MG-100 MG TABLET**

Details

Criteria	Require a 1 month trial of Glyxambi and Trijardy the last 180 days

Dry Eye

Products Affected

- **CEQUA 0.09 % EYE DROPS IN A DROPPERETTE**
- **MIEBO (PF) 100 % EYE DROPS**
- **TYRVAYA 0.03 MG/SPRAY NASAL SPRAY**
- **VEVYE 0.1 % EYE DROPS**

Details

Criteria	Require a 1 month trial of Xiidra and one of the following: Restasis or cyclosporine eye drop (i.e. generic Restasis), in the last 180 days

Dymista

Products Affected

- **DYMISTA 137 MCG-50 MCG/SPRAY NASAL SPRAY**
- **RYALTRIS 665 MCG-25 MCG/SPRAY NASAL SPRAY**

Details

Criteria	Require a 1 month trial of generic azelastine/fluticasone spray in the last 90 days

Erythroid Stimulants

Products Affected

- **ARANESP 10 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 100 MCG/0.5 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 100 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 150 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 200 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 200 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 25 MCG/0.42 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 25 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 300 MCG/0.6 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 40 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 40 MCG/ML (IN POLYSORBATE) INJECTION**
- **ARANESP 500 MCG/ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 60 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE**
- **ARANESP 60 MCG/ML (IN POLYSORBATE) INJECTION**
- **EPOGEN 2,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 20,000 UNIT/2 ML INJECTION SOLUTION**
- **EPOGEN 20,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 3,000 UNIT/ML INJECTION SOLUTION**
- **EPOGEN 4,000 UNIT/ML INJECTION SOLUTION**
- **MIRCERA 100 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 120 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 150 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 200 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 30 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 50 MCG/0.3 ML INJECTION SYRINGE**
- **MIRCERA 75 MCG/0.3 ML INJECTION SYRINGE**

Details

Criteria	Require a 1 month trial of Procrit and Retacrit (Step 1 drugs) in the last 180 days

Filgrastim

Products Affected

- **GRANIX 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE**
- **GRANIX 300 MCG/ML SUBCUTANEOUS SOLUTION**
- **GRANIX 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE**
- **GRANIX 480 MCG/1.6 ML SUBCUTANEOUS SOLUTION**
- **NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE**
- **NEUPOGEN 300 MCG/ML INJECTION SOLUTION**
- **NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE**
- **NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION**
- **RELEUKO 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE**
- **RELEUKO 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE**

Details

Criteria	Require a 1 month trial of Zarxio and Nivestym (step 1 drugs) in the last 180 days

Fortamet

Products Affected

- *metformin er 1,000 mg tablet,extended release 24hr (osmotic)*
- *metformin er 500 mg tablet,extended release 24hr (osmotic)*

Details

Criteria	Require a 1 month trial of generic metformin IR tablets and generic metformin ER (i.e. generic Glucophage XR) tablets in the last 180 days

Glumetza

Products Affected

- **GLUMETZA 1,000 MG TABLET,EXTENDED RELEASE**
- **GLUMETZA 500 MG TABLET,EXTENDED RELEASE**
- *metformin er 1,000 mg 24 hr tablet,extended release (gastric reten.)*
- *metformin er 500 mg 24 hr tablet,extended release (gastric retention)*

Details

Criteria	Require a 1 month trial of generic metformin IR tablets and generic metformin ER (i.e. generic Glucophage XR) tablets in the last 180 days

GnRH Agonists

Products Affected

- **ELIGARD 22.5 MG (3 MONTH) SUBCUTANEOUS SYRINGE**
- **ELIGARD 30 MG (4 MONTH) SUBCUTANEOUS SYRINGE**
- **ELIGARD 45 MG (6 MONTH) SUBCUTANEOUS SYRINGE**
- **ELIGARD 7.5 MG (1 MONTH)**
- **LUTRATE DEPOT (3 MONTH) 22.5 MG IM SUSPENSION**
- **TRELSTAR 11.25 MG IM SUSPENSION**
- **TRELSTAR 22.5 MG IM SUSPENSION**
- **TRELSTAR 3.75 MG IM SUSPENSION**

Details

Criteria	Pending CMS Review

Herpetic Keratitis

Products Affected

- **ZIRGAN 0.15 % EYE GEL**

Details

Criteria	Require a 1 month trial of generic trifluridine eye drops (Step 1 drug) in the last 90 days

Inhaled LAMA

Products Affected

- **INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION**
- **TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED**
- **TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED (30 ACTUAT)**

Details

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

Inhaled LAMA/LABA

Products Affected

- *umeclidinium 62.5 mcg-vilanterol 25 mcg/actuation powdr for inhalation*

Details

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

Lactulose

Products Affected

- **KRISTALOSE 10 GRAM ORAL PACKET**
- **KRISTALOSE 20 GRAM ORAL PACKET**
- *lactulose 10 gram oral packet*
- *lactulose 20 gram oral packet*

Details

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

Metformin IR

Products Affected

- *metformin 750 mg tablet*

Details

Criteria	Require a 1 month trial of generic metformin IR 500mg tablets, 850mg tablets, or 1000mg tablets (step 1 drug) in the last 90 days

Mirabegron ER

Products Affected

- *mirabegron er 25 mg tablet,extended release 24 hr*
- *mirabegron er 50 mg tablet,extended release 24 hr*

Details

Criteria	Require a 1 month trial Myrbetriq (Step 1 drug) the last 90 days

Mupirocin

Products Affected

- *mupirocin calcium 2 % topical cream*

Details

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

Pancreatic Enzymes

Products Affected

- **PANCREAZE 10,500 UNIT-35,500 UNIT-61,500 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 16,800 UNIT-56,800 UNIT-98,400 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 2,600 UNIT-8,800 UNIT-15,200 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 21,000 UNIT-54,700 UNIT-83,900 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 37,000-97,300-149,900 UNIT CAPSULE,DELAYED RELEASE**
- **PANCREAZE 4,200 UNIT-14,200 UNIT-24,600 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 16,000 UNIT-57,500 UNIT-60,500 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 24,000-86,250-90,750 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 4,000 UNIT-14,375 UNIT-15,125 UNIT CAPSULE,DELAYED RELEASE**
- **PERTZYE 8,000 UNIT-28,750 UNIT-30,250 UNIT CAPSULE,DELAYED RELEASE**
- **ZENPEP 10,000 UNIT-32,000 UNIT-42,000 UNIT CAPSULE,DELAYED RELEASE**
- **ZENPEP 15,000 UNIT-47,000 UNIT-63,000 UNIT CAPSULE,DELAYED RELEASE**
- **ZENPEP 20,000 UNIT-63,000 UNIT-84,000 UNIT CAPSULE,DELAYED RELEASE**
- **ZENPEP 25,000 UNIT-79,000 UNIT-105,000 UNIT CAPSULE,DELAYED RELEASE**
- **ZENPEP 3,000 UNIT-10,000 UNIT-14,000 UNIT CAPSULE,DELAYED RELEASE**
- **ZENPEP 40,000 UNIT-126,000 UNIT-168,000 UNIT CAPSULE,DELAYED RELEASE**
- **ZENPEP 5,000 UNIT-17,000 UNIT-24,000 UNIT CAPSULE,DELAYED RELEASE**
- **ZENPEP 60,000-189,600-252,600 UNIT CAPSULE,DELAYED RELEASE**

Details

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

Pegfilgrastim

Products Affected

- **FYLNETRA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **NYVEPRIA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **STIMUFEND 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **UDENYCA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE**
- **UDENYCA AUTOINJECTOR 6 MG/0.6 ML SUBCUTANEOUS AUTO-INJECTOR**

Details

Criteria	Require a trial of 2 of the following (Step 1 drug): Neulasta, Fulphila, or Ziextenzo in the last 180 days

Pennsaid

Products Affected

- *diclofenac 20 mg/gram/actuation (2 %) topical soln metered-dose pump*

Details

Criteria	Require a 1 month trial of Diclofenac 1.5% (Step 1 drug) in the last 90 days

Prostaglandins

Products Affected

- **IYUZEH (PF) 0.005 % EYE DROPS IN A DROPPERETTE**
- **VYZULTA 0.024 % EYE DROPS**
- **ZIOPTAN (PF) 0.0015 % EYE DROPS IN A DROPPERETTE**

Details

Criteria	Require a 1 month trial of brand Lumigan (Step 1 drug) plus one other preferred generic glaucoma drug (Step 1 drug) in the last 180 days.

Pulmonary Antiinflammatory

Products Affected

- *fluticasone propionate 100 mcg/actuation blister powder for inhalation*
- *fluticasone propionate 110 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 220 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 250 mcg/actuation blister powder for inhalation*
- *fluticasone propionate 44 mcg/actuation hfa aerosol inhaler*
- *fluticasone propionate 50 mcg/actuation blister powder for inhalation*

Details

Criteria	Require a 1 month trial of Qvar and Asmanex/Asmanex HFA (Step 1 drugs) in the last 180 days

Pulmonary Antiinflammatory Combo

Products Affected

- **ADVAIR DISKUS 100 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- **ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- **ADVAIR DISKUS 500 MCG-50 MCG/DOSE POWDER FOR INHALATION**
- *fluticasone furoate 100 mcg-vilanterol 25 mcg/dose inhalation powder*
- *fluticasone furoate 200 mcg-vilanterol 25 mcg/dose inhalation powder*
- **SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER**
- **SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER**

Details

Criteria	Require a trial of 2 of the following (Step 1 drugs) when utilized for the same medically accepted indication and age group: Advair HFA, Breo Ellipta and Dulera in the last 180 days

Rapid Acting Insulin

Products Affected

- **AFREZZA (REGULAR INSULIN) 8 UNIT (90)/12 UNIT (90) CARTRIDGE,INHALER**
- **AFREZZA 12 UNIT CARTRIDGE WITH INHALER**
- **AFREZZA 4 UNIT (60)/8 UNIT (60)/12 UNIT (60) CARTRIDGE WITH INHALER**
- **AFREZZA 4 UNIT (90)/8 UNIT (90) CARTRIDGE WITH INHALER**
- **AFREZZA 4 UNIT CARTRIDGE WITH INHALER**
- **AFREZZA 8 UNIT CARTRIDGE WITH INHALER**

Details

Criteria	Require a 1 month trial of Humalog, insulin lispro, Fiasp, Novolog or insulin aspart (Step 1 drug) in the last 90 days

Rho Kinase Inhibitors

Products Affected

- **RHOPRESSA 0.02 % EYE DROPS DROPS**
- **ROCKLATAN 0.02 %-0.005 % EYE**

Details

Criteria	Require a 1 month trial of one preferred glaucoma drug (Step 1 drug) in the last 120 days

Riomet

Products Affected

- *metformin 500 mg/5 ml oral solution*

Details

Criteria	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

Rytary

Products Affected

- **CREXONT 35 MG-140 MG CAPSULE, EXTENDED RELEASE**
- **CREXONT 52.5 MG-210 MG CAPSULE, EXTENDED RELEASE**
- **CREXONT 70 MG-280 MG CAPSULE, EXTENDED RELEASE**
- **CREXONT 87.5 MG-350 MG CAPSULE, EXTENDED RELEASE**
- **DHIVY 25 MG-100 MG TABLET**
- **RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE**
- **RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE**

Details

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

SGLT2 Agents

Products Affected

- *dapagliflozin propaned 10 mg-metformin er 1,000 mg tablet,ext rel 24hr*
- *dapagliflozin propaned 5 mg-metformin er 1,000 mg tablet, ext rel 24hr*
- *dapagliflozin propanediol 10 mg tablet*
- *dapagliflozin propanediol 5 mg tablet*
- **INPEFA 200 MG TABLET**
- **INPEFA 400 MG TABLET**
- **INVOKAMET 150 MG-1,000 MG TABLET**
- **INVOKAMET 150 MG-500 MG TABLET**
- **INVOKAMET 50 MG-1,000 MG TABLET**
- **INVOKAMET 50 MG-500 MG TABLET**
- **INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE**
- **INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE**
- **INVOKANA 100 MG TABLET**
- **INVOKANA 300 MG TABLET**
- **SEGLUROMET 2.5 MG-1,000 MG TABLET**
- **SEGLUROMET 2.5 MG-500 MG TABLET**
- **SEGLUROMET 7.5 MG-1,000 MG TABLET**
- **SEGLUROMET 7.5 MG-500 MG TABLET**
- **STEGLATRO 15 MG TABLET**
- **STEGLATRO 5 MG TABLET**

Details

Criteria	Require a 1 month trial of Farxiga/Xigduo XR and Jardiance/Synjardy/Synjardy XR (Step 1 drugs) in the last 180 days.

Sleeper Meds

Products Affected

- **BELSOMRA 10 MG TABLET**
- **BELSOMRA 15 MG TABLET**
- **BELSOMRA 20 MG TABLET**
- **BELSOMRA 5 MG TABLET**
- **DAYVIGO 10 MG TABLET**
- **DAYVIGO 5 MG TABLET**
- **QUVIVIQ 25 MG TABLET**
- **QUVIVIQ 50 MG TABLET**

Details

Criteria	Require a trial of 2 of the following (Step 1 drug): generic zolpidem tablet/zolpidem ER tablet, zaleplon or eszopiclone in the last 180 days

Soaanz

Products Affected

- **SOAANZ 20 MG TABLET**
- **SOAANZ 40 MG TABLET**
- **SOAANZ 60 MG TABLET**

Details

Criteria	Require a 1 month trial of generic furosemide tablets and generic torsemide tablets in the last 180 days

Suboxone

Products Affected

- **SUBOXONE 12 MG-3 MG SUBLINGUAL FILM**
- **SUBOXONE 2 MG-0.5 MG SUBLINGUAL FILM**
- **SUBOXONE 4 MG-1 MG SUBLINGUAL FILM**
- **SUBOXONE 8 MG-2 MG SUBLINGUAL FILM**

Details

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

Topical Antifungals

Products Affected

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

Details

Criteria	Require a 1 month trial of generic econazole cream and one of the following: generic ketoconazole cream or ketoconazole shampoo (Step 1 drugs),when being utilized for the same medically accepted indication, in the last 180 days

Topical Psoriasis

Products Affected

- *calcipotriene 0.005 % topical foam*
- *calcipotriene-betamethasone 0.005 %-0.064 % topical ointment*
- *calcipotriene-betamethasone 0.005 %-0.064 % topical suspension*
- *calcitriol 3 mcg/gram topical ointment*
- **ENSTILAR 0.005 %-0.064 % TOPICAL FOAM**
- **SORILUX 0.005 % TOPICAL FOAM**
- **TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION**
- **VECTICAL 3 MCG/GRAM TOPICAL OINTMENT**

Details

Criteria	Require a 1 month trial of generic calcipotriene cream, ointment or solution (Step 1 drug) in the last 90 days when utilized for the same medically accepted indication

Topical Rosacea

Products Affected

- *azelaic acid 15 % topical gel*
- *brimonidine 0.33 % topical gel with pump*
- **EPSOLAY 5 % TOPICAL CREAM**
- **FINACEA 15 % TOPICAL FOAM**
- *ivermectin 1 % topical cream*
- **METROCREAM 0.75 % TOPICAL**
- **METROGEL 1 % TOPICAL**
- **METROLOTION 0.75 % TOPICAL**
- **MIRVASO 0.33 % TOPICAL GEL WITH PUMP**
- **NORITATE 1 % TOPICAL CREAM**
- **RHOFADE 1 % TOPICAL CREAM**
- **SOOLANTRA 1 % TOPICAL CREAM**

Details

Criteria	Require a 1 month trial of generic metronidazole cream, lotion, or gel (Step 1 drug) in the last 90 days.

Ursodiol

Products Affected

- **RELTONE 200 MG CAPSULE**
- **RELTONE 400 MG CAPSULE**
- **URSO FORTE 500 MG TABLET**
- *ursodiol 200 mg capsule*
- *ursodiol 400 mg capsule*

Details

Criteria	Require a 1 month trial of generic ursodiol 250mg tablet, 300mg capsule or 500mg tablet (step 1 drug) in the last 90 days

Index of Drugs