Medicare Part D: 5 Tier Closed Performance Formulary

Please click here.

For Medicare Part D: Prior Authorization Criteria

Please click here.

For Medicare Part D: Step Therapy Criteria

Please click here.

Formulary ID: 20136 Version: 20

Updated: 12/2020

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

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

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

This document includes a list of the drugs (formulary) for our plan which is current as of 12/1/2020. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2020, 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, and Community Blue Medicare Plus PPO Formulary?

A formulary is a list of covered drugs selected by Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO 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. Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, and Community Blue Medicare Plus PPO will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

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

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the by Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO Formulary?”

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

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

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2020 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2020 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 year.

The enclosed formulary is current as of December 1, 2020. To get updated information about the drugs covered by Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO, please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, members will be notified by mail and prospective members will receive an update with this formulary. The most up-to-date formulary is available on our website, www.highmarkblueshield.com/medicare.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 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 number 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 77. 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?

Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, and Community Blue Medicare Plus PPO cover both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO before you fill your prescriptions. If you don't get approval, Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO may not cover the drug.

- **Quantity Limits:** For certain drugs, Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO limits the amount of the drug that Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO will cover. For example, Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, and Community Blue Medicare Plus PPO provides 9 tablets per prescription for 100mg Imitrex. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, and Community Blue Medicare Plus PPO 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, Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO 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 Web site. We have posted online document(s) that explain(s) our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO 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, or Community Blue Medicare Plus PPO 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 Customer Service and ask if your drug is covered.

If you learn that Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO.

- You can ask Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO 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, or Community Blue Medicare Plus PPO Formulary?

You can ask Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

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

- You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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

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

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

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

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

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

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

For more information

For more detailed information about your Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

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

The formulary that begins on the next page provides coverage information about the drugs covered by Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO. If you have trouble finding your drug in the list, turn to the Index that begins on page 94.

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 Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Community Blue Medicare PPO, or Community Blue Medicare Plus PPO has any special requirements for coverage of your drug.

The following is a Formulary Format Example Only:

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

Table of Contents

List of Abbreviations

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

T2: Cost-Sharing Tier 2 includes generic drugs.

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

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

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

LA: Limited access

PA: Prior authorization required

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

PA-NS: Prior authorization required for new starts only

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

ST: Step therapy applies

ST-NS: Step therapy applies to new starts only

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

List of Patterns

lowercase italics: Generic drugs

UPPERCASE BOLD: Brand name drugs

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
Anti - Infectives		
abacavir	T3	
abacavir-lamivudine	T5	
abacavir-lamivudine-zidovudine	T5	
ABELCET	T4	PA-BvD
acyclovir oral capsule	T2	
acyclovir oral suspension 200 mg/5 ml	T4	
acyclovir oral tablet	T2	
acyclovir sodium intravenous solution	T4	PA-BvD
adefovir	T4	
albendazole	T4	
ALINIA ORAL TABLET	T4	
amantadine hcl oral capsule	T4	QL (124 EA per 31 days)
amantadine hcl oral solution	T4	
amantadine hcl oral tablet	T4	
AMBISOME	T4	PA-BvD
amikacin injection solution 500 mg/2 ml	T3	
amoxicillin oral capsule	T1	
amoxicillin oral suspension for reconstitution	T1	
amoxicillin oral tablet	T2	
amoxicillin oral tablet,chewable 125 mg, 250 mg	T1	
amoxicillin-pot clavulanate	T2	
amphotericin b	T4	PA-BvD
ampicillin oral capsule 500 mg	T2	
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg	T2	
ampicillin-sulbactam injection	T2	
APTIVUS	T5	
APTIVUS (WITH VITAMIN E)	T5	
ARIKAYCE	T5	PA
atazanavir	T3	
atovaquone	T5	
atovaquone-proguanil	T4	
ATRIPLA	T5	
AZACTAM INJECTION RECON SOLN 2 GRAM	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
azithromycin	T2	
aztreonam injection recon soln 1 gram	T3	
BETHKIS	T4	PA
BICILLIN C-R	T3	
BICILLIN L-A	T3	
BIKTARVY	T5	QL (31 EA per 31 days)
CANCIDAS	T5	
caspofungin intravenous recon soln 50 mg	T5	
caspofungin intravenous recon soln 70 mg	T4	
CAYSTON	T5	
cefaclor oral capsule	T2	
cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml	T2	
cefaclor oral tablet extended release 12 hr	T3	
cefadroxil oral capsule	T2	
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	T2	
cefadroxil oral tablet	T2	
cefazolin injection recon soln 1 gram, 10 gram, 500 mg	T3	
cefdinir	T2	
cefepime injection	T4	
cefixime oral capsule	T3	
cefoxitin	T4	
cefpodoxime	T4	
cefprozil	T3	
ceftazidime	T4	
ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg	T3	
cefuroxime axetil oral tablet	T3	
cefuroxime sodium injection recon soln 750 mg	T3	
cefuroxime sodium intravenous	T3	
cephalexin	T2	
chloroquine phosphate	T3	QL (25 EA per 30 days)
CIMDUO	T5	QL (31 EA per 31 days)
ciprofloxacin hcl oral	T1	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	T2	
clarithromycin oral suspension for reconstitution	T4	
clarithromycin oral tablet	T2	
clarithromycin oral tablet extended release 24 hr	T2	
clindamycin hcl	T2	
clindamycin in 5 % dextrose	T2	
CLINDAMYCIN PEDIATRIC	T2	
clindamycin phosphate injection	T2	
clindamycin phosphate intravenous solution 600 mg/4 ml	T2	
clotrimazole mucous membrane	T3	
COARTEM	T4	
colistin (colistimethate na)	T4	
COMPLERA	T5	
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	T4	
dapsone oral	T3	
daptomycin	T5	
DELSTRIGO	T5	QL (31 EA per 31 days)
DESCOVY	T5	QL (31 EA per 31 days)
dicloxacillin	T2	
didanosine oral capsule,delayed release(dr/ec) 250 mg, 400 mg	T4	
DIFICID	T5	QL (20 EA per 10 days)
DOVATO	T5	QL (31 EA per 31 days)
DOXY-100	T2	
doxycycline hyclate oral capsule	T2	
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	T2	
doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg, 50 mg	T2	
doxycycline monohydrate oral capsule	T2	
doxycycline monohydrate oral suspension for reconstitution	T2	
doxycycline monohydrate oral tablet	T2	
EDURANT	T5	
efavirenz	T3	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
emtricitabine	T3	
EMTRIVA ORAL SOLUTION	T3	
EMVERM	T5	
entecavir	T4	
EPCLUSA ORAL TABLET 400-100 MG	T5	PA; QL (28 EA per 28 days)
EPIVIR HBV ORAL SOLUTION	T4	
ERAXIS(WATER DILUENT)	T4	
ertapenem	T4	
ERY-TAB	T4	
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	T4	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	T4	
erythromycin ethylsuccinate oral suspension for reconstitution	T2	
erythromycin ethylsuccinate oral tablet	T2	
erythromycin oral	T2	
ethambutol	T4	
EVOTAZ	T4	
famciclovir	T3	
FIRVANQ	T4	
fluconazole	T2	
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml	T2	
flucytosine	T4	
fosamprenavir	T4	
FUZEON SUBCUTANEOUS RECON SOLN	T5	
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml	T2	
gentamicin injection solution 40 mg/ml	T1	
GENVOYA	T5	
griseofulvin microsize	T4	
griseofulvin ultramicrosize	T4	
HARVONI ORAL PELLETS IN PACKET	T5	PA; QL (28 EA per 28 days)
HARVONI ORAL TABLET 90-400 MG	T5	PA; QL (28 EA per 28 days)
hydroxychloroquine	T2	QL (93 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
imipenem-cilastatin	T4	
INTELENCE ORAL TABLET 100 MG, 200 MG	T5	
INTELENCE ORAL TABLET 25 MG	T4	
INVIRASE ORAL TABLET	T4	
ISENTRESS	T3	
ISENTRESS HD	T4	
isoniazid oral solution	T2	
isoniazid oral tablet	T1	
itraconazole	T4	PA
ivermectin oral	T3	
JULUCA	T5	
KALETRA ORAL TABLET 100-25 MG	T3	
KALETRA ORAL TABLET 200-50 MG	T5	
ketoconazole oral	T4	
lamivudine	T2	
lamivudine-zidovudine	T2	
ledipasvir-sofosbuvir	T5	PA; QL (28 EA per 28 days)
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	T2	
levofloxacin intravenous	T2	
levofloxacin oral	T2	
LEXIVA ORAL SUSPENSION	T4	
linezolid in dextrose 5%	T5	
linezolid oral suspension for reconstitution	T5	
linezolid oral tablet	T4	
lopinavir-ritonavir	T5	
MAVYRET	T5	PA; QL (84 EA per 28 days)
mefloquine	T3	
meropenem	T4	
methenamine hippurate	T4	
metronidazole in nacl (iso-os)	T2	
metronidazole oral tablet	T2	
micafungin	T5	
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 page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
minocycline oral tablet extended release 24 hr	T2	
MONDOXYNE NL ORAL CAPSULE 100 MG, 75 MG	T2	
MYCAMINE	T5	
nafcillin injection	T4	
neomycin	T2	
nevirapine	T2	
nitrofurantoin	T4	QL (1800 ML per 365 days)
nitrofurantoin macrocrystal oral capsule 100 mg	T2	QL (90 EA per 365 days)
nitrofurantoin macrocrystal oral capsule 25 mg	T2	QL (360 EA per 365 days)
nitrofurantoin macrocrystal oral capsule 50 mg	T2	QL (180 EA per 365 days)
nitrofurantoin monohyd/m-cryst	T2	QL (90 EA per 365 days)
NORVIR ORAL POWDER IN PACKET	T3	
NORVIR ORAL SOLUTION	T3	
NUZYRA	T5	
nystatin oral suspension	T2	
nystatin oral tablet	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
ofloxacin oral tablet 300 mg, 400 mg	T2	
oseltamivir oral capsule 30 mg	T2	QL (170 EA per 365 days)
oseltamivir oral capsule 45 mg, 75 mg	T2	QL (90 EA per 365 days)
oseltamivir oral suspension for reconstitution	T3	QL (1080 ML per 365 days)
oxacillin in dextrose(iso-osm)	T4	
oxacillin injection recon soln 1 gram, 2 gram	T2	
paromomycin	T4	
PASER	T4	
penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml	T4	
penicillin g potassium injection recon soln 20 million unit	T4	
penicillin g procaine intramuscular syringe 1.2 million unit/2 ml	T4	
penicillin v potassium	T1	
pentamidine inhalation	T4	PA-BvD
pentamidine injection	T4	
PIFELTRO	T5	QL (62 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
sulfamethoxazole-trimethoprim oral tablet	T1	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	T3	
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)
TAZICEF INJECTION	T4	
TEFLARO	T5	
tenofovir disoproxil fumarate	T3	
terbinafine hcl oral	T2	QL (90 EA per 180 days)
tetracycline	T4	
tigecycline	T5	
TIVICAY ORAL TABLET 10 MG	T4	
TIVICAY ORAL TABLET 25 MG, 50 MG	T5	
TIVICAY PD	T4	
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	T3	PA; QL (224 EA per 56 days)
tobramycin in 0.225 % nacl	T5	PA
tobramycin sulfate injection solution	T4	
TOLSURA	T5	PA; QL (130 EA per 31 days)
TRECATOR	T4	
trimethoprim	T2	
TRIUMEQ	T5	
TRUVADA	T5	
TYBOST	T3	
VABOMERE	T4	
valacyclovir	T3	
valganciclovir oral recon soln	T4	
valganciclovir oral tablet	T5	
vancomycin intravenous recon soln 1,000 mg, 10 gram, 250 mg, 500 mg, 750 mg	T4	
vancomycin oral capsule 125 mg	T4	
vancomycin oral capsule 250 mg	T5	
vancomycin oral recon soln	T4	
VEMLIDY	T4	QL (31 EA per 31 days)
VIEKIRA PAK	T5	PA; QL (112 EA per 28 days)
VIRACEPT ORAL TABLET	T5	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
VIREAD ORAL POWDER	T4	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	T4	
voriconazole intravenous	T4	
voriconazole oral	T5	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XENLETA ORAL	T5	
XIFAXAN ORAL TABLET 200 MG	T5	QL (9 EA per 3 days)
XIFAXAN ORAL TABLET 550 MG	T5	PA; QL (62 EA per 31 days)
XOFLUZA	T3	QL (18 EA per 365 days)
ZEMDRI	T5	
ZEPATIER	T5	PA; QL (28 EA per 28 days)
zidovudine	T2	
Antineoplastic / Immunosuppressant Drugs		
abiraterone	T5	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)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	T5	PA-NS; QL (31 EA per 31 days)
ALUNBRIG ORAL TABLET 30 MG	T5	PA-NS; QL (186 EA per 31 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	T5	PA-NS; QL (30 EA per 365 days)
anastrozole	T2	
AYVAKIT	T5	PA-NS; QL (31 EA per 31 days)
azathioprine	T2	PA-BvD
BALVERSA	T5	PA-NS
bexarotene	T5	PA-NS
bicalutamide	T3	
BOSULIF	T5	PA-NS
BRAFTOVI ORAL CAPSULE 75 MG	T5	PA-NS; QL (186 EA per 31 days)
BRUKINSA	T5	PA-NS; QL (124 EA per 31 days)
BYNFEZIA	T5	
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CALQUENCE	T5	PA-NS; QL (62 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
CAPRELSA	T5	PA-NS
COMETRIQ	T5	PA-NS
COPIKTRA	T5	PA-NS; QL (62 EA per 31 days)
COTELLIC	T5	PA-NS; LA
cyclophosphamide oral capsule	T3	PA-BvD
cyclosporine modified	T2	PA-BvD
cyclosporine oral capsule	T2	PA-BvD
DAURISMO ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
DAURISMO ORAL TABLET 25 MG	T5	PA-NS; QL (62 EA per 31 days)
DROXIA	T4	
EMCYT	T4	
ENSPRYNG	T5	PA; QL (1 ML per 28 days)
ERIVEDGE	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA	T5	PA-NS; QL (124 EA per 31 days)
erlotinib	T5	PA-NS; QL (31 EA per 31 days)
everolimus (antineoplastic) oral tablet 2.5 mg, 7.5 mg	T5	PA-NS; QL (31 EA per 31 days)
everolimus (antineoplastic) oral tablet 5 mg	T5	PA-NS; QL (62 EA per 31 days)
everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg	T4	PA-BvD
everolimus (immunosuppressive) oral tablet 0.75 mg	T5	PA-BvD
exemestane	T4	
FARYDAK ORAL CAPSULE 10 MG, 20 MG	T5	PA-NS
flutamide	T4	
GAVRETO	T5	PA-NS; QL (124 EA per 31 days)
GENGRAF ORAL CAPSULE 100 MG, 25 MG	T2	PA-BvD
GENGRAF ORAL SOLUTION	T2	PA-BvD
GILOTRIF	T5	PA-NS; QL (31 EA per 31 days)
GLEOSTINE ORAL CAPSULE 10 MG, 40 MG	T4	
GLEOSTINE ORAL CAPSULE 100 MG	T5	
hydroxyurea	T2	
IBRANCE	T5	PA-NS; QL (21 EA per 28 days)
ICLUSIG ORAL TABLET 15 MG	T5	PA-NS; QL (31 EA per 31 days)
ICLUSIG ORAL TABLET 45 MG	T5	PA-NS; QL (62 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
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 TABLET	T5	PA-NS; QL (31 EA per 31 days)
INLYTA	T5	PA-NS; QL (124 EA per 31 days)
INQOVI	T5	PA-NS; QL (5 EA per 28 days)
INREBIC	T5	PA-NS; QL (124 EA per 31 days)
IRESSA	T5	PA-NS
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	T5	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	T5	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	T5	PA-NS; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
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)
LENVIMA	T5	PA-NS
letrozole	T2	
leucovorin calcium oral	T3	
LEUKERAN	T4	
leuprolide subcutaneous kit	T3	
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)
LUPRON DEPOT	T5	
LUPRON DEPOT (3 MONTH)	T5	
LUPRON DEPOT (4 MONTH)	T5	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
LUPRON DEPOT (6 MONTH)	T5	
LYNPARZA ORAL TABLET	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T3	
MATULANE	T5	
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)	T4	PA
megestrol oral tablet	T4	PA-NS
MEKINIST	T5	PA-NS
MEKTOVI	T5	PA-NS; QL (186 EA per 31 days)
mercaptopurine	T2	
MESNEX ORAL	T4	
methotrexate sodium	T2	PA-BvD
methotrexate sodium (pf) injection solution	T2	PA-BvD
MYCAPSSA	T5	PA; QL (124 EA per 31 days)
mycophenolate mofetil	T2	PA-BvD
mycophenolate sodium	T4	PA-BvD
NEORAL	T3	PA-BvD
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
NEXAVAR	T5	PA-NS; QL (124 EA per 31 days)
nilutamide	T5	
NINLARO	T5	PA-NS
NUBEQA	T5	PA-NS; QL (124 EA per 31 days)
octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml	T3	
octreotide acetate injection solution 500 mcg/ml	T5	
ODOMZO	T5	PA-NS; LA
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 GRANULES IN PACKET	T4	PA-BvD
PURIXAN	T4	
QINLOCK	T5	PA-NS; QL (93 EA per 31 days)
RAPAMUNE ORAL SOLUTION	T5	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
RAPAMUNE ORAL TABLET 0.5 MG	T4	PA-BvD
RAPAMUNE ORAL TABLET 1 MG, 2 MG	T5	PA-BvD
RETEVMO ORAL CAPSULE 40 MG	T5	PA-NS; QL (186 EA per 31 days)
RETEVMO ORAL CAPSULE 80 MG	T5	PA-NS; QL (124 EA per 31 days)
REVLIMID	T5	PA-NS; QL (21 EA per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	T5	PA-NS; QL (155 EA per 31 days)
ROZLYTREK ORAL CAPSULE 200 MG	T5	PA-NS; QL (93 EA per 31 days)
RUBRACA	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE ORAL SOLUTION	T3	PA-BvD
SIGNIFOR	T5	PA
SIKLOS	T4	
sirolimus oral solution	T4	PA-BvD
sirolimus oral tablet 0.5 mg, 2 mg	T2	PA-BvD
sirolimus oral tablet 1 mg	T4	PA-BvD
SOLTAMOX	T4	
SOMATULINE DEPOT	T5	
SPRYCEL	T5	PA-NS; QL (31 EA per 31 days)
STIVARGA	T5	PA-NS; QL (84 EA per 28 days)
SUTENT	T5	PA-NS
SYNRIBO	T5	
TABLOID	T4	
TABRECTA	T5	PA-NS; QL (124 EA per 31 days)
tacrolimus oral capsule 0.5 mg, 1 mg	T2	PA-BvD
tacrolimus oral capsule 5 mg	T4	PA-BvD
TAFINLAR	T5	PA-NS
TAGRISSO	T5	PA-NS; LA; QL (31 EA per 31 days)
TALZENNA ORAL CAPSULE 0.25 MG	T5	PA-NS; QL (93 EA per 31 days)
TALZENNA ORAL CAPSULE 1 MG	T5	PA-NS; QL (31 EA per 31 days)
tamoxifen	T1	
TARCEVA	T5	PA-NS; QL (31 EA per 31 days)
TARGRETIN TOPICAL	T5	PA-NS
TASIGNA	T5	PA-NS; QL (124 EA per 31 days)
TAZVERIK	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 page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
THALOMID ORAL CAPSULE 100 MG, 150 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 200 MG	T5	PA-NS; QL (56 EA per 28 days)
TIBSOVO	T5	PA-NS; QL (62 EA per 31 days)
toremifene	T4	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG, 22.5 MG	T3	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG	T5	
tretinoin (antineoplastic)	T5	
TUKYSA ORAL TABLET 150 MG	T5	PA-NS; QL (124 EA per 31 days)
TUKYSA ORAL TABLET 50 MG	T5	PA-NS; QL (248 EA per 31 days)
TURALIO	T5	PA-NS; QL (124 EA per 31 days)
TYKERB	T5	PA-NS
VENCLEXTA ORAL TABLET 10 MG	T4	PA-NS
VENCLEXTA ORAL TABLET 100 MG, 50 MG	T5	PA-NS
VENCLEXTA STARTING PACK	T5	PA-NS
VERZENIO	T5	PA-NS; QL (62 EA per 31 days)
VITRAKVI ORAL CAPSULE 100 MG	T5	PA-NS; QL (62 EA per 31 days)
VITRAKVI ORAL CAPSULE 25 MG	T5	PA-NS; QL (186 EA per 31 days)
VITRAKVI ORAL SOLUTION	T5	PA-NS; QL (310 ML per 31 days)
VIZIMPRO	T5	PA-NS; QL (31 EA per 31 days)
VOTRIENT	T5	PA-NS; QL (124 EA per 31 days)
XALKORI	T5	PA-NS; QL (62 EA per 31 days)
XATMEP	T4	PA-BvD
XERMELO	T5	PA; QL (93 EA per 31 days)
XGEVA	T5	
XOSPATA	T5	PA-NS; QL (124 EA per 31 days)
XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5)	T5	PA-NS; QL (20 EA per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (20 MG X 2)	T5	PA-NS; QL (8 EA per 28 days)
XPOVIO ORAL TABLET 40MG TWICE WEEK (80 MG/WEEK), 80 MG/WEEK (20 MG X 4)	T5	PA-NS; QL (16 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
XPOVIO ORAL TABLET 60 MG/WEEK (20 MG X 3)	T5	PA-NS; QL (12 EA per 28 days)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)	T5	PA-NS; QL (24 EA per 28 days)
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	T5	PA-NS; QL (32 EA per 28 days)
XTANDI	T5	PA-NS; QL (124 EA per 31 days)
YONSA	T5	PA-NS; QL (124 EA per 31 days)
ZEJULA	T5	PA-NS; QL (93 EA per 31 days)
ZELBORAF	T5	PA-NS
ZOLINZA	T5	PA-NS
ZORTRESS ORAL TABLET 0.25 MG, 0.75 MG, 1 MG	T5	PA-BvD
ZORTRESS ORAL TABLET 0.5 MG	T4	PA-BvD
ZYDELIG	T5	PA-NS; QL (62 EA per 31 days)
ZYKADIA ORAL TABLET	T5	PA-NS; QL (93 EA per 31 days)
ZYTIGA ORAL TABLET 500 MG	T5	PA-NS; QL (62 EA per 31 days)
Autonomic / Cns Drugs, Neurology / Psych		
ABILIFY MAINTENA	T5	QL (1 EA per 28 days)
acetaminophen-codeine oral solution 120-12 mg/5 ml	T2	PA; QL (5167 ML per 31 days)
acetaminophen-codeine oral tablet	T2	PA; QL (403 EA per 31 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	T3	PA; QL (1 ML per 28 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	T3	PA; QL (2 ML per 28 days)
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)
amitriptyline	T2	PA-NS
amoxapine	T2	
APOKYN	T5	PA
APTIOM	T5	
aripiprazole oral solution	T4	PA-NS
aripiprazole oral tablet	T4	PA-NS
aripiprazole oral tablet,disintegrating	T5	PA-NS

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
armodafinil	T4	PA; QL (31 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)
baclofen oral tablet 10 mg, 20 mg	T2	
BAFIERTAM	T5	PA; QL (124 EA per 31 days)
BANZEL	T5	PA-NS
benztropine oral	T2	PA
BRIVIACT ORAL	T5	PA-NS
bromocriptine	T4	
BUNAVAIL BUCCAL FILM 2.1-0.3 MG	T4	ST; QL (31 EA per 31 days)
BUNAVAIL BUCCAL FILM 4.2-0.7 MG, 6.3-1 MG	T4	ST; QL (62 EA per 31 days)
buprenorphine	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	T2	QL (62 EA per 31 days)
buprenorphine-naloxone sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg	T2	QL (93 EA per 31 days)
bupropion hcl oral tablet	T3	
bupropion hcl oral tablet extended release 24 hr 150 mg	T3	QL (93 EA per 31 days)
bupropion hcl oral tablet extended release 24 hr 300 mg	T3	QL (31 EA per 31 days)
bupropion hcl oral tablet extended release 24 hr 450 mg	T4	
bupropion hcl oral tablet sustained-release 12 hr	T3	QL (62 EA per 31 days)
buspirone	T2	
butorphanol nasal	T4	QL (5 ML per 28 days)
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	T2	
carbamazepine oral tablet	T2	
carbamazepine oral tablet extended release 12 hr	T2	
carbamazepine oral tablet,chewable	T2	
carbidopa-levodopa	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
carbidopa-levodopa-entacapone	T4	
celecoxib	T4	ST; QL (62 EA per 31 days)
CELONTIN ORAL CAPSULE 300 MG	T4	
chlorpromazine oral	T4	
citalopram	T1	
clobazam oral suspension	T4	PA-NS
clobazam oral tablet 10 mg	T4	PA-NS
clobazam oral tablet 20 mg	T5	PA-NS
clomipramine	T4	PA-NS
clonazepam oral tablet 0.5 mg	T2	QL (93 EA per 31 days)
clonazepam oral tablet 1 mg	T2	QL (124 EA per 31 days)
clonazepam oral tablet 2 mg	T2	QL (310 EA per 31 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg	T2	QL (93 EA per 31 days)
clonazepam oral tablet,disintegrating 1 mg	T2	QL (124 EA per 31 days)
clonazepam oral tablet,disintegrating 2 mg	T2	QL (310 EA per 31 days)
clorazepate dipotassium oral tablet 15 mg	T2	QL (186 EA per 31 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	T2	QL (93 EA per 31 days)
clozapine oral tablet	T2	
clozapine oral tablet,disintegrating	T4	
cyclobenzaprine oral tablet 10 mg, 5 mg	T2	PA
dalfampridine	T5	PA; QL (62 EA per 31 days)
dantrolene oral	T4	
desipramine	T4	
desvenlafaxine succinate	T4	QL (31 EA per 31 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr	T3	QL (31 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	T2	QL (62 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 20 mg	T2	QL (93 EA per 31 days)
diazepam oral concentrate	T2	QL (248 ML per 31 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	T2	QL (1500 ML per 31 days)
diazepam oral tablet	T2	QL (124 EA per 31 days)
diazepam rectal	T4	
diclofenac epolamine	T4	PA; QL (62 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
diclofenac potassium	T2	
diclofenac sodium oral	T2	
diclofenac sodium topical drops	T2	QL (450 ML per 28 days)
diclofenac sodium topical gel 1 %	T3	QL (900 GM per 28 days)
diflunisal	T4	
dihydroergotamine nasal	T4	QL (8 ML per 31 days)
DILANTIN	T4	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	
DILANTIN-125	T4	
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	T3	
divalproex oral tablet,delayed release (dr/ec)	T2	
donepezil	T2	
doxepin oral capsule	T3	PA-NS
doxepin oral concentrate	T2	PA-NS
doxepin oral tablet	T3	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	T3	QL (62 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 30 mg, 40 mg	T3	QL (31 EA per 31 days)
EMGALITY PEN	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	T3	PA; QL (3 ML per 28 days)
EMSAM	T5	QL (30 EA per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	T3	PA; QL (372 EA per 31 days)
entacapone	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
EPIDIOLEX	T5	PA-NS
EPITOL	T2	
ergotamine-caffeine	T2	
escitalopram oxalate oral solution	T4	QL (620 ML per 31 days)
escitalopram oxalate oral tablet 10 mg	T4	QL (45 EA per 30 days)
escitalopram oxalate oral tablet 20 mg, 5 mg	T4	QL (30 EA per 30 days)
ethosuximide	T4	
etodolac	T2	
EVRYSDI	T5	PA; QL (217 ML per 31 days)
FANAPT ORAL TABLET	T4	QL (62 EA per 31 days)
FANAPT ORAL TABLETS,DOSE PACK	T4	QL (16 EA per 365 days)
felbamate	T4	
fentanyl citrate buccal lozenge on a handle 1,200 mcg	T5	PA; QL (40 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 1,600 mcg	T5	PA; QL (30 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 200 mcg	T5	PA; QL (124 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 400 mcg	T5	PA; QL (119 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 600 mcg	T5	PA; QL (79 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 800 mcg	T5	PA; QL (59 EA per 31 days)
fentanyl citrate buccal tablet, effervescent 100 mcg, 200 mcg	T5	PA; QL (124 EA per 31 days)
fentanyl citrate buccal tablet, effervescent 400 mcg	T5	PA; QL (119 EA per 31 days)
fentanyl citrate buccal tablet, effervescent 600 mcg	T5	PA; QL (79 EA per 31 days)
fentanyl citrate buccal tablet, effervescent 800 mcg	T5	PA; QL (59 EA per 31 days)
fentanyl transdermal patch 72 hour 100 mcg/hr	T4	PA; QL (10 EA per 30 days)
fentanyl transdermal patch 72 hour 12 mcg/hr	T4	PA; QL (20 EA per 30 days)
fentanyl transdermal patch 72 hour 25 mcg/hr	T2	PA; QL (20 EA per 30 days)
fentanyl transdermal patch 72 hour 50 mcg/hr	T2	PA; QL (17 EA per 30 days)
fentanyl transdermal patch 72 hour 75 mcg/hr	T4	PA; QL (12 EA per 30 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG	T5	PA; QL (124 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
FENTORA BUCCAL TABLET, EFFERVESCENT 400 MCG	T5	PA; QL (119 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 600 MCG	T5	PA; QL (79 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 800 MCG	T5	PA; QL (59 EA per 31 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	T4	PA-NS; QL (56 EA per 365 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG	T4	PA-NS; QL (31 EA per 31 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	T4	PA-NS; QL (93 EA per 31 days)
FINTEPLA	T5	PA-NS; QL (360 ML per 30 days)
FIRDAPSE	T5	PA; QL (248 EA per 31 days)
FLECTOR	T4	PA; QL (62 EA per 31 days)
fluoxetine oral capsule	T1	
fluoxetine oral solution	T1	
fluoxetine oral tablet 10 mg, 20 mg	T2	
fluphenazine decanoate	T4	
fluphenazine hcl	T2	
flurbiprofen oral tablet 100 mg	T2	
fluvoxamine oral capsule,extended release 24hr	T4	
fluvoxamine oral tablet	T2	
FYCOMPA ORAL SUSPENSION	T4	
FYCOMPA ORAL TABLET 10 MG, 12 MG	T4	
FYCOMPA ORAL TABLET 2 MG, 4 MG, 6 MG, 8 MG	T5	
gabapentin oral capsule	T2	PA-NS
gabapentin oral solution 250 mg/5 ml	T2	PA-NS
gabapentin oral tablet 600 mg, 800 mg	T2	PA-NS
galantamine	T4	
GEODON INTRAMUSCULAR	T4	
GILENYA ORAL CAPSULE 0.5 MG	T5	PA; QL (31 EA per 31 days)
glatiramer subcutaneous syringe 20 mg/ml	T5	QL (31 ML per 31 days)
glatiramer subcutaneous syringe 40 mg/ml	T5	QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	T5	QL (31 ML per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	T5	QL (12 ML per 28 days)
guanfacine oral tablet extended release 24 hr	T4	PA
guanidine	T2	
haloperidol	T2	
haloperidol decanoate	T2	
haloperidol lactate injection	T2	
haloperidol lactate oral	T2	
HETLIOZ	T5	PA
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	T4	PA; QL (5723 ML per 31 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	T3	PA; QL (155 EA per 31 days)
hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml	T2	PA; QL (124 ML per 31 days)
hydromorphone oral liquid	T4	PA; QL (1550 ML per 31 days)
hydromorphone oral tablet	T2	PA; QL (186 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	
ibuprofen oral suspension	T1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	T1	
imipramine hcl	T2	PA-NS
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	T5	PA
indomethacin oral	T2	
INGREZZA INITIATION PACK	T5	PA; QL (56 EA per 365 days)
INGREZZA ORAL CAPSULE 40 MG	T5	PA; QL (62 EA per 31 days)
INGREZZA ORAL CAPSULE 80 MG	T5	PA; QL (31 EA per 31 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	T5	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	T5	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	T5	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T4	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	T5	QL (0.5 ML per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.875 ML	T5	QL (0.875 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.315 ML	T5	QL (1.315 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	T5	QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.625 ML	T5	QL (2.625 ML per 84 days)
KESIMPTA PEN	T5	PA; QL (0.4 ML per 28 days)
ketoprofen oral capsule	T3	
ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg	T3	
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	T5	PA; QL (155 EA per 31 days)
lamotrigine oral tablet	T2	
lamotrigine oral tablet extended release 24hr	T4	
lamotrigine oral tablet, chewable dispersible	T2	
lamotrigine oral tablets,dose pack	T2	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	T5	PA-NS; QL (31 EA per 31 days)
LATUDA ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
levetiracetam oral solution 100 mg/ml	T2	
levetiracetam oral tablet	T2	
levetiracetam oral tablet extended release 24 hr	T2	
lithium carbonate oral capsule	T1	
lithium carbonate oral tablet	T1	
lithium carbonate oral tablet extended release	T2	
lithium citrate oral solution 8 meq/5 ml	T2	
lorazepam oral concentrate	T2	QL (155 ML per 31 days)
lorazepam oral tablet 0.5 mg	T2	QL (124 EA per 31 days)
lorazepam oral tablet 1 mg	T2	QL (186 EA per 31 days)
lorazepam oral tablet 2 mg	T2	QL (155 EA per 31 days)
loxapine succinate	T2	
LUCEMYRA	T5	
LYRICA CR	T4	PA; QL (31 EA per 31 days)
maprotiline	T2	
MARPLAN	T4	
MAVENCLAD (10 TABLET PACK)	T5	PA; QL (40 EA per 365 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
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)
MAYZENT ORAL TABLET 0.25 MG	T5	PA; QL (155 EA per 31 days)
MAYZENT ORAL TABLET 2 MG	T5	PA; QL (31 EA per 31 days)
meloxicam oral tablet	T1	
memantine oral capsule,sprinkle,er 24hr	T3	
memantine oral solution	T3	
memantine oral tablet	T3	
memantine oral tablets,dose pack	T4	
methadone oral solution 10 mg/5 ml	T2	PA; QL (1033 ML per 31 days)
methadone oral solution 5 mg/5 ml	T2	PA; QL (2066 ML per 31 days)
methadone oral tablet 10 mg	T2	PA; QL (206 EA per 31 days)
methadone oral tablet 5 mg	T2	PA; QL (248 EA per 31 days)
methylphenidate hcl oral capsule, er biphasic 30-70	T4	QL (31 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 10 mg	T4	QL (186 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 20 mg	T4	QL (93 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 40 mg	T4	QL (62 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 60 mg	T4	QL (31 EA per 31 days)
methylphenidate hcl oral solution	T2	
methylphenidate hcl oral tablet	T2	QL (93 EA per 31 days)
methylphenidate hcl oral tablet extended release 10 mg	T4	QL (31 EA per 31 days)
methylphenidate hcl oral tablet extended release 20 mg	T4	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)	T4	QL (31 EA per 31 days)
methylphenidate hcl oral tablet,chewable 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 page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
methylphenidate hcl oral tablet,chewable 2.5 mg, 5 mg	T2	QL (93 EA per 31 days)
mirtazapine	T2	
modafinil	T3	PA; QL (31 EA per 31 days)
molindone	T2	
morphine concentrate oral solution	T2	PA; QL (310 ML per 31 days)
morphine oral capsule, er multiphase 24 hr 120 mg	T4	PA; QL (51 EA per 31 days)
morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	T4	PA; QL (62 EA per 31 days)
morphine oral capsule,extend.release pellets	T3	PA; QL (62 EA per 31 days)
morphine oral solution 10 mg/5 ml	T2	PA; QL (2800 ML per 31 days)
morphine oral solution 20 mg/5 ml (4 mg/ml)	T2	PA; QL (1400 ML per 31 days)
morphine oral tablet	T2	PA; QL (186 EA per 31 days)
morphine oral tablet extended release 100 mg	T3	PA; QL (62 EA per 31 days)
morphine oral tablet extended release 15 mg, 30 mg, 60 mg	T3	PA; QL (100 EA per 31 days)
morphine oral tablet extended release 200 mg	T3	PA; QL (31 EA per 31 days)
nabumetone	T2	
naloxone injection solution	T2	
naloxone injection syringe	T2	
naltrexone	T3	
NAMZARIC	T4	PA
naproxen oral suspension	T2	
naproxen oral tablet	T1	
naproxen oral tablet,delayed release (dr/ec)	T2	
naproxen sodium oral tablet 275 mg, 550 mg	T4	
naratriptan oral tablet 1 mg	T3	QL (20 EA per 28 days)
naratriptan oral tablet 2.5 mg	T3	QL (8 EA per 28 days)
NARCAN NASAL SPRAY,NON-AEROSOL 4 MG/ACTUATION	T3	
NAYZILAM	T4	PA-NS; QL (10 EA per 30 days)
nefazodone	T4	
NEUPRO	T4	
nortriptyline	T2	
NOURIANZ	T5	PA; QL (31 EA per 31 days)
NUEDEXTA	T3	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
NUPLAZID ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
NUPLAZID ORAL TABLET 10 MG	T5	PA-NS; QL (31 EA per 31 days)
NURTEC ODT	T4	QL (15 EA per 28 days)
olanzapine intramuscular	T4	
olanzapine oral tablet	T2	QL (31 EA per 31 days)
olanzapine oral tablet,disintegrating	T4	QL (31 EA per 31 days)
ONGENTYS	T4	PA; QL (31 EA per 31 days)
oxcarbazepine	T2	
oxycodone oral capsule	T2	PA; QL (186 EA per 31 days)
oxycodone oral concentrate	T4	PA; QL (180 ML per 31 days)
oxycodone oral solution	T2	PA; QL (4133 ML per 31 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg	T2	PA; QL (186 EA per 31 days)
oxycodone oral tablet 30 mg	T3	PA; QL (138 EA per 31 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	T3	PA; QL (372 EA per 31 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	T4	QL (31 EA per 31 days)
paliperidone oral tablet extended release 24hr 6 mg	T4	QL (62 EA per 31 days)
paroxetine hcl oral tablet	T1	
PAXIL ORAL SUSPENSION	T4	
PEGANONE	T4	
perphenazine	T4	
PERSERIS	T5	QL (1 EA per 28 days)
phenelzine	T2	
phenobarbital	T2	
PHENYTEK	T4	
phenytoin oral suspension 125 mg/5 ml	T2	
phenytoin oral tablet,chewable	T2	
phenytoin sodium extended	T2	
pimozide	T4	
piroxicam	T4	
pramipexole oral tablet	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)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
primidone	T2	
protriptyline	T4	
pyridostigmine bromide	T3	
quetiapine	T3	QL (62 EA per 31 days)
ramelteon	T4	QL (31 EA per 31 days)
rasagiline	T4	
REXULTI	T5	PA-NS; QL (31 EA per 31 days)
REYVOW ORAL TABLET 100 MG	T4	QL (8 EA per 28 days)
REYVOW ORAL TABLET 50 MG	T4	QL (4 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	T4	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	T5	QL (2 EA per 28 days)
risperidone oral solution	T2	QL (496 ML per 31 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	T2	QL (31 EA per 31 days)
risperidone oral tablet 3 mg	T2	QL (93 EA per 31 days)
risperidone oral tablet 4 mg	T2	QL (124 EA per 31 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg	T4	QL (31 EA per 31 days)
risperidone oral tablet,disintegrating 3 mg	T4	QL (93 EA per 31 days)
risperidone oral tablet,disintegrating 4 mg	T4	QL (124 EA per 31 days)
rivastigmine	T4	QL (30 EA per 30 days)
rivastigmine tartrate	T3	
rizatriptan oral tablet 10 mg	T3	QL (12 EA per 28 days)
rizatriptan oral tablet 5 mg	T3	QL (24 EA per 28 days)
rizatriptan oral tablet,disintegrating 10 mg	T3	QL (12 EA per 28 days)
rizatriptan oral tablet,disintegrating 5 mg	T3	QL (24 EA per 28 days)
ropinirole oral tablet	T2	
ROWEEPRA	T2	
ROWEEPRA XR	T2	
RUZURGI	T5	PA; QL (310 EA per 31 days)
SAPHRIS SUBLINGUAL TABLET 10 MG	T5	QL (62 EA per 31 days)
SAPHRIS SUBLINGUAL TABLET 2.5 MG, 5 MG	T4	QL (62 EA per 31 days)
SECUADO	T5	QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
selegiline hcl	T2	
sertraline	T1	
SPRITAM	T4	
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY	T5	PA; QL (124 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 400 MCG/SPRAY	T5	PA; QL (86 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 600 MCG/SPRAY	T5	PA; QL (57 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 800 MCG/SPRAY	T5	PA; QL (43 EA per 31 days)
sulindac	T2	
sumatriptan nasal spray,non-aerosol 20 mg/actuation	T2	QL (8 EA per 28 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	T2	QL (32 EA per 28 days)
sumatriptan succinate oral tablet 100 mg	T2	QL (9 EA per 28 days)
sumatriptan succinate oral tablet 25 mg	T2	QL (36 EA per 28 days)
sumatriptan succinate oral tablet 50 mg	T2	QL (18 EA per 28 days)
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml	T2	QL (6 ML per 28 days)
sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml	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)
sumatriptan succinate subcutaneous solution	T2	QL (4 ML per 28 days)
sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml	T2	QL (4 ML per 28 days)
SUNOSI	T4	PA; QL (31 EA per 31 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	T5	PA-NS
SYMPAZAN ORAL FILM 5 MG	T4	PA-NS
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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
TEGRETOL ORAL TABLET	T4	
TEGRETOL XR	T4	
TEGSEDI	T5	PA; QL (6 ML per 28 days)
temazepam	T3	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	T4	
thiothixene	T4	
tiagabine	T4	
tizanidine oral tablet	T2	
tolcapone	T5	
topiramate oral capsule, sprinkle	T2	
topiramate oral capsule,sprinkle,er 24hr 100 mg, 200 mg, 25 mg, 50 mg	T4	
topiramate oral tablet	T2	
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 50 mg	T2	PA; QL (240 EA per 30 days)
tramadol-acetaminophen	T2	PA; QL (372 EA per 31 days)
tranylcypromine	T4	
trazodone oral tablet 100 mg, 150 mg, 50 mg	T1	
trifluoperazine	T4	
trimipramine	T3	PA-NS
TRINTELLIX	T3	PA-NS
UBRELVY ORAL TABLET 100 MG	T4	QL (17 EA per 28 days)
UBRELVY ORAL TABLET 50 MG	T4	QL (34 EA per 28 days)
valproic acid	T2	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	T2	
VALTOCO	T4	PA-NS; QL (10 EA per 30 days)
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	T2	QL (31 EA per 31 days)
venlafaxine oral capsule,extended release 24hr 75 mg	T2	QL (93 EA per 31 days)
venlafaxine oral tablet	T2	
VERSACLOZ	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
vigabatrin	T5	PA-NS
VIGADRONE	T5	PA-NS
VIIBRYD ORAL TABLET	T3	PA-NS; QL (31 EA per 31 days)
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)	T3	PA-NS; QL (60 EA per 365 days)
VIMPAT ORAL SOLUTION	T4	PA-NS
VIMPAT ORAL TABLET	T4	PA-NS
VIVITROL	T5	
VRAYLAR ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
VRAYLAR ORAL CAPSULE,DOSE PACK	T4	PA-NS; QL (14 EA per 365 days)
VUMERITY	T5	PA; QL (124 EA per 31 days)
WAKIX	T5	PA; QL (62 EA per 31 days)
XCOPRI MAINTENANCE PACK	T5	PA-NS
XCOPRI ORAL TABLET 100 MG, 150 MG, 50 MG	T4	PA-NS
XCOPRI ORAL TABLET 200 MG	T5	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	T4	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	T5	PA-NS
XYREM	T5	PA; QL (540 ML per 30 days)
zaleplon oral capsule 10 mg	T4	QL (62 EA per 31 days)
zaleplon oral capsule 5 mg	T4	QL (93 EA per 31 days)
ZEPOSIA	T5	PA; QL (31 EA per 31 days)
ZEPOSIA STARTER KIT	T5	PA; QL (74 EA per 365 days)
ZEPOSIA STARTER PACK	T5	PA; QL (14 EA per 365 days)
ziprasidone hcl	T4	QL (62 EA per 31 days)
ziprasidone mesylate	T4	
zolmitriptan oral tablet 2.5 mg	T4	QL (16 EA per 28 days)
zolmitriptan oral tablet 5 mg	T4	QL (8 EA per 28 days)
zolmitriptan oral tablet,disintegrating 2.5 mg	T4	QL (16 EA per 28 days)
zolmitriptan oral tablet,disintegrating 5 mg	T4	QL (8 EA per 28 days)
zolpidem oral tablet	T4	QL (31 EA per 31 days)
zonisamide	T2	
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG, 2.9-0.71 MG	T3	QL (93 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 8.6-2.1 MG	T3	QL (62 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 5.7-1.4 MG	T3	QL (31 EA per 31 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	T4	QL (2 EA per 28 days)
Cardiovascular, Hypertension / Lipids		
acebutolol	T2	
aliskiren	T4	
amiloride	T2	
amiloride-hydrochlorothiazide	T2	
amiodarone oral	T2	
amlodipine	T1	
amlodipine-benazepril	T1	
amlodipine-olmesartan	T4	QL (31 EA per 31 days)
amlodipine-valsartan	T2	
amlodipine-valsartan-hcthiazid	T2	
aspirin-dipyridamole	T4	
atenolol	T1	
atenolol-chlorthalidone	T2	
atorvastatin	T1	
benazepril	T1	
benazepril-hydrochlorothiazide	T1	
bisoprolol fumarate	T2	
bisoprolol-hydrochlorothiazide	T1	
BRILINTA	T3	
bumetanide	T2	
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG	T4	QL (93 EA per 31 days)
BYSTOLIC ORAL TABLET 20 MG	T4	QL (62 EA per 31 days)
BYSTOLIC ORAL TABLET 5 MG	T4	QL (217 EA per 31 days)
CABLIVI INJECTION KIT	T5	PA
candesartan	T1	
candesartan-hydrochlorothiazid	T1	
captopril	T1	
captopril-hydrochlorothiazide	T1	
CARTIA XT	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
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	T2	
cilostazol	T2	
clonidine	T4	
clonidine hcl oral tablet	T1	
clopidogrel oral tablet 75 mg	T2	
colesevelam	T3	
colestipol oral packet	T4	
colestipol oral tablet	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)
DEMSER	T3	
DIGITEK ORAL TABLET 125 MCG (0.125 MG)	T1	QL (62 EA per 31 days)
DIGITEK ORAL TABLET 250 MCG (0.25 MG)	T2	QL (31 EA per 31 days)
DIGOX ORAL TABLET 125 MCG (0.125 MG)	T1	QL (62 EA per 31 days)
DIGOX ORAL TABLET 250 MCG (0.25 MG)	T2	QL (31 EA per 31 days)
digoxin oral solution 50 mcg/ml (0.05 mg/ml)	T2	QL (155 ML per 31 days)
digoxin oral tablet 125 mcg (0.125 mg)	T1	QL (62 EA per 31 days)
digoxin oral tablet 250 mcg (0.25 mg)	T2	QL (31 EA per 31 days)
diltiazem hcl oral capsule,extended release 12 hr	T2	
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	T2	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	T2	
diltiazem hcl oral tablet	T1	
DILT-XR	T2	
dofetilide	T4	
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 page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
DOPTELET (30 TAB PACK)	T5	PA
doxazosin	T2	
ELIQUIS DVT-PE TREAT 30D START	T3	QL (74 EA per 31 days)
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 31 days)
enalapril maleate	T1	
enalapril-hydrochlorothiazide	T1	
enoxaparin subcutaneous syringe	T4	
ENTRESTO ORAL TABLET 24-26 MG	T3	QL (186 EA per 31 days)
ENTRESTO ORAL TABLET 49-51 MG	T3	QL (93 EA per 31 days)
ENTRESTO ORAL TABLET 97-103 MG	T3	QL (62 EA per 31 days)
eplerenone	T4	
ethacrynic acid	T2	
ezetimibe	T2	
ezetimibe-simvastatin	T3	
felodipine	T2	
fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg	T2	
fenofibrate nanocrystallized oral tablet 145 mg, 48 mg	T2	
fenofibrate oral tablet 160 mg, 54 mg	T2	
flecainide	T2	
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	T5	
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	T4	
fosinopril	T1	
fosinopril-hydrochlorothiazide	T1	
furosemide injection	T2	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	T2	
furosemide oral tablet	T1	
gemfibrozil	T2	
heparin (porcine) injection solution	T2	
hydralazine oral	T2	
hydrochlorothiazide	T1	
indapamide	T2	
irbesartan	T1	QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
irbesartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)
isosorbide dinitrate oral tablet	T2	
isosorbide mononitrate	T2	
isradipine	T4	
JANTOVEN	T2	
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG	T5	PA
labetalol oral	T2	
lisinopril	T1	
lisinopril-hydrochlorothiazide	T1	
losartan oral tablet 100 mg	T1	QL (31 EA per 31 days)
losartan oral tablet 25 mg	T1	QL (93 EA per 31 days)
losartan oral tablet 50 mg	T1	QL (62 EA per 31 days)
losartan-hydrochlorothiazide	T1	
lovastatin	T1	
metolazone	T2	
metoprolol succinate	T2	
metoprolol ta-hydrochlorothiaz	T2	
metoprolol tartrate oral	T1	
mexiletine	T4	
minoxidil oral	T2	
moexipril	T1	
MULPLETA	T5	PA
MULTAQ	T4	
nadolol	T4	
NEXLETOL	T4	PA; QL (31 EA per 31 days)
NEXLIZET	T4	PA; QL (31 EA per 31 days)
niacin oral tablet extended release 24 hr 1,000 mg, 750 mg	T4	
niacin oral tablet extended release 24 hr 500 mg	T4	QL (31 EA per 31 days)
NIACOR	T4	
nicardipine oral	T4	
nifedipine oral tablet extended release	T2	
nifedipine oral tablet extended release 24hr	T2	
nimodipine	T5	
NITRO-BID	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
NITRO-DUR	T4	
nitroglycerin sublingual	T2	
nitroglycerin transdermal patch 24 hour	T2	
nitroglycerin translingual spray,non-aerosol	T4	
NYMALIZE ORAL SYRINGE 60 MG/10 ML	T4	
olmesartan-amlodipin-hcthiazid	T4	
omega-3 acid ethyl esters	T4	
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	T4	PA; QL (93 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG	T5	PA; QL (186 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG	T5	PA; QL (521 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG	T5	PA; QL (261 EA per 31 days)
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	T2	
pentoxifylline	T2	
perindopril erbumine	T1	
pindolol	T4	
PRALUENT PEN	T4	PA; QL (2 ML per 28 days)
prasugrel	T3	
pravastatin	T1	
prazosin	T2	
PREVALITE ORAL POWDER IN PACKET	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 oral capsule,extended release 12 hr	T4	
propafenone oral tablet	T2	
propranolol oral capsule,extended release 24 hr	T4	
propranolol oral solution	T2	
propranolol oral tablet	T2	
propranolol-hydrochlorothiazid	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
quinapril	T1	
quinapril-hydrochlorothiazide	T1	
quinidine gluconate oral	T2	
quinidine sulfate oral tablet	T2	
ramipril	T1	
ranolazine	T3	QL (62 EA per 31 days)
REPATHA PUSHTRONEX	T3	PA; QL (3.5 ML per 28 days)
REPATHA SURECLICK	T3	PA; QL (2 ML per 28 days)
REPATHA SYRINGE	T3	PA; QL (2 ML per 28 days)
rosuvastatin	T2	
simvastatin oral tablet	T1	
SORINE	T1	
SOTALOL AF	T2	
sotalol oral	T2	
spironolactone	T1	
spironolacton-hydrochlorothiaz	T2	
TAVALISSE	T5	PA; QL (62 EA per 31 days)
TAZTIA XT	T2	
telmisartan	T2	
telmisartan-amlodipine	T3	
telmisartan-hydrochlorothiazid	T2	
terazosin	T1	
TIADYLT ER	T2	
timolol maleate oral	T1	
torsemide oral	T2	
trandolapril	T1	
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg	T1	
triamterene-hydrochlorothiazid oral tablet	T1	
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	T5	PA; QL (62 EA per 31 days)
UPTRAVI ORAL TABLET 200 MCG	T5	PA; QL (224 EA per 28 days)
UPTRAVI ORAL TABLETS,DOSE PACK	T5	PA; QL (200 EA per 28 days)
valsartan oral tablet 160 mg, 40 mg, 80 mg	T1	QL (62 EA per 31 days)
valsartan oral tablet 320 mg	T2	QL (31 EA per 31 days)
valsartan-hydrochlorothiazide	T2	QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
VASCEPA	T4	
verapamil oral capsule, 24 hr er pellet ct	T2	
verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg	T2	
verapamil oral capsule,ext rel. pellets 24 hr 360 mg	T3	
verapamil oral tablet	T2	
verapamil oral tablet extended release	T2	
VYNDAMAX	T5	PA; QL (31 EA per 31 days)
VYNDAQEL	T5	PA; QL (124 EA per 31 days)
warfarin	T1	
XARELTO DVT-PE TREAT 30D START	T3	QL (51 EA per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG	T3	QL (31 EA per 31 days)
XARELTO ORAL TABLET 15 MG	T3	QL (52 EA per 31 days)
XARELTO ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
ZONTIVITY	T4	
Dermatologicals/Topical Therapy		
acitretin	T4	PA
acyclovir topical cream	T4	
acyclovir topical ointment	T3	QL (30 GM per 30 days)
ALA-CORT TOPICAL CREAM 1 %	T1	
alclometasone	T3	
ammonium lactate	T2	
AMNESTEEM	T4	
AVITA	T4	PA
BESER	T2	
betamethasone dipropionate	T2	
betamethasone valerate	T2	
betamethasone, augmented	T2	
calcipotriene scalp	T4	QL (60 ML per 28 days)
calcipotriene topical cream	T4	QL (60 GM per 28 days)
calcipotriene topical ointment	T4	QL (60 GM per 28 days)
calcitriol topical	T2	
ciclopirox topical cream	T2	QL (90 GM per 28 days)
ciclopirox topical gel	T2	QL (45 GM per 28 days)
ciclopirox topical shampoo	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
ciclopirox topical solution	T2	
ciclopirox topical suspension	T2	QL (60 ML per 28 days)
CLARAVIS	T4	
CLINDACIN P	T4	
clindamycin phosphate topical foam	T2	
clindamycin phosphate topical gel	T2	
clindamycin phosphate topical lotion	T2	
clindamycin phosphate topical solution	T2	
clindamycin phosphate topical swab	T2	
clindamycin-tretinoin	T2	
clotrimazole topical	T3	
clotrimazole-betamethasone	T2	QL (60 GM per 28 days)
COSENTYX (2 SYRINGES)	T5	PA; QL (2 ML per 28 days)
COSENTYX PEN (2 PENS)	T5	PA; QL (2 ML per 28 days)
dapsone topical	T4	
DENAVIR	T4	
desoximetasone topical cream	T4	
desoximetasone topical gel	T4	
desoximetasone topical spray,non-aerosol	T4	
diclofenac sodium topical gel 3 %	T4	PA; QL (100 GM per 28 days)
doxepin topical	T5	QL (45 GM per 28 days)
DUOBRII	T5	PA; QL (200 GM per 28 days)
DUPIXENT PEN	T5	PA; QL (4 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	T5	PA; QL (4 ML per 28 days)
ERY PADS	T2	
ERYGEL	T3	
erythromycin with ethanol topical gel	T2	
erythromycin with ethanol topical solution	T2	
erythromycin-benzoyl peroxide	T4	
fluocinolone and shower cap	T4	
fluocinolone topical cream	T4	
fluocinolone topical ointment	T4	
fluocinolone topical solution	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
fluocinonide topical gel	T2	QL (60 GM per 28 days)
fluocinonide topical ointment	T2	QL (60 GM per 28 days)
fluocinonide topical solution	T2	QL (60 ML per 28 days)
FLUOCINONIDE-E	T2	QL (60 GM per 28 days)
fluorouracil topical cream 0.5 %	T5	
fluorouracil topical cream 5 %	T3	
fluorouracil topical solution 2 %	T2	
fluorouracil topical solution 5 %	T3	
flurandrenolide	T3	
fluticasone propionate topical	T2	
gentamicin topical	T2	
halobetasol propionate topical cream	T4	
halobetasol propionate topical ointment	T4	
hydrocortisone butyrate topical lotion	T2	
hydrocortisone butyrate topical ointment	T2	
hydrocortisone butyrate topical solution	T2	
hydrocortisone topical cream 1 %, 2.5 %	T1	
hydrocortisone topical lotion 2.5 %	T2	
hydrocortisone topical ointment 1 %, 2.5 %	T1	
hydrocortisone valerate topical ointment	T2	
imiquimod topical cream in packet	T2	
isotretinoin	T4	
ketoconazole topical	T2	
KETODAN	T2	
lidocaine hcl mucous membrane jelly	T2	PA; QL (60 ML 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 %	T4	PA; QL (93 EA per 31 days)
lidocaine topical ointment	T4	PA; QL (50 GM per 28 days)
LIDOCAINE VISCOUS	T2	
lidocaine-prilocaine topical cream	T2	PA; QL (30 GM per 28 days)
malathion	T4	
methoxsalen	T2	
metronidazole topical cream	T4	
metronidazole topical gel	T4	
metronidazole topical lotion	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
mometasone topical	T2	
mupirocin	T2	
mupirocin calcium	T2	
MYORISAN	T4	
NOLIX	T3	
NYAMYC	T2	
nystatin topical	T2	
NYSTOP	T2	
PANRETIN	T5	
permethrin topical cream	T2	
podofilox	T3	
REGRANEX	T5	PA
SANTYL	T4	
selenium sulfide topical lotion	T2	
SILIQ	T5	PA; QL (6 ML per 28 days)
silver sulfadiazine	T2	
SKYRIZI SUBCUTANEOUS SYRINGE KIT	T5	PA; QL (1 EA per 28 days)
SSD	T2	
STELARA SUBCUTANEOUS SOLUTION	T5	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 28 days)
sulfacetamide sodium (acne)	T2	
SULFAMYLON TOPICAL CREAM	T3	
tacrolimus topical	T4	
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE	T5	PA; QL (1 ML per 28 days)
tazarotene	T4	PA
TAZORAC TOPICAL CREAM 0.05 %	T4	PA
TAZORAC TOPICAL GEL	T4	PA
tretinoin	T2	PA
tretinoin microspheres topical gel	T4	PA
triamcinolone acetonide topical	T2	
TRIDERM TOPICAL CREAM	T2	
VALCHLOR	T5	PA-NS

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
Diagnostics / Miscellaneous Agents		
acamprosate	T4	
anagrelide	T4	
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
AURYXIA	T4	PA
bupropion hcl (smoking deter)	T3	QL (62 EA per 31 days)
CARBAGLU	T5	PA
cevimeline	T4	
CHANTIX	T4	QL (60 EA per 30 days)
CHANTIX CONTINUING MONTH BOX	T4	QL (60 EA per 30 days)
CHANTIX STARTING MONTH BOX	T4	QL (106 EA per 365 days)
CHEMET	T4	
CLINIMIX 4.25%/D5W SULFIT FREE	T4	PA-BvD
CLOVIQUE	T4	
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 tablet, dispersible	T5	
deferiprone	T5	
dextrose 10 % and 0.2 % nacl	T2	
dextrose 10 % in water (d10w)	T2	
dextrose 5 % in water (d5w) intravenous parenteral solution	T2	
dextrose 5%-0.2 % sod chloride	T2	
disulfiram	T4	
ENDARI	T4	PA; QL (180 EA per 30 days)
FERRIPROX	T5	
INCRELEX	T5	PA
KIONEX (WITH SORBITOL)	T4	
levocarnitine (with sugar)	T4	PA-BvD
levocarnitine oral tablet	T4	PA-BvD
LOKELMA	T3	PA; QL (93 EA per 31 days)
midodrine	T4	
NICOTROL	T3	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
NICOTROL NS	T4	
nitisinone	T5	
NITYR	T5	
NORTHERA	T5	PA
ORFADIN	T5	
OXBRYTA	T5	PA; QL (155 EA per 31 days)
pilocarpine hcl oral	T2	
PROLASTIN-C INTRAVENOUS RECON SOLN	T5	PA
RAVICTI	T5	PA
riluzole	T4	
risedronate oral tablet 30 mg	T2	
sevelamer carbonate oral powder in packet	T5	
sevelamer carbonate oral tablet	T3	
sevelamer hcl	T4	
sodium chloride 0.9 % intravenous parenteral solution	T2	
sodium chloride irrigation	T2	
sodium phenylbutyrate	T5	
SODIUM POLYSTYRENE (SORB FREE)	T4	
sodium polystyrene sulfonate oral powder	T4	
SPS (WITH SORBITOL) ORAL	T2	
TIGLUTIK	T5	PA
trientine	T4	
VELTASSA	T3	PA; QL (30 EA per 30 days)
XURIDEN	T5	PA
ZEMAIRA	T5	PA
Ear, Nose / Throat Medications		
acetic acid otic (ear)	T3	
azelastine nasal	T2	QL (30 ML per 25 days)
chlorhexidine gluconate mucous membrane	T1	
CIPRO HC	T4	
ciprofloxacin-dexamethasone	T3	
ciprofloxacin-fluocinolone	T4	
fluocinolone acetonide oil	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
ipratropium bromide nasal spray,non-aerosol 0.03 %	T1	QL (30 ML per 28 days)
ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)	T1	QL (15 ML per 28 days)
neomycin-polymyxin-hc otic (ear)	T3	
ofloxacin otic (ear)	T2	
olopatadine nasal	T4	QL (30.5 GM per 30 days)
OTOVEL	T4	
triamcinolone acetonide dental	T2	
Endocrine/Diabetes		
acarbose	T2	QL (93 EA per 31 days)
ACTHAR	T5	PA
ALCOHOL PADS	T4	
ANADROL-50	T4	PA
ANDRODERM	T3	PA
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	
BAQSIMI	T3	
BASAGLAR KWIKPEN U-100 INSULIN	T3	
cabergoline	T4	
calcitonin (salmon)	T3	PA-BvD
calcitriol oral	T2	PA-BvD
CERDELGA	T5	PA
cinacalcet oral tablet 30 mg, 60 mg	T5	PA-BvD; QL (62 EA per 31 days)
cinacalcet oral tablet 90 mg	T5	PA-BvD; QL (124 EA per 31 days)
cortisone	T4	
danazol	T4	
desmopressin nasal spray,non-aerosol	T2	
desmopressin oral	T2	
DEXABLISS	T2	
dexamethasone oral elixir	T2	
dexamethasone oral tablet	T2	
dexamethasone oral tablets,dose pack	T2	
diazoxide	T3	
doxercalciferol oral capsule 0.5 mcg	T2	PA-BvD
doxercalciferol oral capsule 1 mcg, 2.5 mcg	T4	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
EMFLAZA	T5	PA
FIASP FLEXTOUCH U-100 INSULIN	T3	
FIASP PENFILL U-100 INSULIN	T3	
FIASP U-100 INSULIN	T3	
fludrocortisone	T2	
GALAFOLD	T5	PA; QL (14 EA per 28 days)
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T3	
glimepiride	T1	
glipizide	T1	
glipizide-metformin	T1	
GLUCAGEN HYPOKIT	T3	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
glyburide	T2	PA
glyburide micronized	T2	PA
glyburide-metformin	T2	PA
GLYXAMBI	T3	QL (31 EA per 31 days)
GVOKE HYPOPEN 2-PACK	T3	
GVOKE PFS 2-PACK SYRINGE	T3	
HUMALOG JUNIOR KWIKPEN U-100	T3	
HUMALOG KWIKPEN INSULIN	T3	
HUMALOG MIX 50-50 INSULN U-100	T3	
HUMALOG MIX 50-50 KWIKPEN	T3	
HUMALOG MIX 75-25 KWIKPEN	T3	
HUMALOG MIX 75-25(U-100)INSULN	T3	
HUMALOG U-100 INSULIN	T3	
HUMULIN 70/30 U-100 INSULIN	T3	
HUMULIN 70/30 U-100 KWIKPEN	T3	
HUMULIN N NPH INSULIN KWIKPEN	T3	
HUMULIN N NPH U-100 INSULIN	T3	
HUMULIN R REGULAR U-100 INSULN	T3	
HUMULIN R U-500 (CONC) INSULIN	T3	
HUMULIN R U-500 (CONC) KWIKPEN	T3	
hydrocortisone oral	T1	
insulin asp prt-insulin aspart	T3	
insulin aspart u-100	T3	
insulin lispro	T3	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
insulin lispro protamin-lispro	T3	
insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge	T4	
INVOKAMET	T3	QL (62 EA per 31 days)
INVOKAMET XR	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 100 MG	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 300 MG	T3	QL (31 EA per 31 days)
ISTURISA	T5	PA
JANUMET	T3	QL (62 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	T3	QL (31 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	T3	QL (62 EA per 31 days)
JANUVIA ORAL TABLET 100 MG, 50 MG	T3	QL (31 EA per 31 days)
JANUVIA ORAL TABLET 25 MG	T3	QL (93 EA per 31 days)
JARDIANCE	T3	
JENTADUETO	T3	QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	T3	QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	T3	QL (31 EA per 31 days)
JYNARQUE	T5	PA
KORLYM	T5	PA
KUVAN ORAL TABLET,SOLUBLE	T5	PA
LANTUS SOLOSTAR U-100 INSULIN	T3	
LANTUS U-100 INSULIN	T3	
LEVEMIR FLEXTOUCH U-100 INSULN	T3	
LEVEMIR U-100 INSULIN	T3	
levothyroxine oral 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	
metformin oral tablet	T1	
metformin oral tablet extended release 24 hr	T1	
metformin oral tablet extended release 24hr	NF	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
metformin oral tablet,er gast.retention 24 hr	NF	
methimazole oral tablet 10 mg, 5 mg	T2	
methylprednisolone	T2	
miglustat	T5	PA
MYALEPT	T5	PA
nateglinide	T1	QL (93 EA per 31 days)
NATPARA	T5	PA; QL (31 EA per 31 days)
NOVOLIN 70/30 U-100 INSULIN	T3	
NOVOLIN 70-30 FLEXPEN U-100	T3	
NOVOLIN N FLEXPEN	T3	
NOVOLIN N NPH U-100 INSULIN	T3	
NOVOLIN R FLEXPEN	T3	
NOVOLIN R REGULAR U-100 INSULN	T3	
NOVOLOG FLEXPEN U-100 INSULIN	T3	
NOVOLOG MIX 70-30 U-100 INSULN	T3	
NOVOLOG MIX 70-30FLEXPEN U-100	T3	
NOVOLOG PENFILL U-100 INSULIN	T3	
NOVOLOG U-100 INSULIN ASPART	T3	
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)
oxandrolone oral tablet 10 mg	T5	PA
oxandrolone oral tablet 2.5 mg	T3	PA
OZEMPIC	T3	QL (3 ML per 28 days)
PALYNZIQ	T5	PA
paricalcitol oral	T4	PA-BvD
pen needle, diabetic needle 29 gauge x 1/2"	T4	
pioglitazone	T1	QL (31 EA per 31 days)
pioglitazone-metformin	T2	QL (93 EA per 31 days)
prednisolone oral solution 15 mg/5 ml	T2	
prednisolone sodium phosphate oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	T2	
PREDNISONE INTENSOL	T2	
prednisone oral solution	T2	
prednisone oral tablet	T1	
prednisone oral tablets,dose pack	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
propylthiouracil	T2	
repaglinide oral tablet 0.5 mg, 1 mg	T2	QL (124 EA per 31 days)
repaglinide oral tablet 2 mg	T2	QL (248 EA per 31 days)
RYBELSUS	T3	QL (31 EA per 31 days)
SAMSCA	T5	PA
SENSIPAR ORAL TABLET 30 MG, 60 MG	T5	PA-BvD; QL (62 EA per 31 days)
SENSIPAR ORAL TABLET 90 MG	T5	PA-BvD; QL (124 EA per 31 days)
SOMAVERT	T5	
STIMATE	T3	
SYMLINPEN 120	T3	QL (10.8 ML per 28 days)
SYMLINPEN 60	T3	QL (6 ML per 28 days)
SYNAREL	T5	
SYNJARDY	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	T3	QL (31 EA per 31 days)
SYNTHROID	T3	
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	T3	PA
testosterone enanthate	T3	PA
testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)	T3	PA
testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)	T3	PA
tolvaptan oral tablet 30 mg	T5	PA
TOUJEO MAX U-300 SOLOSTAR	T3	
TOUJEO SOLOSTAR U-300 INSULIN	T3	
TRADJENTA	T3	QL (31 EA per 31 days)
TRESIBA FLEXTOUCH U-100	T3	
TRESIBA FLEXTOUCH U-200	T3	
TRESIBA U-100 INSULIN	T3	
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	T3	QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	T3	QL (62 EA per 31 days)
TRULICITY	T3	QL (2 ML per 28 days)
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	T3	
VICTOZA 3-PAK	T3	QL (9 ML per 30 days)
XULTOPHY 100/3.6	T3	
Gastroenterology		
alosetron	T5	
AMITIZA	T3	QL (62 EA per 31 days)
aprepitant	T4	PA-BvD
balsalazide	T4	
budesonide oral	T4	
CHOLBAM	T5	PA
CIMZIA	T5	PA; QL (2 EA per 28 days)
CIMZIA POWDER FOR RECONST	T5	PA; QL (6 EA per 28 days)
CLENPIQ	T4	
COMPRO	T4	
CONSTULOSE	T2	
CREON	T3	
cromolyn oral	T4	
CYSTADANE	T4	
dicyclomine oral capsule	T2	
dicyclomine oral solution	T2	
dicyclomine oral tablet	T2	
diphenoxylate-atropine	T2	
dronabinol	T4	PA-BvD
ENULOSE	T2	
esomeprazole magnesium oral capsule,delayed release(dr/ec)	T4	QL (31 EA per 31 days)
famotidine oral suspension	T2	
famotidine oral tablet 20 mg, 40 mg	T1	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
GAVILYTE-G	T2	
GAVILYTE-N	T2	
GENERLAC	T2	
glycopyrrolate oral tablet 1 mg, 2 mg	T2	
GOLYTELY ORAL POWDER IN PACKET	T4	
granisetron hcl oral	T3	PA-BvD
hydrocortisone rectal	T1	
hydrocortisone-pramoxine rectal cream 1-1 %	T4	
lactulose oral packet	T4	
lactulose oral solution 10 gram/15 ml	T2	
LINZESS	T3	QL (31 EA per 31 days)
loperamide oral capsule	T2	
meclizine oral tablet 12.5 mg, 25 mg	T2	
mesalamine oral capsule (with del rel tablets)	T3	
mesalamine oral capsule,extended release 24hr	T4	
mesalamine oral tablet,delayed release (dr/ec)	T4	
mesalamine rectal enema	T4	
metoclopramide hcl oral solution	T2	
metoclopramide hcl oral tablet	T2	
misoprostol	T2	
MOVANTIK	T3	QL (31 EA per 31 days)
MYTESI	T4	QL (62 EA per 31 days)
OCALIVA	T5	PA; QL (31 EA per 31 days)
omeprazole oral capsule,delayed release(dr/ec)	T1	
ondansetron	T2	PA-BvD
ondansetron hcl oral	T3	PA-BvD
pantoprazole oral tablet,delayed release (dr/ec)	T2	
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram	T2	
peg3350-sod sul-nacl-kcl-asb-c	T4	
peg-electrolyte soln	T2	
PENTASA	T3	
prochlorperazine	T2	
prochlorperazine maleate	T2	
PROCTO-PAK	T4	
PROCTOSOL HC TOPICAL	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
PROCTOZONE-HC	T4	
rabeprazole oral tablet,delayed release (dr/ec)	T2	QL (62 EA per 31 days)
RECTIV	T4	
RELISTOR ORAL	T5	PA; QL (93 EA per 31 days)
scopolamine base	T3	QL (10 EA per 30 days)
SUCRAID	T5	
sucralfate	T2	
sulfasalazine	T2	
SUPREP BOWEL PREP KIT	T3	
SYMPROIC	T4	PA; QL (31 EA per 31 days)
TRILYTE WITH FLAVOR PACKETS	T2	
ursodiol oral capsule	T4	
ursodiol oral tablet	T3	
VIBERZI	T5	PA; QL (62 EA per 31 days)
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 3,000-10,000 -14,000- UNIT, 5,000-17,000- 24,000 UNIT	T3	
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 25,000-79,000- 105,000 UNIT, 40,000-126,000- 168,000 UNIT	T5	
Immunology, Vaccines / Biotechnology		
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 300 MCG/ML	T5	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	T4	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML, 60 MCG/0.3 ML	T4	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML	T5	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
ARCALYST	T5	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	QL (4 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	QL (4 EA per 28 days)
bcg vaccine, live (pf)	T4	
BETASERON SUBCUTANEOUS KIT	T5	QL (14 EA per 28 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T3	
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
EGRIFTA SV	T5	PA
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	T5	PA
FULPHILA	T5	
GAMMAGARD LIQUID	T5	PA
GAMMAGARD S-D (IGA < 1 MCG/ML)	T5	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T4	PA
GAMMAPLEX	T5	PA
GAMMAPLEX (WITH SORBITOL)	T5	PA
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T3	PA
GARDASIL 9 (PF)	T3	
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	T4	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML	T5	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG/ML (36 UNIT/ML)	T5	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
GENOTROPIN SUBCUTANEOUS CARTRIDGE 5 MG/ML (15 UNIT/ML)	T4	PA
GRANIX	T5	
GRASTEK	T4	PA
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	T3	
HAVRIX (PF) INTRAMUSCULAR SYRINGE	T3	
HIBERIX (PF)	T3	
HUMATROPE	T5	PA
IMOVAX RABIES VACCINE (PF)	T3	PA-BvD
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	T3	
INTRON A INJECTION	T5	PA-NS
IPOL	T3	
IXIARO (PF)	T3	
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)	T3	
M-M-R II (PF)	T3	
NIVESTYM	T5	
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML)	T5	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
NUTROPIN AQ NUSPIN	T5	PA
OCTAGAM	T5	PA
ODACTRA	T4	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T4	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	T4	PA
PANZYGA	T5	PA
PEDIARIX (PF)	T3	PA-BvD
PEDVAX HIB (PF)	T3	
PEGASYS	T5	PA
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML	T5	PA
PLEGRIDY	T5	QL (1 ML per 28 days)
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 40,000 UNIT/ML	T5	PA-BvD
PROQUAD (PF)	T3	
QUADRACEL (PF)	T3	
RABAVERT (PF)	T3	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	T3	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	T5	PA-BvD
ROTARIX	T3	
ROTATEQ VACCINE	T3	
SAIZEN	T5	PA
SAIZEN SAIZENPREP	T5	PA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	T5	PA
SHINGRIX (PF)	T3	
TDVAX	T3	
TENIVAC (PF) INTRAMUSCULAR SYRINGE	T3	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
tetanus,diphtheria tox ped(pf)	T4	
TRUMENBA	T3	
TWINRIX (PF) INTRAMUSCULAR SYRINGE	T3	
TYPHIM VI	T3	
UDENYCA	T5	
VAQTA (PF)	T3	
VARIVAX (PF)	T3	
VARIZIG INTRAMUSCULAR SOLUTION	T4	
YF-VAX (PF)	T3	
ZARXIO	T5	
ZIEXTENZO	T5	
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG	T5	PA
ZOMACTON SUBCUTANEOUS RECON SOLN 5 MG	T4	PA
ZORBTIVE	T5	PA
Musculoskeletal / Rheumatology		
ACTEMRA ACTPEN	T5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
alendronate oral tablet 10 mg, 35 mg, 70 mg	T1	
allopurinol	T1	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
colchicine oral tablet	T4	QL (124 EA per 31 days)
DEPEN TITRATABS	T5	
ENBREL MINI	T5	PA; QL (7.84 ML per 28 days)
ENBREL SUBCUTANEOUS RECON SOLN	T5	PA; QL (8 EA per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)	T5	PA; QL (7.84 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (7.84 ML per 28 days)
EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	T5	PA; QL (2.34 ML per 28 days)
FORTEO	T5	PA; QL (2.4 ML per 28 days)
HUMIRA	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 page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA PEN CROHNS-UC-HS START	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN PSOR-UVEITS-ADOL HS	T5	PA; QL (4 EA per 28 days)
HUMIRA(CF)	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	T5	PA; QL (2 EA per 28 days)
ibandronate oral	T4	
KEVZARA	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
leflunomide	T3	
MITIGARE	T3	QL (62 EA per 31 days)
OLUMIANT	T5	PA; QL (31 EA per 31 days)
ORENCIA CLICKJECT	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	T5	PA; QL (2.8 ML per 28 days)
OTEZLA	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (55 EA per 28 days)
penicillamine	T5	
probenecid	T2	
probenecid-colchicine	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)
raloxifene	T3	
RIDAURA	T4	
RINVOQ	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 page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg	T2	
risedronate oral tablet,delayed release (dr/ec)	T2	
SAVELLA	T4	PA
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
teriparatide	T5	PA; QL (2.48 ML per 28 days)
TYMLOS	T5	PA; QL (1.56 ML per 31 days)
XELJANZ	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
Obstetrics / Gynecology		
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
AMABELZ	T2	
AMETHIA	T2	
AMETHIA LO	T2	
APRI	T2	
ARANELLE (28)	T2	
AVIANE	T2	
BALZIVA (28)	T2	
BLISOVI FE 1.5/30 (28)	T2	
BRIELLYN	T2	
CAMILA	T2	
CAMRESE LO	T2	
CAZIANT (28)	T2	
clindamycin phosphate vaginal	T2	
CLINDESSE	T4	
CRINONE	T4	PA
CRYSELLE (28)	T2	
CYCLAFEM 1/35 (28)	T2	
CYCLAFEM 7/7/7 (28)	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
CYRED	T2	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	T4	
drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4)	T2	
drospirenone-ethinyl estradiol	T2	
ELURYNG	T3	
EMOQUETTE	T2	
ENPRESSE	T2	
ENSKYCE	T2	
ERRIN	T2	
ESTARYLLA	T2	
estradiol oral	T2	
estradiol transdermal patch weekly	T2	
estradiol vaginal	T4	
estradiol valerate intramuscular oil 20 mg/ml	T2	
estradiol-norethindrone acet	T2	
ethynodiol diac-eth estradiol	T2	
etonogestrel-ethinyl estradiol	T3	
FAYOSIM	T2	
FEMYNOR	T2	
FYAVOLV	T4	
GYNAZOLE-1	T4	
HAILEY 24 FE	T2	
INCASSIA	T2	
INTRAROSA	T4	PA; QL (28 EA per 28 days)
INTROVALE	T2	
ISIBLOOM	T2	
JASMIEL (28)	T2	
JINTELI	T4	
JULEBER	T2	
JUNEL 1.5/30 (21)	T2	
JUNEL 1/20 (21)	T2	
JUNEL FE 1.5/30 (28)	T2	
JUNEL FE 1/20 (28)	T2	
JUNEL FE 24	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
KARIVA (28)	T2	
KELNOR 1/35 (28)	T2	
KELNOR 1-50 (28)	T2	
KURVELO (28)	T2	
l norgest/e.estradiol-e.estrad	T2	
LARISSIA	T2	
LESSINA	T2	
LEVONEST (28)	T2	
levonorgestrel-ethinyl estrad	T2	
levonorg-eth estrad triphasic	T2	
LEVORA-28	T2	
LOPREEZA ORAL TABLET 1-0.5 MG	T2	
LORYNA (28)	T2	
LOW-OGESTREL (28)	T2	
LUTERA (28)	T2	
LYZA	T2	
MARLISSA (28)	T2	
medroxyprogesterone	T2	
MELODETTA 24 FE	T2	
metronidazole vaginal	T2	
MIBELAS 24 FE	T2	
MICONAZOLE-3 VAGINAL SUPPOSITORY	T2	
MICROGESTIN 1.5/30 (21)	T2	
MICROGESTIN 1/20 (21)	T2	
MICROGESTIN FE 1.5/30 (28)	T2	
MICROGESTIN FE 1/20 (28)	T2	
MILI	T2	
NECON 0.5/35 (28)	T2	
noreth-ethinyl estradiol-iron	T2	
norethindrone (contraceptive)	T2	
norethindrone acetate	T2	
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-20 mg-mcg, 1-5 mg-mcg	T2	
norethindrone-e.estradiol-iron oral tablet,chewable	T2	
norgestimate-ethinyl estradiol	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
NORTREL 0.5/35 (28)	T2	
NORTREL 1/35 (21)	T2	
NORTREL 1/35 (28)	T2	
NORTREL 7/7/7 (28)	T2	
ORIAHNN	T5	PA; QL (56 EA per 28 days)
ORSYTHIA	T2	
PIMTREA (28)	T2	
PIRMELLA ORAL TABLET 1-35 MG-MCG	T2	
PORTIA 28	T2	
PREMARIN VAGINAL	T3	
PREVIFEM	T2	
RECLIPSEN (28)	T2	
RIVELSA	T2	
SETLAKIN	T2	
SPRINTEC (28)	T2	
SRONYX	T2	
SYEDA	T2	
terconazole	T2	
tranexamic acid oral	T3	
TRI-ESTARYLLA	T2	
TRI-LEGEST FE	T2	
TRI-LO-ESTARYLLA	T2	
TRI-LO-SPRINTEC	T2	
TRI-MILI	T2	
TRI-PREVIFEM (28)	T2	
TRI-SPRINTEC (28)	T2	
TRIVORA (28)	T2	
TRI-VYLIBRA	T2	
TRI-VYLIBRA LO	T2	
TYDEMY	T2	
VANDAZOLE	T3	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VIENVA	T2	
VYFEMLA (28)	T2	
VYLIBRA	T2	
YUVAFEM	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
ZARAH	T2	
ZOVIA 1/35E (28)	T2	
Ophthalmology		
acetazolamide	T3	
ALOMIDE	T3	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
apraclonidine	T2	
azelastine ophthalmic (eye)	T2	
AZOPT	T3	
bacitracin ophthalmic (eye)	T2	
bacitracin-polymyxin b ophthalmic (eye)	T2	
BESIVANCE	T4	
betaxolol ophthalmic (eye)	T4	
BLEPHAMIDE	T4	
BLEPHAMIDE S.O.P.	T4	
brimonidine	T2	
bromfenac	T4	
carteolol	T2	
CILOXAN OPHTHALMIC (EYE) OINTMENT	T4	
ciprofloxacin hcl ophthalmic (eye)	T2	
COMBIGAN	T3	
cromolyn ophthalmic (eye)	T2	
CYSTARAN	T5	
dexamethasone sodium phosphate ophthalmic (eye)	T2	
diclofenac sodium ophthalmic (eye)	T3	
dorzolamide	T2	
dorzolamide-timolol	T2	
DUREZOL	T3	
erythromycin ophthalmic (eye)	T2	
fluorometholone	T3	
flurbiprofen sodium	T2	
gatifloxacin	T4	
GENTAK OPHTHALMIC (EYE) OINTMENT	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
gentamicin ophthalmic (eye) drops	T2	
ILEVRO	T3	
ketorolac ophthalmic (eye)	T3	
LACRISERT	T4	
LASTACAFT	T4	
latanoprost	T2	
levobunolol ophthalmic (eye) drops 0.5 %	T2	
levofloxacin ophthalmic (eye)	T2	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
methazolamide	T4	
MOXEZA	T4	
moxifloxacin ophthalmic (eye) drops	T4	
NATACYN	T4	
neomycin-bacitracin-poly-hc	T3	
neomycin-bacitracin-polymyxin	T3	
neomycin-polymyxin b-dexameth	T2	
neomycin-polymyxin-gramicidin	T3	
neomycin-polymyxin-hc ophthalmic (eye)	T3	
ofloxacin ophthalmic (eye)	T2	
olopatadine ophthalmic (eye) drops 0.2 %	T3	
OXERVATE	T5	PA; QL (112 ML per 56 days)
PAZEO	T3	
PHOSPHOLINE IODIDE	T4	
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	T2	
polymyxin b sulf-trimethoprim	T2	
prednisolone acetate	T3	
prednisolone sodium phosphate ophthalmic (eye)	T3	
RESTASIS	T3	QL (60 EA per 30 days)
SIMBRINZA	T3	
sulfacetamide sodium ophthalmic (eye)	T2	
sulfacetamide-prednisolone	T2	
timolol maleate ophthalmic (eye) drops	T1	
timolol maleate ophthalmic (eye) gel forming solution	T3	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
TOBRADEX ST	T3	
tobramycin ophthalmic (eye)	T2	
tobramycin-dexamethasone	T4	
TOBREX OPHTHALMIC (EYE) OINTMENT	T4	
travoprost	T3	
trifluridine	T2	
XIIDRA	T4	QL (60 EA per 30 days)
ZIRGAN	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)
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)	NF	
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	T4	
albuterol sulfate oral tablet extended release 12 hr	T4	
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)
ASMANEX HFA	T3	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	T3	QL (1 EA per 30 days)
ATROVENT HFA	T4	QL (25.8 GM per 30 days)
azelastine-fluticasone	T4	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
BECONASE AQ	T4	
BERINERT INTRAVENOUS KIT	T5	PA
bosentan	T5	PA; QL (62 EA per 31 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
budesonide inhalation	T4	PA-BvD
cetirizine oral solution 1 mg/ml	T2	QL (310 ML per 31 days)
CINRYZE	T5	PA; QL (20 EA per 28 days)
COMBIVENT RESPIMAT	T4	QL (4 GM per 30 days)
cromolyn inhalation	T2	PA-BvD
cyproheptadine	T4	PA
DALIRESP	T4	QL (31 EA per 31 days)
desloratadine	T2	QL (31 EA per 31 days)
dexchlorpheniramine maleate oral solution	T2	
epinephrine injection auto-injector	T3	
ESBRIET ORAL CAPSULE	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 267 MG	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 801 MG	T5	PA; QL (93 EA per 31 days)
FASENRA	T5	PA
FASENRA PEN	T5	PA
FIRAZYR	T5	PA; QL (18 ML per 30 days)
flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)	T2	QL (50 ML per 25 days)
fluticasone propionate nasal	T2	QL (16 GM per 30 days)
fluticasone propion-salmeterol inhalation aerosol powdr breath activated	T3	QL (1 EA per 30 days)
fluticasone propion-salmeterol inhalation blister with device	T3	QL (60 EA per 30 days)
HAEGARDA	T5	PA
hydroxyzine hcl oral solution 10 mg/5 ml	T2	PA
hydroxyzine hcl oral tablet	T2	PA
icatibant	T5	PA; QL (18 ML per 30 days)
INCRUSE ELLIPTA	T3	QL (30 EA per 30 days)
ipratropium bromide inhalation	T2	PA-BvD
ipratropium-albuterol	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET 25 MG	T5	PA; QL (62 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
LETAIRIS	T5	PA; QL (31 EA per 31 days)
levalbuterol hcl inhalation solution for nebulization 1.25 mg/0.5 ml, 1.25 mg/3 ml	T2	PA-BvD
levalbuterol tartrate	T4	QL (30 GM per 30 days)
levocetirizine oral solution	T2	QL (310 ML per 31 days)
levocetirizine oral tablet	T2	QL (31 EA per 31 days)
mometasone nasal	T3	QL (34 GM per 30 days)
montelukast oral granules in packet	T2	QL (31 EA per 31 days)
montelukast oral tablet	T3	QL (31 EA per 31 days)
montelukast oral tablet,chewable	T2	QL (31 EA per 31 days)
NUCALA	T5	PA
OFEV	T5	PA; QL (62 EA per 31 days)
OMNARIS	T4	
OPSUMIT	T5	PA; QL (31 EA per 31 days)
ORKAMBI ORAL GRANULES IN PACKET	T5	PA; QL (62 EA per 31 days)
ORKAMBI ORAL TABLET	T5	PA; QL (124 EA per 31 days)
PROAIR HFA	T3	QL (17 GM per 30 days)
PROAIR RESPICLICK	T3	QL (2 EA per 30 days)
PULMOZYME	T5	PA
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	T3	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	T3	QL (21.2 GM per 30 days)
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	T5	PA; QL (224 ML per 31 days)
RUCONEST	T5	PA
SEREVENT DISKUS	T4	QL (60 EA per 30 days)
sildenafil (pulm.hypertension) oral suspension for reconstitution	T5	PA; QL (224 ML per 31 days)
sildenafil (pulm.hypertension) oral tablet	T3	PA; QL (93 EA per 31 days)
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)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
STRIVERDI RESPIMAT	T4	QL (4 GM per 30 days)
SYMBICORT	T3	QL (10.2 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
tadalafil (pulm. hypertension)	T5	PA; QL (62 EA per 31 days)
TAKHZYRO	T5	PA; QL (4 ML per 28 days)
terbutaline oral	T4	
THEO-24	T4	
theophylline oral solution	T2	
theophylline oral tablet extended release 12 hr 300 mg	T2	
theophylline oral tablet extended release 24 hr	T2	
TRACLEER ORAL TABLET	T5	PA; QL (62 EA per 31 days)
TRACLEER ORAL TABLET FOR SUSPENSION	T5	PA; QL (124 EA per 31 days)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG	T3	QL (60 EA per 30 days)
TRIKAFTA	T5	PA; QL (84 EA per 28 days)
VENTAVIS	T5	PA
VENTOLIN HFA	T3	QL (36 GM per 30 days)
WIXELA INHUB	T3	QL (60 EA per 30 days)
XOLAIR	T5	PA
YUPELRI	T4	PA-BvD
zafirlukast	T4	
zileuton	T5	PA
Urologicals		
alfuzosin	T2	QL (31 EA per 31 days)
bethanechol chloride	T2	
CIALIS ORAL TABLET 2.5 MG	T4	PA; QL (62 EA per 31 days)
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T4	
darifenacin	T3	QL (31 EA per 31 days)
dutasteride	T3	QL (31 EA per 31 days)
dutasteride-tamsulosin	T4	QL (31 EA per 31 days)
ELMIRON	T5	
finasteride oral tablet 5 mg	T2	
MYRBETRIQ	T3	QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
oxybutynin chloride oral syrup	T2	
oxybutynin chloride oral tablet	T2	
oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg	T3	QL (31 EA per 31 days)
oxybutynin chloride oral tablet extended release 24hr 15 mg	T3	QL (62 EA per 31 days)
potassium citrate	T4	
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET	T5	PA
silodosin	T4	
solifenacin	T4	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	T4	QL (31 EA per 31 days)
tolterodine oral tablet	T4	QL (62 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)
Vitamins, Hematinics / Electrolytes		
AMINOSYN II 10 %	T4	PA-BvD
AMINOSYN II 15 %	T4	PA-BvD
AMINOSYN-PF 7 % (SULFITE-FREE)	T4	PA-BvD
calcium acetate(phosphat bind)	T2	
CLINIMIX 5%/D15W SULFITE FREE	T4	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T4	PA-BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	T4	PA-BvD
CLINISOL SF 15 %	T4	PA-BvD
DOJOLVI	T5	PA
fluoride (sodium) oral tablet	T2	
FREAMINE HBC 6.9 %	T4	PA-BvD
HEPATAMINE 8%	T4	PA-BvD
INTRALIPID INTRAVENOUS EMULSION 20 %	T2	PA-BvD
INTRALIPID INTRAVENOUS EMULSION 30 %	T4	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T3	PA-BvD
ISOLYTE-S	T3	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
KLOR-CON	T2	
KLOR-CON 10	T2	
KLOR-CON 8	T2	
KLOR-CON M10	T2	
KLOR-CON M15	T2	
KLOR-CON M20	T2	
magnesium sulfate injection	T2	
NEPHRAMINE 5.4 %	T3	PA-BvD
NORMOSOL-M IN 5 % DEXTROSE	T4	PA-BvD
PLASMA-LYTE 148	T4	PA-BvD
PLASMA-LYTE A	T4	PA-BvD
PLENAMINE	T3	PA-BvD
potassium chlorid-d5-0.45%nacl	T2	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	T2	
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l	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	T2	
potassium chloride oral liquid	T2	
potassium chloride oral tablet extended release	T2	
potassium chloride oral tablet,er particles/crystals	T2	
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 %	T3	PA-BvD
PRENATAL VITAMIN PLUS LOW IRON	T2	
PROCALAMINE 3%	T4	PA-BvD
PROSOL 20 %	T4	PA-BvD
sodium chloride 0.45 % intravenous parenteral solution	T2	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Drug Name	Drug Tier	Requirements/Limits
sodium chloride 3 %	T2	
sodium chloride 5 %	T2	
TRAVASOL 10 %	T4	PA-BvD
TROPHAMINE 10 %	T4	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

actemra

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Kineret, Remicade, Humira, Orencia, Enbrel, Simponi, Cimzia
Required Medical Information	Documentation of diagnosis. For rheumatoid arthritis and polyarticular juvenile idiopathic arthritis, patients must have an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide). For giant cell arteritis, patients must have an adequate trial or intolerance to one systemic corticosteroid (e.g., prednisone). Documentation of systemic juvenile idiopathic arthritis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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 4. Collagen diseases 5. Dermatologic diseases 6. Allergic states 7. Ophthalmic diseases 8. Respiratory diseases 9. Transfusion reaction due to serum protein reaction 10. Proteinuria in nephrotic syndrome and trial/failure or contraindication to two therapies from any of the following different classes: corticosteroids (e.g., cortisone or dexamethasone), calcineurin inhibitors (e.g., cyclosporine or tacrolimus, per DRUGDEX). 11. Diagnosis for adrenal insufficiency with trial/failure or contraindication to cosyntropin. 12. Gout and intolerance or contraindication to at least two first-line gout therapies (e.g., allopurinol, probenecid, colchicine). 13. Pediatric acquired epileptic aphasia. For covered indications 2 through 9, limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (i.e. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Other Criteria	For reauthorization, the following (1. and 2.) must be met. 1) Prescriber attestation that the member cannot use corticosteroids (e.g. IVmethylprednisolone, 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 an acute exacerbation and not on a routine basis to prevent an exacerbation as supported by Compendia.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Gout

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

actimmune

Products Affected

- **ACTIMMUNE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ADHD Drugs

Products Affected

- *guanfacine oral tablet extended release 24 hr*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

afinitor

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) HR mutation status and HER2 mutation status 2) Alternatives tried/failed 3) Concomitant therapy 4) Candidacy for surgical resection
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For renal cell carcinoma with clear cell histology additional trial/failure of cabozantinib or nivolumab per NCCN guidelines.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

aimovig

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

alecensa

Products Affected

- **ALECENSA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ALPHA1-PROTEINASE INHIBITORS

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

alunbrig

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ampyra

Products Affected

- *dalfampridine*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

anabolic steroids

Products Affected

- **ANADROL-50**
- *oxandrolone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis (oxymetholone, oxandrolone) -AND- either 1 or 2 when applicable to diagnosis. 1. For the diagnosis of anemia of chronic renal failure (oxymetholone) the trial/failure, intolerance or contraindication to an erythropoiesis stimulating agent is required. 2. For the diagnosis of osteoporosis (oxandrolone) the trial/failure, intolerance or contraindication to at least 2 federal legend drugs indicated for use in osteoporosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

apokyn

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

arikayce

Products Affected

- **ARIKAYCE**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

attr-cm drugs

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

atypical antipsychotics

Products Affected

- *aripiprazole*
- **REXULTI**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

aubagio

Products Affected

- **AUBAGIO**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Aubagio and other disease modifying agents such as fingolimod, interferons, Copaxone, Tysabri
Required Medical Information	Documentation of relapsing-remitting or relapsing secondary progressive multiple sclerosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	Doses greater than 14 mg per day will not be approved
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

auryxia

Products Affected

- **AURYXIA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ayvakit

Products Affected

- **AYVAKIT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of unresectable or metastatic gastrointestinal stromal tumor -AND- PDGFRA exon 18 mutation
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

bafiertam

Products Affected

- **BAFIERTAM**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

balversa

Products Affected

- **BALVERSA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

banzel

Products Affected

- **BANZEL**

PA Criteria	Criteria Details
Exclusion Criteria	Patients with familial short QT syndrome
Required Medical Information	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- an adequate trial or intolerance of a previous antiepileptic therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses greater than 3200mg per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

benlysta

Products Affected

- **BENLYSTA SUBCUTANEOUS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of active systemic lupus erythematosus (SLE) -AND- documentation of positive anti-nuclear antibody (ANA) titer (greater than or equal to 1:80) or anti-double-stranded DNA antibody (anti-dsDNA) greater than or equal to 30IU/mL -AND- trial, intolerance, or inadequate response to at least 2 of the following standard of care drug classes: 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate) -AND- member will continue to receive concomitant standard of care treatment with use of at least one of the following (alone or in combination): 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate)
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 is required.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

berinert

Products Affected

- **BERINERT INTRAVENOUS KIT**

PA Criteria	Criteria Details
Exclusion Criteria	Member should not be on two acute therapies simultaneously.
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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

bosulif

Products Affected

- **BOSULIF**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

braftovi

Products Affected

- **BRAFTOVI ORAL CAPSULE 75 MG**

PA Criteria	Criteria Details
Exclusion Criteria	Use in wild-type BRAF melanoma or wild-type BRAF CRC
Required Medical Information	Documentation of unresectable or metastatic melanoma in patients with a BRAF V600E or V600K mutation -AND- used in combination with binimetinib. Documentation of metastatic colorectal cancer with a BRAF V600E or V600K mutation -AND- received prior therapy for CRC -AND- used in combination with cetuximab
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

briviact

Products Affected

- **BRIVIACT ORAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure or intolerance of at least two standard of care anticonvulsants.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	If requesting Briviact solution, the member is unable to tolerate Briviact tablets or is unable to swallow. Applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

brukinsa

Products Affected

- **BRUKINSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of mantle cell lymphoma and treatment with at least one prior therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

butrans

Products Affected

- *buprenorphine*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	Buprenorphine topical patch should not be used concomitantly with substance abuse therapies.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	2 months 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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

cabometyx

Products Affected

- **CABOMETYX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced renal cell carcinoma (RCC) -OR- Documentation of hepatocellular carcinoma previously treated with sorafenib
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

calquence

Products Affected

- **CALQUENCE**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

caplyta

Products Affected

- **CAPLYTA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

caprelsa

Products Affected

- **CAPRELSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

carbaglu

Products Affected

- **CARBAGLU**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of use as an adjunct therapy for acute hyperammonemia or maintenance therapy for chronic hyperammonemia due to hepatic enzyme N-acetylglutamate synthase (NAGS) deficiency
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

CERDELGA

Products Affected

- **CERDELGA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of mild to moderate type 1 Gaucher disease confirmed by the following A. or B. A) With one of the following symptoms (1, 2, 3, 4, or, 5): 1)Hepatomegaly. 2)Splenomegaly. 3)Bone disease (i.e. osteonecrosis, osteopenia, secondary pathologic fractures, bone infarct). 4)Bone marrow complications as defined by anemia with hemoglobin less than or equal to 11.5 g/dL for females or 12.5 g/dL for males. 5)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). -OR- B) Glucocerebrosidase activity in peripheral leukocytes is less than or equal to 15 percent of normal activity or genetic testing confirms mutant alleles -AND- Documentation of CYP2D6 metabolizer status (e.g. intermediate metabolizer).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

CF drugs

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

cholbam

Products Affected

- **CHOLBAM**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

cialis

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of benign prostatic hyperplasia (BPH) and trial/failure of at least two alternative medications in the following classes (alpha-1 adrenergic blockers and/or 5-alpha reductase inhibitors)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

cimzia

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

cinryze

Products Affected

- **CINRYZE**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

cometriq

Products Affected

- **COMETRIQ**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

copiktra

Products Affected

- **COPIKTRA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

corlanor

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Cosentyx

Products Affected

- **COSENTYX (2 SYRINGES)**
- **COSENTYX PEN (2 PENS)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For ankylosing spondylitis, inadequate response or intolerance to a 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 non-radiographic axial spondyloarthritis
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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

cotellic

Products Affected

- **COTELLIC**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

daurismo

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

dojolvi

Products Affected

- **DOJOLVI**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	12 months
Other Criteria	Platelet count is provided for applicable dosing.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

drizalma

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

duobrii

Products Affected

- **DUOBRII**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

dupixent

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3): 1) moderate to severe atopic dermatitis 2) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- trial & failure, intolerance, or contraindication to at least one non-fluorinated topical corticosteroid for patients requesting treatment for atopic dermatitis of the face 3) trial & failure, intolerance, or contraindication to tacrolimus ointment, or pimecrolimus cream, or crisaborole ointment -OR- Documentation of the following (4-7): 4) moderate-to-severe asthma 5) documented FEV1 reversibility of at least 12% or 200 milliliters (mL) after albuterol (salbutamol) administration 6) Blood eosinophils greater than or equal to 150 cells/uL -OR- patient is currently taking daily or alternate-day oral corticosteroids 7) using a medium- or high-dose inhaled corticosteroid and a long acting beta agonist -OR- Documentation of the following (8-9): 8) chronic rhinosinusitis with nasal polyposis 9) trial & failure, intolerance or contraindication to intra-nasal corticosteroid and 14 day course of oral corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. Reauthorization or continuation of therapy will be approved when documentation of improvement or response to therapy is provided.

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

egfr tyrosine kinase inhibitors

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- both of the following. 1) Epidermal growth factor receptor (EGFR) mutations, if applicable to diagnosis. 2) Alternatives tried/failed and concomitant therapy, if applicable to diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Coverage of pancreatic cancer diagnosis applies only to erlotinib (Tarceva). The use of Tarceva and Gilotrif for non-small cell lung cancer (NSCLC) will be approved as a first-line therapy. Applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

egrifta

Products Affected

- **EGRIFTA SV**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of HIV and lipodystrophy, member must actively be receiving antiretroviral therapy including protease inhibitors, nucleoside reverse transcriptase inhibitors, or non-nucleoside reverse transcriptase inhibitors
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

emflaza

Products Affected

- **EMFLAZA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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 reauthorization, attestation of reduction in average monthly migraine days or number of migraine episodes is required -OR- attestation of reduction in the number of mean weekly cluster headaches from baseline is required.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

enbrel

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Remicade, Cimzia, Humira, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of diagnosis. For rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to 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). For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
Age Restrictions	Deny if less than 2 years old
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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

endari

Products Affected

- **ENDARI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Sickle Cell Disease with 2 or more sickle cell complications within the previous 12 months -AND-documentation of previous trial of antisickling treatment (e.g. hydroxyurea) and plans of continued therapy while taking Endari
Age Restrictions	Deny if less than 5 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

enspryng

Products Affected

- **ENSPRYNG**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

epclusa

Products Affected

- **EPCLUSA ORAL TABLET 400-100 MG**
- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 6 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than one tablet per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

epidiolex

Products Affected

- **EPIDIOLEX**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

erivedge

Products Affected

- **ERIVEDGE**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

erleada

Products Affected

- **ERLEADA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

evenity

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

evrysdi

Products Affected

- **EVRYSDI**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

farydak

Products Affected

- **FARYDAK ORAL CAPSULE 10 MG, 20 MG**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

fasenra

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

fetzima

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

fintepla

Products Affected

- **FINTEPLA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

firazyr

Products Affected

- **FIRAZYR**
- *icatibant*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

firdapse

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

flector

Products Affected

- *diclofenac epolamine*
- **FLECTOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to 2 oral generic NSAIDs one of which must be diclofenac
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

forteo

Products Affected

- **FORTEO**
- *teriparatide*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

gabapentin

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

galafold

Products Affected

- **GALAFOLD**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

gattex

Products Affected

- **GATTEX 30-VIAL**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

gavreto

Products Affected

- **GAVRETO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer (NSCLC) -AND- classified as RET fusion-positive as detected by an FDA approved test
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

gilenya

Products Affected

- **GILENYA ORAL CAPSULE 0.5 MG**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

gleevec

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and alternatives tried or concomitant therapy, if applicable for diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

grastek

Products Affected

- **GRASTEK**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

growth hormone

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

HARVONI

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 3 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than one tablet per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

HETLIOZ

Products Affected

- **HETLIOZ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Non-24 Sleep-Wake disorder -AND- patient is totally blind
Age Restrictions	
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
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

high-risk meds

Products Affected

- *amitriptyline*
- *benztropine oral*
- *clomipramine*
- *cyclobenzaprine oral tablet 10 mg, 5 mg*
- *cyproheptadine*
- *doxepin oral capsule*
- *doxepin oral concentrate*
- *doxepin oral tablet*
- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *imipramine hcl*
- *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 the target high-risk medications glyburide and TCAs, in addition to criteria 1 through 3 above, trial and failure or documentation of intolerance or contraindication to at least 2 non-high risk alternative drugs for the same indication, if available, is required. Non-high risk alternative medications for those target high-risk medications include the following: 1. Glyburide (non-high risk alternatives include glipizide and glimepiride) 2. TCAs (non-high risk alternatives include SSRIs and SNRIs) If using one of the above 2 high-risk medications for a medically-accepted indication not shared by the safer alternatives listed, then no trial of alternatives is required for that target high-risk medication.
Age Restrictions	Automatic approval if less than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only for protected class drugs. Doxepin doses less than or equal to 6mg per day will receive automatic approval.

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

homozygous fh

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

humira

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Remicade, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID). For juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD. For moderate to severe juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide). For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For ulcerative colitis, inadequate response or intolerance to 2 immunosuppressants -OR- require continuous steroid therapy. For uveitis, inadequate response or intolerance to 2 immunosuppressants.
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Ibrance

Products Affected

- **IBRANCE**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

iclusig

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of newly-diagnosed chronic phase CML
Required Medical Information	Documentation of chronic phase, accelerated phase, or blast phase CML in patients for whom no other tyrosine kinase inhibitor therapy is indicated -OR- Documentation of PH+ ALL in patients for whom no other tyrosine kinase inhibitor is indicated -OR- Documentation of T3151 positive chronic phase, accelerated phase or blast phase CML -OR- Documented T3151 positive PH+ ALL
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

idhifa

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ig

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Required Medical Information	Documentation of diagnosis. For select diagnoses the following apply- 1) For Myasthenia Gravis Syndrome, documentation that the patient is refractory to other standard therapies (e.g., cholinesterase inhibitors, corticosteroids, azathioprine) given in therapeutic doses over at least 3 months OR is intolerant of/has a contraindication to those standard therapies. 2) For Multiple Sclerosis, patient is refractory to other standard therapies (e.g., interferons) given in therapeutic doses over at least 3 months, OR is intolerant of/has a contraindication to those standard therapies. 3) For Inflammatory Myopathies, the patient is refractory to corticosteroids given in therapeutic doses over at least 4 months, OR is intolerant of/has a contraindication to corticosteroids or immunosuppressants. 4) For CLL, IgG level less than 600mg/dL or evidence of a specific antibody deficiency or recurrent bacterial infections. 5) For Bone Marrow Transplant, when indicated within the first 100 days after transplantation. 6) For Dermatomyositis/Polymyositis, trial and failure, intolerance, or contraindication to standard fist line therapy (i.e. corticosteroids or immunosuppressants). 7) For Pediatric HIV, the patient is less than 13 y.o. who have entry CD4 lymphocyte count greater than or equal to 200/mm3 and IgG less than 400 mg/dL OR a history of recurrent bacterial infections. 8) For Guillain-Barre syndrome, impaired function by objective assessment and/or objective findings on physical exam at the time of initial therapy and IVIG therapy must be initiated within 2 weeks of symptom onset. 9) For Autoimmune Mucocutaneous Blistering Diseases (e.g. Stevens-Johnson Syndrome), trial and failure, intolerance, or contraindication to conventional therapy (e.g. corticosteroids) or the patient has rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Covered under Part B when administered in the home to a member with a diagnosis of primary immunodeficiency disease
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Off Label Uses	Myasthenia Gravis syndrome, Multiple Sclerosis, Inflammatory Myopathies, Polymyositis, Dermatomyositis, Bone Marrow Transplant, Pediatric HIV, Guillain-Barre syndrome, Autoimmune Mucocutaneous Blistering Diseases

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

imbruvica

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of mantle cell lymphoma and treatment with at least one prior therapy -OR- documentation of chronic lymphocytic leukemia or small lymphocytic lymphoma -OR- documentation of chronic lymphocytic leukemia or small lymphocytic lymphoma with 17p deletion -OR- documentation of Waldenstrom macroglobulinemia -OR- documentation of marginal zone lymphoma in patients who require systemic therapy and have received at least one prior anti-CD20-based therapy -OR- documentation of chronic graft versus host disease in patients who have tried and failed one or more lines of systemic therapy -OR- documentation of chronic lymphocytic leukemia or small lymphocytic lymphoma used in combination with rituximab, obinutuzumab or bendamustine with rituximab.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

increlex

Products Affected

- **INCRELEX**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ingrezza

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

inlyta

Products Affected

- **INLYTA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

inqovi

Products Affected

- **INQOVI**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

inrebic

Products Affected

- **INREBIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate-2 or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis -AND- If a new start, baseline platelet count of greater than 50x10*9/L
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

interferon alfa

Products Affected

- **INTRON A INJECTION** **MCG/0.5 ML**
- **PEGASYS**
- **PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180**

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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

interleukin-1b blockers

Products Affected

- **ARCALYST**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with agents that inhibit IL-1 or TNF including Remicade, Humira, Enbrel, Orencia, or Kineret
Required Medical Information	Documentation of diagnosis
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

IPF AGENTS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of pirfenidone and nintedanib
Required Medical Information	Documentation of idiopathic pulmonary fibrosis -AND- baseline forced vital capacity (FVC) of at least 50% and a percent predicted diffusing capacity of the lungs of carbon monoxide (DLCO) of at least 30%. 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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

iressa

Products Affected

- **IRESSA**

PA Criteria	Criteria Details
Exclusion Criteria	Use in tumors with EGFR mutations other than exon 19 deletions or exon 21 (L858R) substitution mutations.
Required Medical Information	Documentation of metastatic non-small cell lung cancer (NSCLC) in patients whose tumors express EGFR exon 19 deletion mutations or exon 21 (L858R) mutations as detected by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

isturisa

Products Affected

- **ISTURISA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

itraconazole

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. If using for diagnosis of onychomycosis, confirmation through positive laboratory testing (e.g. KOH preparation, fungal culture, or nail biopsy) is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Onychomycosis: 3 months. All other indications: 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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

jakafi

Products Affected

- **JAKAFI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis -OR- documentation of polycythemia vera and inadequate response or intolerance to hydroxyurea -OR- Documentation of steroid refractory acute graft-versus-host disease and prior therapy with at least one systemic corticosteroid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. Platelet count to be provided.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

jynarque

Products Affected

- **JYNARQUE**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

kalydeco

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

kevzara

Products Affected

- **KEVZARA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

kineret

Products Affected

- **KINERET**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Actemra, Remicade, Humira, Orencia, Enbrel, Simponi, Cimzia
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra and Xeljanz/Xeljanz XR.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

kisqali

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

korlym

Products Affected

- **KORLYM**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

koselugo

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

kuvan

Products Affected

- **KUVAN ORAL TABLET,SOLUBLE**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

latuda

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

lenvima

Products Affected

- **LENVIMA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally recurrent or metastatic, progressive, radioactive iodine refractory differentiated thyroid cancer -OR- documentation of unresectable hepatocellular carcinoma -OR- advanced renal cell carcinoma -AND- all of the following (1 and 2). 1) Lenvima will be used in combination with everolimus and 2) Trial of at least one prior anti-angiogenic therapy -OR- documentation of advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) -AND- Lenvima will be used in combination with pembrolizumab -AND- progression following prior systemic therapy -AND- Not a candidate for curative surgery or radiation
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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 -OR- myeloid reconstitution following transplantation of autologous peripheral blood progenitor cells -OR- acceleration of myeloid recovery in patients with non-Hodgkin's lymphoma (NHL), acute lymphoblastic leukemia (ALL) and Hodgkin's disease undergoing autologous bone marrow transplantation (BMT) -OR- acceleration of myeloid recovery in patients undergoing allogeneic BMT from HLA-match related donors -OR- patients who have undergone allogeneic or autologous BMT in whom engraftment is delayed or has failed -OR- treatment of delayed neutrophil recovery or graft failure after autologous or allogenic bone marrow transplantation -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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

leukotriene modifiers

Products Affected

- *zileuton*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

lidoderm

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of postherpetic neuralgia (PHN) and trial and failure of 1 other agent used to treat PHN (e.g. gabapentin) -OR- documentation of diabetic peripheral neuropathy (DPN) and trial and failure of one other agent used to treat DPN (e.g. duloxetine).
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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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- one of the following: 1) Modification of medications to reduce serum potassium levels were not successful, when applicable. 2) Diagnosis of chronic kidney disease and medications known to cause hyperkalemia (e.g. ACE inhibitors, ARBs) have been discontinued or reduced to the lowest effective dose.
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, documentation of diagnosis of a chronic condition that is contributing to persistent hyperkalemia and attestation of reduction in serum potassium levels following Lokelma administration is required.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

lonsurf

Products Affected

- **LONSURF**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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) -AND- one of the following (1 or 2): 1. Disease progression on crizotinib and at least one other ALK inhibitor -OR- 2. Disease progression on alectinib or ceritinib as the first ALK therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For reauthorization, attestation of disease improvement or delayed disease progression.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

lynparza

Products Affected

- **LYNPARZA ORAL TABLET**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

lyrica

Products Affected

- **LYRICA CR**
- *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg*
- *pregabalin oral solution*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

mavenclad

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

mavyret

Products Affected

- **MAVYRET**

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 12 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than three tablets per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

mayzent

Products Affected

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

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 diagnosis of a relapsing form of multiple sclerosis -AND- new starts to therapy have the following baseline information documented within 6 months of initiating therapy: ophthalmologic evaluation, liver function test, complete blood count, and cardiac evaluation (e.g. electrocardiogram) -AND- Testing for CYP2C9 variants has confirmed member does not have CYP2C9*3/*3 genotype -AND- new starts to therapy do not have any of the following: history of myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, Class III/IV heart failure, Mobitz type II second-degree, third-degree AV block and sick sinus syndrome unless patient has a functioning pacemaker..
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

megace

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For tablets, applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

mekinist

Products Affected

- **MEKINIST**

PA Criteria	Criteria Details
Exclusion Criteria	Patients with melanoma who have disease progression on prior BRAF inhibitor therapy
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

mektovi

Products Affected

- **MEKTOVI**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

myalept

Products Affected

- **MYALEPT**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

mycapssa

Products Affected

- **MYCAPSSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acromegaly -AND- High pretreatment insulin-like growth factor-1 (IGF-1) based on laboratory reference range -AND- Previous response to and tolerated treatment with octreotide or lanreotide.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of decreased or normalized IGF-1 from baseline
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

namzaric

Products Affected

- **NAMZARIC**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

natpara

Products Affected

- **NATPARA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

nayzilam

Products Affected

- **NAYZILAM**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

nerlynx

Products Affected

- **NERLYNX**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

nexavar

Products Affected

- **NEXAVAR**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

nexletol

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ninlaro

Products Affected

- **NINLARO**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

NORTHERA

Products Affected

- **NORTHERA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

nourianz

Products Affected

- **NOURIANZ**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

nubeqa

Products Affected

- **NUBEQA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

nucala

Products Affected

- **NUCALA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

nuplazid

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

nuvigil

Products Affected

- *armodafinil*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ocaliva

Products Affected

- **OCALIVA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

odactra

Products Affected

- **ODACTRA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

odomzo

Products Affected

- **ODOMZO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced basal cell carcinoma (laBCC) that has recurred following surgery or radiation therapy or for use in patients who are not candidates for surgery or radiation therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

olumiant

Products Affected

- **OLUMIANT**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

onfi

Products Affected

- *clobazam*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ongentys

Products Affected

- **ONGENTYS**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

oralair

Products Affected

- **ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

orencia

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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- Treatment with Oriahnn 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- Treatment with Oriahnn does not exceed 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

orilissa

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

orkambi

Products Affected

- **ORKAMBI ORAL TABLET**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

orkambi granules

Products Affected

- **ORKAMBI ORAL GRANULES IN PACKET**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

OTEZLA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated. For oral ulcers associated with Behcet's Disease, inadequate response or intolerance to topical triamcinolone for acute flare-up of oral ulcers -AND- inadequate response or intolerance to colchicine for prevention of recurrent oral ulcers
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Maintenance doses greater than 60 mg per day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

oxbryta

Products Affected

- **OXBRYTA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

palynziq

Products Affected

- **PALYNZIQ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of phenylketonuria. Member meets the following criteria 1.) Baseline Phe level greater than 600 micrometers/L -AND- 2.) Failure or intolerance to existing management (i.e. Kuvan therapy).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in baseline pretreatment Phe levels -OR- blood Phe levels are within recommended target range.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

pemazyre

Products Affected

- **PEMAZYRE**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

piqray

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of HR-positive, HER2-negative advanced or metastatic breast cancer in men and postmenopausal women with disease progression on or after endocrine-based therapy -AND- Used in combination with fulvestrant - AND- PI3K mutation positive as detected by an FDA approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new start only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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 after failure of highly active antiretroviral therapy (HAART) or in patients with Kaposi sarcoma who are HIV-negative.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

praluent

Products Affected

- **PRALUENT PEN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FD (e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190 mg/dL prior to lipid lowering therapy (greater than or equal to 160 mg/dL if age less than 20) or LDL-C greater than or equal to 160 mg/dL after treatment with antihyperlipidemic agents but prior to Praluent therapy AND Prior therapy with the highest dose of a high intensity statin (i.e. atorvastatin 80mg, rosuvastatin 40mg) or a maximally tolerated dose of high intensity statin with documentation demonstrating why higher strengths of the statin could not be tolerated, would not be tolerated (e.g., exacerbate existing skeletal muscle symptoms) or would not enable member to achieve LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. 2. Hypercholesterolemia ASCVD or Primary Hyperlipidemia AND unable to acheive LDL goal on prior therapy AND baseline LDL-C AND Prior therapy with the highest dose of a high intensity statin (i.e. atorvastatin 80mg, rosuvastatin 40mg) or a maximally tolerated dose of high intensity statin with documentation demonstrating why higher strengths of the statin could not be tolerated, would not be tolerated (e.g., exacerbate existing skeletal muscle symptoms) or would not enable member to achieve LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

prescription drug combo

Products Affected

- *acetaminophen-codeine oral solution 120-12 mg/5 ml*
- *acetaminophen-codeine oral tablet*
- *alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- **ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG**
- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*
- *hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml*
- *hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg*
- *hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg*
- *hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml*
- *hydromorphone oral liquid*
- *hydromorphone oral tablet*
- *methadone oral solution 10 mg/5 ml, 5 mg/5 ml*
- *methadone oral tablet 10 mg, 5 mg*
- *morphine concentrate oral solution*
- *morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg*
- *morphine oral 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*
- *oxycodone oral capsule*
- *oxycodone oral concentrate*
- *oxycodone oral solution*
- *oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg*
- *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg*
- *tramadol oral capsule,er biphase 24 hr 25-75 100 mg, 200 mg*
- *tramadol oral tablet 100 mg, 50 mg*
- *tramadol-acetaminophen*

PA Criteria	Criteria Details
Exclusion Criteria	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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 AND attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For concomitant use of an opiate agonist and other opiate potentiators (e.g. gabapentinoids, benzodiazepines) attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For long acting (e.g. extended release) opioid medications, the following apply (1-5). 1)Pain is severe enough to require daily, around-the-clock, long-term opioid treatment. 2)Patient is not long acting opioid naive. 3)Attestation that non-opiate alternative therapies have been explored (e.g. NSAIDs). 4)Attestation that controlled substance Rx history has been reviewed in the state Prescription Drug Monitoring Program. 5)Attestation of counseling on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Opiate+subs. abuse tx, approve opiate x 1mo. All other combos approve x 12mo.
Other Criteria	Opiate agonists will receive automatic approval if no recent claims for a substance abuse therapy (e.g. buprenorphine-naloxone) OR a benzodiazepine (e.g. triazolam, alprazolam) OR a benzodiazepine with a centrally acting skeletal muscle relaxant (e.g., carisoprodol) OR a gabapentinoid. Benzodiazepines (e.g. triazolam, alprazolam) will receive automatic approval if no recent claims for an opiate agonist (e.g. oxycodone, hydrocodone, oxymorphone) or an opiate agonist with a centrally acting skeletal muscle relaxant (e.g. carisoprodol). Infusible opiate agonists will be covered under Part B when administered via infusion pump.
Indications	All FDA-approved Indications.

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

procysbi

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

prolia

Products Affected

- **PROLIA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

provigil

Products Affected

- *modafinil*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Fatigue associated with Multiple Sclerosis (MS)

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

pulmonary arterial hypertension

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization, defined as a mean pulmonary arterial pressure (mPAP) of greater than or equal to 25 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than 3 Wood units -AND- WHO Group -AND- other causes of pulmonary hypertension have been ruled out (e.g. left heart disease, chronic lung disease, venous thromboembolism). For Adempas, additional diagnosis of CTEPH as documented by right heart catheterization and V/Q scan substantiating mPAP greater than or equal to 25 mmHg at rest and PWP less than or equal to 15 mmHg and documented presence of occlusive thrombi within the pulmonary arteries will be approved.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Other Criteria	Ventavis covered under Part B when using via nebulizer in the home setting. For brand Adcirca, trial and failure of generic tadalafil is required. For brand Letairis, trial and failure of generic ambrisentan is required.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

qinlock

Products Affected

- **QINLOCK**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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 FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ravicti

Products Affected

- **RAVICTI**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

regranex

Products Affected

- **REGRANEX**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

relistor

Products Affected

- **RELISTOR ORAL**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

repatha

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1.HoFH supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL(or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 yrs or HeFH in both parents AND used with max tolerated statin unless all statins are contraindicated or not tolerated AND not used with lomitapide, mipomersen, or another PCSK9 inhibitor. 2. HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FD(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190mg/dL prior to lipid lowering therapy (greater than or equal to 160mg/dL if age less than 20) or LDL-C greater than or equal to 160mg/dL after treatment with antihyperlipidemic agents but prior to Repatha therapy AND Prior therapy with the highest dose of a high intensity statin (i.e. atorvastatin 80mg, rosuvastatin 40mg) or a maximally tolerated dose of high intensity statin with documentation demonstrating why higher strengths of the statin could not be tolerated, would not be tolerated (e.g., exacerbate existing skeletal muscle symptoms) or would not enable member to achieve LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. 3. Hypercholesterolemia ASCVD or Primary Hyperlipidemia AND unable to achieve LDL goal on prior therapy AND baseline LDL-C AND Prior therapy with the highest dose of a high intensity statin (i.e. atorvastatin 80mg, rosuvastatin 40mg) or a maximally tolerated dose of high intensity statin with documentation demonstrating why higher strengths of the statin could not be tolerated, would not be tolerated or would not enable member to achieve LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance.

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Age Restrictions	Deny if less than 18 years of age for HeFH, ASCVD and Primary Hyperlipidemia, or less than 13 years of age for HoFH.
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. For HoFH diagnosis, 3 syringes per month will be approved aligned with recommended dosing regimen for this indication. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

repatha pushtronex

Products Affected

- **REPATHA PUSHTRONEX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1.HoFH supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL(or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 yrs or HeFH in both parents AND used with max tolerated statin unless all statins are contraindicated or not tolerated AND not used with lomitapide, mipomersen, or another PCSK9 inhibitor. 2. HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FD(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190mg/dL prior to lipid lowering therapy (greater than or equal to 160mg/dL if age less than 20) or LDL-C greater than or equal to 160mg/dL after treatment with antihyperlipidemic agents but prior to Repatha therapy AND Prior therapy with the highest dose of a high intensity statin (i.e. atorvastatin 80mg, rosuvastatin 40mg) or a maximally tolerated dose of high intensity statin with documentation demonstrating why higher strengths of the statin could not be tolerated, would not be tolerated (e.g., exacerbate existing skeletal muscle symptoms) or would not enable member to achieve LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance. 3. Hypercholesterolemia ASCVD or Primary Hyperlipidemia AND unable to achieve LDL goal on prior therapy AND baseline LDL-C AND Prior therapy with the highest dose of a high intensity statin (i.e. atorvastatin 80mg, rosuvastatin 40mg) or a maximally tolerated dose of high intensity statin with documentation demonstrating why higher strengths of the statin could not be tolerated, would not be tolerated or would not enable member to achieve LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance.

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Age Restrictions	Deny if less than 18 years of age for HeFH, ASCVD and Primary Hyperlipidemia, or less than 13 years of age for HoFH.
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. For HoFH diagnosis, one Pushtronex system per month will be approved aligned with recommended dosing regimen for this indication. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

retevmo

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

revlimid

Products Affected

- **REVLIMID**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

rinvoq

Products Affected

- **RINVOQ**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

rozlytrek

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

rubraca

Products Affected

- **RUBRACA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ruconest

Products Affected

- **RUCONEST**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

rydapt

Products Affected

- **RYDAPT**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

sabril

Products Affected

- *vigabatrin*
- **VIGADRONE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of refractory complex partial seizures -AND- documentation of adjunctive therapy -AND- an adequate trial or intolerance to at least two alternative treatments (e.g. carbamazepine, lamotrigine, levetiracetam, oxcarbazepine, tiagabine) -OR- documentation of use as monotherapy in treatment of infantile spasms
Age Restrictions	Deny if less than 2 years of age in treatment of refractory complex partial seizures -OR- if less than 1 month old and greater than 2 years of age in treatment of infantile spasms
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

samsca

Products Affected

- **SAMSCA**
- *tolvaptan oral tablet 30 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Patients with documentation of hypovolemic hyponatremia -OR- patients with the need to increase serum sodium acutely
Required Medical Information	Documentation of symptomatic hypervolemic or euvolemic hyponatremia evidenced by 1.) Serum Na less than 125 mEq/L -OR- 2.) Serum NA less than 135mEq/Ls 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
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

signifor

Products Affected

- **SIGNIFOR**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

siliq

Products Affected

- **SILIQ**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

simponi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Actemra, Kineret, Remicade, Humira, Orencia, Enbrel, Cimzia
Required Medical Information	Documentation of diagnosis. Simponi 50mg: For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide) and Simponi will be used in combination with methotrexate. For ankylosing spondylitis, inadequate response or intolerance to a nonsteroidal anti-inflammatory drug (NSAID). Simponi 100mg: For moderate to severe ulcerative colitis, inadequate response or intolerance to two immunosuppressants (e.g. azathioprine) -OR- use in those patients requiring continuous steroid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Rheumatoid arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel, Cosentyx, Xeljanz/Xeljanz XR, Otezla, and Stelara. For ankylosing spondylitis, patients must have an adequate trial or intolerance to 2 of the following preferred products Humira, Enbrel and Cosentyx. For ulcerative colitis, patients must have an adequate trial or intolerance to the preferred products Humira and Xeljanz. For ulcerative colitis indication therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

skyrizi

Products Affected

- **SKYRIZI SUBCUTANEOUS SYRINGE KIT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine) -OR- inadequate response to phototherapy. If not a candidate for phototherapy: treatment with systemic therapy has been ineffective, not tolerated, or is contraindicated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

solaraze

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure, intolerance, or contraindication to topical fluorouracil
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

sovaldi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance -AND- the member is unable to utilize regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
Age Restrictions	Deny if less than 3 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	Doses greater than or less than 400 mg/day will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

sprycel

Products Affected

- **SPRYCEL**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

stelara

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

stivarga

Products Affected

- **STIVARGA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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.

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

PA Criteria	Criteria Details
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

sutent

Products Affected

- **SUTENT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and failure of imatinib therapy, if applicable
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

sympazan

Products Affected

- **SYMPAZAN**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

symproic

Products Affected

- **SYMPROIC**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tabrecta

Products Affected

- **TABRECTA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tagrisso

Products Affected

- **TAGRISSO**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

takhzyro

Products Affected

- **TAKHZYRO**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

taltz

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

talzenna

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

targretin

Products Affected

- *bexarotene*
- **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	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tasigna

Products Affected

- **TASIGNA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tavalisse

Products Affected

- **TAVALISSE**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tazorac

Products Affected

- *tazarotene*
- **TAZORAC TOPICAL CREAM 0.05 %**
- **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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tazverik

Products Affected

- **TAZVERIK**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tecfidera

Products Affected

- *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 240 mg*
- **TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
Required Medical Information	Pending CMS Review
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	Doses greater than 240 mg twice-daily will not be approved
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tegsedi

Products Affected

- **TEGSEDI**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

testosterone (androgens)

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of primary or secondary hypogonadism in males with testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, radiation or toxic damage -OR- documentation of primary or secondary hypogonadism in males with multiple symptoms of hypogonadism including at least one of the following specific symptoms: height loss due to vertebral fractures, low trauma fractures, low bone density, incomplete or delayed sexual development, breast discomfort, loss of axillar and/or pubic body hair, hot flushes -OR- documentation of HIV infection in men with weight loss -OR- documentation of chronic steroid treatment in men. In all previously noted indications, members must also have documented low testosterone level below the normal range for the laboratory -OR- a total testosterone level near the lower limit of the normal range with a low free testosterone level which is less than normal based upon the laboratory reference range. Additional approvable indications include vulvar dystrophies in women (topical ointment only) -AND- palliative treatment in female patients with metastatic breast cancer (testosterone enanthate only), primary or secondary hypogonadism in males with testicular failure due to double orchidectomy and delayed puberty in males (testosterone enanthate only).
Age Restrictions	Deny if less than recommended age per FDA product labeling
Prescriber Restrictions	
Coverage Duration	12 months

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

thalomid

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

thrombopoiesis stimulating agents

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tibsovo

Products Affected

- **TIBSOVO**

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 -OR- Documentation of newly-diagnosed acute myeloid leukemia with an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA approved test and at least 75 years of age or comorbidities that preclude us of intensive induction chemotherapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tiglutik

Products Affected

- **TIGLUTIK**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tolsura

Products Affected

- **TOLSURA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

topical lidocaine

Products Affected

- *lidocaine hcl mucous membrane jelly*
- *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	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

transmucosal fentanyl citrate

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tretinoin

Products Affected

- **AVITA**
- *tretinoin*
- *tretinoin microspheres topical gel*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

trikafta

Products Affected

- **TRIKAFTA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tukysa

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

turalio

Products Affected

- **TURALIO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic tenosynovial giant cell tumor associated with severe morbidity and functional limitations -AND- patient is not amenable to improvement with surgery or not a candidate for surgery
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tykerb

Products Affected

- **TYKERB**

PA Criteria	Criteria Details
Exclusion Criteria	Use without disease progression on trastuzumab prior to initiation of therapy.
Required Medical Information	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) HER2 mutations 2) Alternatives tried/failed 3) Concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

tymlos

Products Affected

- **TYMLOS**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

VALCHLOR

Products Affected

- **VALCHLOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received prior skin-directed therapy (e.g. topical corticosteroids, topical chemotherapy, local radiation and topical retinoids).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

valtoco

Products Affected

- **VALTOCO**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

veltassa

Products Affected

- **VELTASSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hyperkalemia as defined by serum potassium level between 5.1 and 6.4 mmol/L on at least two (2) screenings -AND- one of the following: 1) Modification of medications to reduce serum potassium levels were not successful, when applicable. 2) Diagnosis of chronic kidney disease and medications known to cause hyperkalemia (e.g. ACE inhibitors, ARBs) have been discontinued or reduced to the lowest effective dose.
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, documentation of diagnosis of a chronic condition that is contributing to persistent hyperkalemia and attestation of reduction in serum potassium levels following Veltassa administration is required.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

venclexta

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) Genetic mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis. For newly-diagnosed acute myeloid leukemia presence of one comorbidity that precludes use of intensive induction chemotherapy (i.e. age greater than or equal to 75 years, severe cardiac or pulmonary comorbidity, reduced renal function, and hepatic impairment) is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

verzenio

Products Affected

- **VERZENIO**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

viberzi

Products Affected

- **VIBERZI**

PA Criteria	Criteria Details
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Documentation of diarrhea predominant, irritable bowel syndrome (IBS-D) -AND- no alcohol abuse in the previous six months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

VIEKIRA PAK

Products Affected

- **VIEKIRA PAK**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

viibryd

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

vimpat

Products Affected

- **VIMPAT ORAL SOLUTION**
- **VIMPAT ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Inadequate response or intolerance to 2 other anticonvulsants.
Age Restrictions	Deny if less than 4 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

vitrakvi

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

vizimpro

Products Affected

- **VIZIMPRO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer -AND- one of the following (1 or 2): 1. Epidermal growth factor (EGFR) exon 19 deletions - OR- 2. Epidermal growth factor receptor (EGFR) exon 21 L858R substitution mutations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For reauthorization, attestation of disease improvement or delayed disease progression.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

vosevi

Products Affected

- **VOSEVI**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

votrient

Products Affected

- **VOTRIENT**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

vraylar

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

vumerity

Products Affected

- **VUMERITY**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trial and failure, intolerance, or contraindication to generic modafinil and a generic CNS stimulant indicated for use in narcolepsy (e.g. methylphenidate, amphetamine salts) is required -OR- Prescriber attests a significant concern about the potential for illegal drug diversion. For reauthorization, provider attestation of improvement in symptoms of narcolepsy
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xalkori

Products Affected

- **XALKORI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive -OR- that is ROS-1 positive
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xeljanz

Products Affected

- **XELJANZ**
- **XELJANZ XR**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orencia, Stelara, Actemra, azathioprine, cyclosporine
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis and an inadequate response or intolerance to methotrexate -OR- Documentation of psoriatic arthritis in combination with a nonbiologic DMARD (e.g. methotrexate) -OR- Documentation of ulcerative colitis and patients must have an inadequate response or intolerance to two immunosuppressants (e.g. azathioprine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doses greater than 10 mg per day for Xeljanz and 11 mg per day for Xeljanz XR will not be approved for rheumatoid arthritis and psoriatic arthritis. Doses greater than 20mg per day for Xeljanz and 22 mg per day for Xeljanz XR will not be approved for ulcerative colitis.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patients with comorbid depression should have controlled depression and are on an antidepressant medication. Doses above 50mg/day may be approved up to 100mg/day (FDA max) when documentation of adequate trial of 50mg/day had inadequate response and CYP2D6 genotype response demonstrating poor CYP metabolism.
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xermelo

Products Affected

- **XERMELO**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xifaxan

Products Affected

- **XIFAXAN ORAL TABLET 550 MG**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xolair

Products Affected

- **XOLAIR**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xospata

Products Affected

- **XOSPATA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xpovio

Products Affected

- **XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 40 MG/WEEK (20 MG X 2), 40MG TWICE WEEK (80 MG/WEEK), 60 MG/WEEK (20 MG X 3), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (20 MG X 4), 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 relapsing or refractory diffuse large B-cell lymphoma with failure, intolerance or contraindication to at least 2 lines of systemic therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xtandi

Products Affected

- **XTANDI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of castration-resistant prostate cancer -OR- Documentation of metastatic castration-sensitive prostate cancer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only
Indications	All FDA-approved Indications.
Off Label Uses	

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xuriden

Products Affected

- **XURIDEN**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

xyrem

Products Affected

- **XYREM**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

yonsa

Products Affected

- **YONSA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

zavesca

Products Affected

- *miglustat*

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

zejula

Products Affected

- **ZEJULA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

zelboraf

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

zepatier

Products Affected

- **ZEPATIER**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

zeposia

Products Affected

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

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

zolinza

Products Affected

- **ZOLINZA**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

ZYDELIG

Products Affected

- **ZYDELIG**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

zykadia

Products Affected

- **ZYKADIA ORAL TABLET**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

zytiga

Products Affected

- *abiraterone*
- **ZYTIGA ORAL TABLET 500 MG**

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Index of Drugs

bunavail

Products Affected

- **BUNAVAIL 2.1 MG-0.3 MG BUCCAL FILM**
- **BUNAVAIL 4.2 MG-0.7 MG BUCCAL FILM**
- **BUNAVAIL 6.3 MG-1 MG BUCCAL FILM**

Details

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

celecoxib

Products Affected

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

Details

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

You can find information on what the symbols and abbreviations on this table mean by going to page 11 of this booklet.

Index of Drugs