ALAMEDA ALLIANCE WELLNESS (HMO D-SNP) NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

English

ATTENTION: If you need help in your language, call **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). These services are free of charge.

العربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). هذه الخدمات مجانية.

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**): Այդ ծառայություններն անվճար են:

ខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពជំ ក៍អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

中文 (Chinese – Simplified)

请注意：如果您需要以您的母语提供帮助，请致电 **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**)。这些服务都是免费的。

繁體中文 (Chinese Traditional)

请注意：如果您需要以您的母语提供的帮助，請撥打 **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**)。我們可為殘障人士提供相應的輔助設施和服務，如盲文和大字印刷體格式的文件。請撥打 **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**)。此類服務均免費提供。

فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Hmoob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Cov kev pab cuam no yog pab dawb xwb.

日本語 (Japanese)

注意日本語での対応が必要な場合は **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**) へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**)へお電話ください。これらのサービスは無料で提供しています。

한국어 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1.888.88A.DSNP** (**1.888.882.3767**) (линия TTY: **1.800.735.2929**). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1.888.88A.DSNP** (**1.888.882.3767**) (линия TTY: **1.800.735.2929**). Такие услуги предоставляются бесплатно.

Español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Estos servicios son gratuitos.

Tagalog (Filipino)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Libre ang mga serbisyong ito.

ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Українська (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Ці послуги безкоштовні.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1.888.88A.DSNP** (**1.888.882.3767**) (TTY: **1.800.735.2929**). Các dịch vụ này đều miễn phí.

ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	OSTEOPOROSIS: HAS NOT RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ABEMACICLIB

Products Affected

- VERZENIO

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

ABIRATERONE

Products Affected

- *abiraterone oral tablet 250 mg*
- *abirtega*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC HIGH-RISK CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC), METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ACALABRUTINIB

Products Affected

- CALQUENCE (ACALABRUTINIB MAL)

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

ADAGRASIB

Products Affected

- KRAZATI

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

ADALIMUMAB

Products Affected

- HUMIRA PEN
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PEDIATRIC UC
- HUMIRA(CF) PEN PSOR-UV-ADOL HS

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ADALIMUMAB-AATY

Products Affected

- *adalimumab-aaty*
- *adalimumab-aaty(cf) ai crohns*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ADALIMUMAB-BWWD

Products Affected

- HADLIMA
- HADLIMA PUSHTOUCH
- HADLIMA(CF)
- HADLIMA(CF) PUSHTOUCH

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

AFATINIB

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ALECTINIB

Products Affected

- ALECENSA

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

ALPELISIB-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	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AMBRISENTAN

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

AMIKACIN LIPOSOMAL INH

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MYCOBACTERIUM AVIUM COMPLEX (MAC) LUNG DISEASE: RENEWAL: 1) NO POSITIVE MAC SPUTUM CULTURE AFTER CONSECUTIVE NEGATIVE CULTURES, AND 2) IMPROVEMENT IN SYMPTOMS. ADDITIONALLY, FOR FIRST RENEWAL, APPROVAL REQUIRES AT LEAST ONE NEGATIVE SPUTUM CULTURE FOR MAC BY SIX MONTHS OF ARIKAYCE TREATMENT. FOR SECOND AND SUBSEQUENT RENEWALS, APPROVAL REQUIRES AT LEAST THREE NEGATIVE SPUTUM CULTURES FOR MAC BY 12 MONTHS OF ARIKAYCE TREATMENT.
Age Restrictions	
Prescriber Restrictions	MAC LUNG DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AMIVANTAMAB-HYALURONIDASE-LPUJ

Products Affected

- RYBREVANT FASPRO

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

AMIVANTAMAB-VMJW

Products Affected

- RYBREVANT

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

ANAKINRA

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ANIFROLUMAB-FNIA

Products Affected

- SAPHNELO PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	SLE: INITIAL: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR SLE. RENEWAL: 1) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SLE, 2) CLINICAL IMPROVEMENT WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

APALUTAMIDE

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC), METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

APOMORPHINE - ONAPGO

Products Affected

- ONAPGO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER
- OTEZLA XR
- OTEZLA XR INITIATION

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ARMODAFINIL

Products Affected

- *armodafinil*

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

ASCIMINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED OR T315I MUTATION PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND SCEMBLIX IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ASFOTASE ALFA

Products Affected

- STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOPHOSPHATASIA (HPP): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, GENETICIST, OR METABOLIC SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PERINATAL/INFANTILE-ONSET HPP: 1) 6 MONTHS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC CHEST DEFORMITY, (II) CRANIOSYNOSTOSIS, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, (V) NEPHROCALCINOSIS OR HISTORY OF ELEVATED SERUM CALCIUM, (VI) HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. JUVENILE-ONSET HPP: 1) 18 YEARS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TNSALP ALPL GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALP LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PLP LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PEA LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC DEFORMITIES, (II) PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. ALL INDICATIONS: 1) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE, 2) CALCIUM OR PHOSPHATE LEVELS ARE NOT BELOW THE NORMAL RANGE, 3)
	NOT HAVE A TREATABLE FORM OF RICKETS. RENEWAL: ALL INDICATIONS: 1) IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HPP, AND 2) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE.
Indications	All FDA-approved Indications.
Off Label Uses	

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

ATOGEPANT

Products Affected

- QULIPTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AVACOPAN

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ANTI-NEUTROPHIL CYTOPLASMIC AUTOANTIBODY (ANCA)-ASSOCIATED VASCULITIS: INITIAL: ANCA SEROPOSITIVE (ANTI-PR3 OR ANTI-MPO).
Age Restrictions	
Prescriber Restrictions	ANCA-ASSOCIATED VASCULITIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ANCA-ASSOCIATED VASCULITIS: RENEWAL: CONTINUES TO BENEFIT FROM THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AVAPRITINIB

Products Affected

- AYVAKIT

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

AVUTOMETINIB-DEFACTINIB

Products Affected

- AVMAPKI
- AVMAPKI-FAKZYNJA

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

AXATILIMAB-CSFR

Products Affected

- NIKTIMVO INTRAVENOUS SOLUTION 10 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CHRONIC GRAFT VS HOST DISEASE (CGVHD): 1) FAILURE OF AT LEAST TWO LINES OF SYSTEMIC THERAPY, ONE OF WHICH MUST BE A TRIAL OF OR CONTRAINDICATION TO JAKAFI, AND 2) NO CONCURRENT USE WITH JAKAFI, REZUROCK, OR IMBRUVICA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

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

AZACITIDINE

Products Affected

- ONUREG

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

AZTREONAM INHALED

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	7 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BEDAQUILINE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BELIMUMAB

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

BELUMOSUDIL

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CHRONIC GRAFT VS HOST DISEASE (CGVHD): 1) FAILURE OF AT LEAST TWO LINES OF SYSTEMIC THERAPY, ONE OF WHICH MUST BE A TRIAL OF OR CONTRAINDICATION TO JAKAFI, AND 2) NO CONCURRENT USE WITH JAKAFI, NIKTIMVO, OR IMBRUVICA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BELZUTIFAN

Products Affected

- WELIREG

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

BENDAMUSTINE

Products Affected

- *bendamustine intravenous recon soln 25 mg*

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

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

BETAINE

Products Affected

- *betaine*

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

BEXAROTENE

Products Affected

- *bexarotene*

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

BINIMETINIB

Products Affected

- MEKTOVI

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

BORTEZOMIB

Products Affected

- *bortezomib injection*

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

BOSUTINIB

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 500 MG
- *bosutinib oral tablet 100 mg, 400 mg, 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND BOSULIF IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BRIGATINIB

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	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BUDESONIDE-TARPEYO

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

C1 ESTERASE INHIBITOR-HAEGARDA

Products Affected

- HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) TYPE I OR II HAE CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q, OR 2) TYPE III HAE CONFIRMED BY: (A) RECURRENT, NON-URTICARIAL ANGIOEDEMA INVOLVING THE SKIN, GASTROINTESTINAL TRACT, OR AIRWAY, CONSISTENT WITH BRADYKININ-MEDIATED HAE AND ATTACKS NOT EXPLAINED BY HISTAMINERGIC/URTICARIAL ANGIOEDEMA, AND (B) OTHER CAUSES OF ANGIOEDEMA HAVE BEEN EXCLUDED, INCLUDING ACE-INHIBITOR/ARB-ASSOCIATED ANGIOEDEMA, ACQUIRED C1-INH DEFICIENCY, AND MAST-CELL/HISTAMINERGIC ANGIOEDEMA.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, ALLERGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HAE: INITIAL/RENEWAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

CABOZANTINIB CAPSULE

Products Affected

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

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

CABOZANTINIB TABLET

Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

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

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

CAPIVASERTIB

Products Affected

- TRUQAP

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

CAPMATINIB

Products Affected

- TABRECTA

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

CARGLUMIC ACID

Products Affected

- *carglumic acid*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

CERITINIB

Products Affected

- ZYKADIA

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

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: LENNOX-GASTAUT SYNDROME (LGS): THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	LGS: INITIAL: CONTRAINDICATION TO OR UNABLE TO SWALLOW CLOBAZAM TABLETS OR SUSPENSION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

COBIMETINIB

Products Affected

- COTELLIC

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

CORTICOTROPIN-CORTROPHIN

Products Affected

- CORTROPHIN GEL INJECTION

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

CRIZOTINIB CAPSULE

Products Affected

- XALKORI ORAL CAPSULE

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

CRIZOTINIB PELLETS

Products Affected

- XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	NON-SMALL CELL LUNG CANCER (NSCLC), ANAPLASTIC LARGE CELL LYMPHOMA (ALCL), INFLAMMATORY MYOFIBROBLASTIC TUMOR (IMT): UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DABRAFENIB CAPSULES

Products Affected

- TAFINLAR ORAL CAPSULE

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

DABRAFENIB SUSPENSION

Products Affected

- TAFINLAR ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	UNABLE TO SWALLOW TAFINILAR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DACOMITINIB

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	MULTIPLE SCLEROSIS (MS): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MS: INITIAL: HAS SYMPTOMS OF A WALKING DISABILITY (E.G., MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS, UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA). RENEWAL: IMPROVEMENT IN WALKING ABILITY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DARAXONRASIB

Products Affected

- RASONQUE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	METASTATIC PANCREATIC ADENOCARCINOMA: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DAROLUTAMIDE

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC), METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DASATINIB-SPRYCEL

Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND DASATINIB IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

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

DEFERASIROX

Products Affected

- *deferasirox oral granules in packet*
- *deferasirox oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L. CHRONIC IRON OVERLOAD IN NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT): 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS), AND 2) LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G OF LIVER DRY WEIGHT OR GREATER. RENEWAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L. NTDT: 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR 2) LIC OF 3 MG FE/G OF LIVER DRY WEIGHT OR GREATER.
Age Restrictions	
Prescriber Restrictions	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS OR NTDT: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS OR NTDT: DEFERASIROX SPRINKLE PACKETS: TRIAL OF OR CONTRAINDICATION TO GENERIC DEFERASIROX ORAL TABLET OR TABLET FOR ORAL SUSPENSION.
Indications	All FDA-approved Indications.
Off Label Uses	

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

DENOSUMAB-BMWO - OSENVELT

Products Affected

- OSENVELT

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

DEUTETRABENAZINE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTON DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	PLAN YEAR
Other Criteria	TARDIVE DYSKINESIA: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DIAZEPAM

Products Affected

- VALTOCO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	EPILEPSY: AGES 12 YEARS OR OLDER: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: NAYZILAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DICLOFENAC TOPICAL SOLUTION

Products Affected

- *diclofenac sodium topical solution in metered-dose pump*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	OSTEOARTHRITIS OF THE KNEE: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DICLOFENAC SODIUM 1.5% TOPICAL DROPS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DIHYDROERGOTAMINE - NASAL

Products Affected

- *dihydroergotamine nasal*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	ACUTE MIGRAINE TREATMENT: 1) NO CONCURRENT USE WITH ANY OTHER DIHYDROERGOTAMINE OR ERGOTAMINE MEDICATIONS, AND 2) TRIAL OF OR CONTRAINDICATION TO BOTH OF THE FOLLOWING PREFERRED AGENTS: TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), CGRP INHIBITOR FOR ACUTE MIGRAINE TREATMENT (NURTEC ODT, UBRELVY).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DIMETHYL FUMARATE

Products Affected

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

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

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

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

DORDAVIPRONE

Products Affected

- MODEYSO

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

DRONABINOL CAPSULE

Products Affected

- *dronabinol oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY: TRIAL OF OR CONTRAINDICATION TO ONE ANTIEMETIC THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DROXIDOPA

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

DUPILUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

DUVELISIB

Products Affected

- COPIKTRA

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

EFLORNITHINE

Products Affected

- IWILFIN

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

ELACESTRANT

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

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

ELAGOLIX

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 2) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND A PROGESTIN-CONTAINING PREPARATION. RENEWAL: 1) IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ELAPEGADEMASE-LVLR

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ADENOSINE DEAMINASE SEVERE COMBINED IMMUNE DEFICIENCY (ADA-SCID): INITIAL: ADA-SCID AS MANIFESTED BY: 1) CONFIRMATORY GENETIC TEST, OR 2) SUGGESTIVE LABORATORY FINDINGS (E.G., ELEVATED DEOXYADENOSINE NUCLEOTIDE [DAXP] LEVELS, LYMPHOPENIA) AND HALLMARK SIGNS/SYMPTOMS (E.G., RECURRENT INFECTIONS, FAILURE TO THRIVE, PERSISTENT DIARRHEA).
Age Restrictions	
Prescriber Restrictions	ADA-SCID: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH IMMUNOLOGIST, HEMATOLOGIST/ONCOLOGIST, OR PHYSICIAN SPECIALIZING IN INHERITED METABOLIC DISORDERS.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ADA-SCID: RENEWAL: 1) IMPROVEMENT OR MAINTENANCE OF IMMUNE FUNCTION FROM BASELINE, AND 2) HAS NOT RECEIVED SUCCESSFUL HCT OR GENE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ELEXACAFTOR-TEZACAFTOR-IVACAFTOR

Products Affected

- TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL
- TRIKAFTA ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ELTROMBOPAG - PROMACTA

Products Affected

- *eltrombopag olamine oral powder in packet 12.5 mg, 25 mg*
- *eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ENASIDENIB

Products Affected

- IDHIFA

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

ENCORAFENIB

Products Affected

- BRAFTOVI

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

ENSARTINIB

Products Affected

- ENSACOVE ORAL CAPSULE 100 MG, 25 MG

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

ENTRECTINIB CAPSULES

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

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

ENTRECTINIB PELLETS

Products Affected

- ROZLYTREK ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC), SOLID TUMORS: 1) TRIAL OF OR CONTRAINDICATION TO ROZLYTREK CAPSULES MADE INTO AN ORAL SUSPENSION, AND 2) DIFFICULTY OR UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ENZALUTAMIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (NMCSPC): HIGH RISK FOR METASTASIS (I.E. PSA DOUBLING TIME OF 9 MONTHS OR LESS). METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC), NON-METASTATIC CRPC (NMCRPC), METASTATIC CSPC (MCSPC), NMCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

EPOETIN ALFA-EPBX

Products Affected

- RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ERDAFITINIB

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

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

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ERLOTINIB

Products Affected

- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ETANERCEPT

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ETRASIMOD

Products Affected

- VELSIPITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ULCERATIVE COLITIS (UC): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	UC: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

EVEROLIMUS-AFINITOR

Products Affected

- *everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *yulithira oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*

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

EVEROLIMUS-AFINITOR DISPERZ

Products Affected

- *everolimus (antineoplastic) oral tablet for suspension*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TUBEROUS SCLEROSIS COMPLEX (TSC) ASSOCIATED PARTIAL-ONSET SEIZURES: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	TSC ASSOCIATED PARTIAL-ONSET SEIZURES: INITIAL: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENTS: 1) EPIDIOLEX, AND 2) ONE OTHER ANTIEPILEPTIC AGENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FECAL MICROBIOTA CAPSULE

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

FENFLURAMINE

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: DRAVET SYNDROME, LENNOX-GASTAUT SYNDROME (LGS): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CANCER RELATED PAIN: 1) CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR PATIENT HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FEZOLINETANT

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

FILGRASTIM-AAFI

Products Affected

- NIVESTYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

FINERENONE

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: HEART FAILURE (HF): 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS II-IV, AND 2) LEFT VENTRICULAR EJECTION FRACTION OF AT LEAST 40 PERCENT NOT DUE TO AN UNDERLYING CAUSE (E.G., INFILTRATIVE CARDIOMYOPATHY, HYPERTROPHIC CARDIOMYOPATHY, VALVULAR DISEASE, PERICARDIAL DISEASE, HIGH-OUTPUT HEART FAILURE).
Age Restrictions	
Prescriber Restrictions	INITIAL: HF: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CHRONIC KIDNEY DISEASE (CKD) ASSOCIATED WITH TYPE 2 DIABETES (T2D): INITIAL: HISTORY OF AND WILL CONTINUE ON, HAS A CONTRAINDICATION, OR INTOLERANCE TO AN ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE-I) OR AN ANGIOTENSIN RECEPTOR BLOCKER (ARB). HF: INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER MINERALOCORTICOID (ALDOSTERONE) RECEPTOR ANTAGONIST.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

FINGOLIMOD

Products Affected

- *fingolimod*

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

FOSCARBIDOPA-FOSLEVODOPA

Products Affected

- VYALEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PD: INITIAL: ONE OF THE FOLLOWING: 1) UNABLE TO SWALLOW EXTENDED-RELEASE (ER) TABLETS OR ADMINISTER ER CAPSULES VIA A FEEDING TUBE, OR 2) FAILURE TO ADHERE OR TOLERATE VIA A FEEDING TUBE AN ORAL CARBIDOPA/LEVODOPA REGIMEN. RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

FRUQUINTINIB

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

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

FUTIBATINIB

Products Affected

- LYTGOBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INTRAHEPATIC CHOLANGIOCARCINOMA (ICCA): COMPLETE A COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GALCANEZUMAB-GNLM

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	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

GANAXOLONE

Products Affected

- ZTALMY

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

GEFITINIB

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GEPIRONE

Products Affected

- EXXUA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

GILTERITINIB

Products Affected

- XOSPATA

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

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

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

GLATIRAMER

Products Affected

- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

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

GLP1-DULAGLUTIDE

Products Affected

- TRULICITY

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

GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC ORAL
- OZEMPIC SUBCUTANEOUS
- RYBELSUS

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

GLP1-TIRZEPATIDE

Products Affected

- MOUNJARO

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

GUSELKUMAB

Products Affected

- TREMFYA INTRAVENOUS
- TREMFYA ONE-PRESS
- TREMFYA PEN INDUCTION PK(2PEN)
- TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML
- TREMFYA SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

HIGH RISK DRUGS IN THE ELDERLY - BUTALBITAL/APAP/CAF

Products Affected

- *butalbital-acetaminophen-caff oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY - BUTALBITAL/APAP/CAF/COD

Products Affected

- *butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY - DIPYRIDAMOLE

Products Affected

- *dipyridamole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY - ESTRADIOL-NORETHINDRONE

Products Affected

- *abigale*
- *estradiol-norethindrone acet*
- *mimvey*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS, AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HYPOESTROGENISM TREATMENT AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY - ESTROGEN-MEDROXYPROGESTERONE

Products Affected

- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY - GLYBURIDE

Products Affected

- *glyburide*
- *glyburide micronized*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	TYPE 2 DIABETES MELLITUS (DM): 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: GLIMEPIRIDE, GLIPIZIDE, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY - GLYBURIDE/METFORMIN

Products Affected

- *glyburide-metformin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	TYPE 2 DIABETES MELLITUS (DM): 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: GLIMEPIRIDE, GLIPIZIDE, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY - KETOROLAC

Products Affected

- *ketorolac oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY - PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	EPILEPSY/SEIZURES: PATIENTS WHO ARE NEWLY PRESCRIBED PHENOBARBITAL: 1) HAS NOT RESPONDED TO AT LEAST ONE ANTICONVULSANT, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

HIGH RISK DRUGS IN THE ELDERLY - PROMETHAZINE

Products Affected

- *promethazine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: 1) TRIAL OF OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH-RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

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

HIGH RISK DRUGS IN THE ELDERLY - SCOPOLAMINE

Products Affected

- *scopolamine base*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY-DIPHENOXYLATE-ATROPINE

Products Affected

- *diphenoxylate-atropine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY-INDOMETHACIN

Products Affected

- *indomethacin oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY-MEGESTROL

Products Affected

- *megestrol 400 mg/10 ml susp cup outer*
- *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	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HIGH RISK DRUGS IN THE ELDERLY-PAROXETINE

Products Affected

- *paroxetine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IBERDOMIDE

Products Affected

- ZENBEXUS

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

IBRUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CHRONIC GRAFT VS HOST DISEASE (CGVHD): NO CONCURRENT USE WITH JAKAFI, NIKTIMVO, OR REZUROCK.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ICATIBANT

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) TYPE I OR II HAE CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q, OR 2) TYPE III HAE CONFIRMED BY: (A) RECURRENT, NON-URTICARIAL ANGIOEDEMA INVOLVING THE SKIN, GASTROINTESTINAL TRACT, OR AIRWAY, CONSISTENT WITH BRADYKININ-MEDIATED HAE AND ATTACKS NOT EXPLAINED BY HISTAMINERGIC/URTICARIAL ANGIOEDEMA, AND (B) OTHER CAUSES OF ANGIOEDEMA HAVE BEEN EXCLUDED, INCLUDING ACE-INHIBITOR/ARB-ASSOCIATED ANGIOEDEMA, ACQUIRED C1-INH DEFICIENCY, AND MAST-CELL/HISTAMINERGIC ANGIOEDEMA.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HAE: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR THE TREATMENT OF ACUTE HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

IDELALISIB

Products Affected

- ZYDELIG

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

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IMATINIB SOLUTION

Products Affected

- IMKELDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR. ALL INDICATIONS: UNABLE TO SWALLOW GENERIC IMATINIB TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IMLUNESTRANT

Products Affected

- INLURIYO

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

INAVOLISIB

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

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

INFLIXIMAB

Products Affected

- *infliximab*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/ADALIMUMAB-AATY/HADLIMA, SELARSDI/YESINTEK/OTULFI, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, OTEZLA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/ADALIMUMAB-AATY/HADLIMA, SELARSDI/YESINTEK/OTULFI, SKYRIZI, TREMFYA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. MODERATE TO SEVERE CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: SELARSDI/YESINTEK/OTULFI, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. INITIAL/RENEWAL: RA, PSA, AS, PSO, MODERATE TO SEVERE CD, UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PSA, AS, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

INFLIXIMAB-DYYB SQ

Products Affected

- ZYMFENTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

INSULIN SUPPLIES PAYMENT DETERMINATION

Products Affected

- 1ST TIER UNIFINE PENTP 5MM 31G
- 1ST TIER UNIFINE PNTIP 4MM 32G
- 1ST TIER UNIFINE PNTIP 6MM 31G
- 1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT
- 1ST TIER UNIFINE PNTP 29GX1/2"
- 1ST TIER UNIFINE PNTP 31GX3/16
- 1ST TIER UNIFINE PNTP 32GX5/32
- ADVOCATE INS 0.3 ML 30GX5/16"
- ADVOCATE INS 0.3 ML 31GX5/16"
- ADVOCATE INS 0.5 ML 30GX5/16"
- ADVOCATE INS 0.5 ML 31GX5/16"
- ADVOCATE INS 1 ML 31GX5/16"
- ADVOCATE INS SYR 1 ML 30GX5/16
- ADVOCATE PEN NEEDLE 32G 4MM
- ADVOCATE PEN NEEDLE 4MM 33G
- ADVOCATE PEN NEEDLES 5MM 31G
- ADVOCATE PEN NEEDLES 8MM 31G
- ALCOHOL PADS
- AQINJECT PEN NEEDLE 31G 5MM
- AQINJECT PEN NEEDLE 32G 4MM
- ASSURE ID DUO PRO NDL 31G 5MM
- ASSURE ID DUO-SHIELD 30GX3/16"
- ASSURE ID DUO-SHIELD 30GX5/16"
- ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- ASSURE ID PEN NEEDLE 30GX5/16"
- ASSURE ID PRO PEN NDL 30G 5MM
- ASSURE ID SYR 0.5 ML 31GX15/64"
- ASSURE ID SYR 1 ML 31GX15/64"
- AUTOKEEPER SAF PEN NDL 30G 8MM
- BD AUTOSHIELD DUO NDL 5MMX30G
- BD ECLIPSE 30GX1/2" SYRINGE
- BD INS SYR 0.3 ML 8MMX31G(1/2)
- BD INS SYR UF 0.3 ML 12.7MMX30G
- BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE
- BD INSULIN SYR 1 ML 27GX12.7MM
- BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE
- BD SAFETGLD INS 0.3 ML 29G 13MM
- BD SAFETYGLD INS 0.3 ML 31G 8MM
- BD SAFETYGLD INS 0.5 ML 30G 8MM
- BD SAFETYGLD INS 1 ML 29G 13MM
- BD SAFETYGLID INS 1 ML 6MMX31G
- BD SAFETYGLIDE SYRINGE 27GX5/8
- BD SAFTYGLD INS 0.3 ML 6MMX31G
- BD SAFTYGLD INS 0.5 ML 29G 13MM
- BD SAFTYGLD INS 0.5 ML 6MMX31G
- BD SINGLE USE SWAB
- BD UF MICRO PEN NEEDLE 6MMX32G
- BD UF MINI PEN NEEDLE 5MMX31G
- BD UF NANO PEN NEEDLE 4MMX32G
- BD UF ORIG PEN NDL 12.7MMX29G
- BD UF SHORT PEN NEEDLE 8MMX31G
- BD VEO INS 0.3 ML 6MMX31G (1/2)
- BD VEO INS SYRING 1 ML 6MMX31G
- BD VEO INS SYRN 0.3 ML 6MMX31G
- BD VEO INS SYRN 0.5 ML 6MMX31G
- BORDERED GAUZE 2"X2"
- CAREFINE PEN NEEDLE 12.7MM 29G HRI
- CAREFINE PEN NEEDLE 4MM 32G
- CAREFINE PEN NEEDLE 5MM 32G
- CAREFINE PEN NEEDLE 6MM 31G HRI
- CAREFINE PEN NEEDLE 8MM 30G HRI
- CAREFINE PEN NEEDLES 6MM 32G
- CAREFINE PEN NEEDLES 8MM 31G
- CARETOUCH ALCOHOL 70% PREP PAD
- CARETOUCH PEN NEEDLE 29G 12MM
- CARETOUCH PEN NEEDLE 31GX1/4"
- CARETOUCH PEN NEEDLE 31GX3/16"
- CARETOUCH PEN NEEDLE 31GX5/16"
- CARETOUCH PEN NEEDLE 32GX3/16"
- CARETOUCH PEN NEEDLE 32GX5/32"
- CARETOUCH SYR 0.3 ML 31GX5/16"
- CARETOUCH SYR 0.5 ML 30GX5/16"
- CARETOUCH SYR 0.5 ML 31GX5/16"
- CARETOUCH SYR 1 ML 28GX5/16"
- CARETOUCH SYR 1 ML 29GX5/16"
- CARETOUCH SYR 1 ML 30GX5/16"
- CARETOUCH SYR 1 ML 31GX5/16"

- CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE
- CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND
- COMFORT EZ 0.3 ML 31G 15/64"
- COMFORT EZ 0.5 ML 31G 15/64"
- COMFORT EZ INS 0.3 ML 30GX1/2"
- COMFORT EZ INS 0.3 ML 30GX5/16"
- COMFORT EZ INS 1 ML 31G 15/64"
- COMFORT EZ INS 1 ML 31GX5/16"
- COMFORT EZ INSULIN SYR 0.3 ML
- COMFORT EZ INSULIN SYR 0.5 ML
- COMFORT EZ PEN NEEDLE 12MM 29G
- COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO
- COMFORT EZ PEN NEEDLES 4MM 33G
- COMFORT EZ PEN NEEDLES 5MM 31G MINI
- COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI
- COMFORT EZ PEN NEEDLES 5MM 33G
- COMFORT EZ PEN NEEDLES 6MM 31G
- COMFORT EZ PEN NEEDLES 6MM 32G
- COMFORT EZ PEN NEEDLES 6MM 33G
- COMFORT EZ PEN NEEDLES 8MM 31G SHORT
- COMFORT EZ PEN NEEDLES 8MM 32G
- COMFORT EZ PEN NEEDLES 8MM 33G
- COMFORT EZ PLS PEN NDL 32G 4MM
- COMFORT EZ PRO PEN NDL 30G 8MM
- COMFORT EZ PRO PEN NDL 31G 4MM
- COMFORT EZ PRO PEN NDL 31G 5MM
- COMFORT EZ SYR 0.3 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 28GX1/2"
- COMFORT EZ SYR 0.5 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 27G 12.7MM
- COMFORT EZ SYR 1 ML 28GX1/2"
- COMFORT EZ SYR 1 ML 29GX1/2"
- COMFORT EZ SYR 1 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 30GX5/16"
- COMFORT POINT PEN NDL 31GX1/3"
- COMFORT POINT PEN NDL 31GX1/6"
- COMFORT TOUCH PEN NDL 31G 4MM
- COMFORT TOUCH PEN NDL 31G 5MM
- COMFORT TOUCH PEN NDL 31G 6MM
- COMFORT TOUCH PEN NDL 31G 8MM
- COMFORT TOUCH PEN NDL 32G 4MM
- COMFORT TOUCH PEN NDL 32G 5MM
- COMFORT TOUCH PEN NDL 32G 6MM
- COMFORT TOUCH PEN NDL 32G 8MM
- COMFORT TOUCH PEN NDL 33G 4MM
- COMFORT TOUCH PEN NDL 33G 5MM
- COMFORT TOUCH PEN NDL 33G 6MM
- CURITY ALCOHOL PREPS 2 PLY,MEDIUM
- CURITY GAUZE PADS
- CURITY GAUZE SPONGES (12 PLY)-200/BAG
- DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII
- DERMACEA GAUZE 2"X2" SPONGE 8 PLY
- DERMACEA NON-WOVEN 2"X2" SPNGE
- DROPLET 0.3 ML 29G 12.7MM(1/2) OUTER
- DROPLET 0.3 ML 30G 12.7MM(1/2) OUTER
- DROPLET 0.5 ML 29GX12.5MM(1/2)
- DROPLET 0.5 ML 30GX12.5MM(1/2)
- DROPLET INS 0.3 ML 29GX12.5MM
- DROPLET INS 0.3 ML 30G 8MM(1/2) OUTER
- DROPLET INS 0.3 ML 30GX12.5MM
- DROPLET INS 0.3 ML 31G 6MM(1/2) OUTER
- DROPLET INS 0.3 ML 31G 8MM(1/2) OUTER
- DROPLET INS 0.5 ML 29G 12.7MM OUTER
- DROPLET INS 0.5 ML 30G 12.7MM OUTER
- DROPLET INS 0.5 ML 30GX6MM(1/2)
- DROPLET INS 0.5 ML 30GX8MM(1/2)
- DROPLET INS 0.5 ML 31GX6MM(1/2)
- DROPLET INS 0.5 ML 31GX8MM(1/2)
- DROPLET INS SYR 0.3 ML 30GX6MM
- DROPLET INS SYR 0.3 ML 30GX8MM
- DROPLET INS SYR 0.3 ML 31GX6MM
- DROPLET INS SYR 0.3 ML 31GX8MM
- DROPLET INS SYR 0.5 ML 30G 8MM OUTER
- DROPLET INS SYR 0.5 ML 31G 6MM

OUTER
- DROPLET INS SYR 0.5 ML 31G 8MM OUTER
- DROPLET INS SYR 1 ML 29G 12.7MM OUTER
- DROPLET INS SYR 1 ML 30G 12.5MM
- DROPLET INS SYR 1 ML 30G 6MM
- DROPLET INS SYR 1 ML 30G 8MM OUTER
- DROPLET INS SYR 1 ML 31G 6MM OUTER
- DROPLET INS SYR 1 ML 31G 8MM
- DROPLET MICRON 34G X 9/64"
- DROPLET PEN NEEDLE 29G 10MM
- DROPLET PEN NEEDLE 29G 12MM
- DROPLET PEN NEEDLE 30G 8MM
- DROPLET PEN NEEDLE 31G 5MM
- DROPLET PEN NEEDLE 31G 6MM
- DROPLET PEN NEEDLE 31G 8MM
- DROPLET PEN NEEDLE 32G 4MM
- DROPLET PEN NEEDLE 32G 5MM
- DROPLET PEN NEEDLE 32G 6MM
- DROPLET PEN NEEDLE 32G 8MM
- DROPSAFE ALCOHOL 70% PREP PADS
- DROPSAFE INS SYR 0.3 ML 31G 6MM
- DROPSAFE INS SYR 0.3 ML 31G 8MM
- DROPSAFE INS SYR 0.5 ML 31G 6MM
- DROPSAFE INS SYR 0.5 ML 31G 8MM
- DROPSAFE INSUL SYR 1 ML 31G 6MM
- DROPSAFE INSUL SYR 1 ML 31G 8MM
- DROPSAFE INSULN 1 ML 29G 12.5MM
- DROPSAFE PEN NEEDLE 31G 4MM
- DROPSAFE PEN NEEDLE 31G 5MM
- DROPSAFE PEN NEEDLE 31G 8MM
- DROPSAFE PEN NEEDLE 31GX1/4"
- EASY CMFT SFTY PEN NDL 31G 5MM
- EASY CMFT SFTY PEN NDL 31G 6MM
- EASY CMFT SFTY PEN NDL 32G 4MM
- EASY COMFORT 0.3 ML 31G 1/2"
- EASY COMFORT 0.3 ML 31G 5/16"
- EASY COMFORT 0.5 ML 30GX1/2"
- EASY COMFORT 0.5 ML 31GX5/16"
- EASY COMFORT 0.5 ML 32GX5/16"
- EASY COMFORT 0.5 ML SYRINGE
- EASY COMFORT 1 ML 31GX5/16"
- EASY COMFORT 1 ML 32GX5/16"
- EASY COMFORT ALCOHOL 70% PAD
- EASY COMFORT INSULIN 1 ML SYR
- EASY COMFORT PEN NDL 29G 4MM
- EASY COMFORT PEN NDL 29G 5MM
- EASY COMFORT PEN NDL 31GX1/4"
- EASY COMFORT PEN NDL 31GX3/16"
- EASY COMFORT PEN NDL 31GX5/16"
- EASY COMFORT PEN NDL 32GX5/32"
- EASY COMFORT PEN NDL 33G 4MM
- EASY COMFORT PEN NDL 33G 5MM
- EASY COMFORT PEN NDL 33G 6MM
- EASY COMFORT SYR 0.5 ML 29G 8MM
- EASY COMFORT SYR 1 ML 29G 8MM
- EASY COMFORT SYR 1 ML 30GX1/2"
- EASY GLIDE INS 0.3 ML 31GX6MM
- EASY GLIDE INS 0.5 ML 31GX6MM
- EASY GLIDE INS 1 ML 31GX6MM
- EASY GLIDE PEN NEEDLE 4MM 33G
- EASY TOUCH 0.3 ML 30G 8MM(1/2)
- EASY TOUCH 0.3 ML 31G 6MM(1/2)
- EASY TOUCH 0.3 ML 31G 8MM(1/2)
- EASY TOUCH 0.3 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 27GX1/2"
- EASY TOUCH 0.5 ML SYR 29GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX5/16
- EASY TOUCH 1 ML SYR 29GX1/2"
- EASY TOUCH 1 ML SYR 30GX1/2"
- EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED
- EASY TOUCH AUTO 0.5 ML 30G 6MM
- EASY TOUCH AUTO 0.5 ML 30G 8MM
- EASY TOUCH AUTORET 1 ML 30G 6MM
- EASY TOUCH AUTORET 1 ML 30G 8MM
- EASY TOUCH FLIPLOK 1 ML 27GX0.5
- EASY TOUCH INS 0.3 ML 30G 8MM
- EASY TOUCH INS 0.3 ML 31G 8MM
- EASY TOUCH INS 0.5 ML 30G 8MM
- EASY TOUCH INS 0.5 ML 31G 6MM
- EASY TOUCH INS 0.5 ML 31G 8MM
- EASY TOUCH INS 1 ML 27G 1/2"
- EASY TOUCH INS 1 ML 28G 12.7MM
- EASY TOUCH INS SYR 1 ML 30G 8MM
- EASY TOUCH INS SYR 1 ML 31G 6MM
- EASY TOUCH INS SYR 1 ML 31G 8MM
- EASY TOUCH INSULIN 1 ML 29GX1/2
- EASY TOUCH INSULIN 1 ML 30GX1/2
- EASY TOUCH INSULIN SYR 1 ML

- EASY TOUCH INSULIN SYR 1 ML RETRACTABLE
- EASY TOUCH INSULN 1 ML 29GX1/2"
- EASY TOUCH INSULN 1 ML 30GX1/2"
- EASY TOUCH INSULN 1 ML 30GX5/16
- EASY TOUCH INSULN 1 ML 31GX5/16
- EASY TOUCH LUER LOK INSUL 1 ML
- EASY TOUCH PEN NEEDLE 29GX1/2"
- EASY TOUCH PEN NEEDLE 30GX5/16
- EASY TOUCH PEN NEEDLE 31GX1/4"
- EASY TOUCH PEN NEEDLE 31GX3/16
- EASY TOUCH PEN NEEDLE 31GX5/16
- EASY TOUCH PEN NEEDLE 32GX1/4"
- EASY TOUCH PEN NEEDLE 32GX3/16
- EASY TOUCH PEN NEEDLE 32GX5/32
- EASY TOUCH SAF PEN NDL 29G 5MM
- EASY TOUCH SAF PEN NDL 29G 8MM
- EASY TOUCH SAF PEN NDL 30G 5MM
- EASY TOUCH SAF PEN NDL 30G 8MM
- EASY TOUCH SYR 0.5 ML 28G 12.7MM
- EASY TOUCH SYR 0.5 ML 29G 12.7MM
- EASY TOUCH SYR 1 ML 27G 16MM
- EASY TOUCH UNI-SLIP SYR 1 ML
- EASYLIFE ALCOHOL 70% PADS
- EASYLIFE INS PEN NDL 29G 12MM
- EASYLIFE INS PEN NDL 31G 4MM
- EASYLIFE INS PEN NDL 31G 5MM
- EASYLIFE INS PEN NDL 31G 6MM
- EASYLIFE INS PEN NDL 31G 8MM
- EASYLIFE INS PEN NDL 32G 4MM
- EASYLIFE INS PEN NDL 32G 5MM
- EASYLIFE INS PEN NDL 32G 6MM
- EASYLIFE INS PEN NDL 32G 8MM
- EASYLIFE INS PEN NDL 33G 4MM
- EASYLIFE INS PEN NDL 33G 5MM
- EASYLIFE INS PEN NDL 33G 6MM
- EASYLIFE INS PEN NDL 33G 8MM
- EASYLIFE INS SYR 0.5 ML 30G 8MM
- EASYLIFE INS SYR 1 ML 30G 8MM
- EASYLIFE INS SYR 1 ML 31G 8MM
- EASYLIFE SAFTY PEN NDL 31G 4MM
- EASYLIFE SAFTY PEN NDL 31G 5MM
- EASYLIFE SYR 1 ML 30G 12.7MM
- EASYTOUCH SAF PEN NDL 30G 6MM
- EMBRACE PEN NEEDLE 29G 12MM
- EMBRACE PEN NEEDLE 30G 5MM
- EMBRACE PEN NEEDLE 30G 8MM
- EMBRACE PEN NEEDLE 31G 5MM
- EMBRACE PEN NEEDLE 31G 6MM
- EMBRACE PEN NEEDLE 31G 8MM
- EMBRACE PEN NEEDLE 32G 4MM
- EXEL U100 0.3 ML 29GX1/2"
- EXEL U100 0.3 ML 30GX5/16"
- FT STERILE PADS 2" X 2"
- GAUZE PAD TOPICAL BANDAGE 2 X 2 "
- GNP ALCOHOL SWAB STERILE, TWO PLY
- GNP PEN NEEDLE 31G 5MM
- GNP PEN NEEDLE 32G 6MM
- GNP SIMPLI PEN NEEDLE 32G 4MM
- GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT
- GNP ULT CMFRT 0.5 ML 29GX1/2"
- GNP ULTR CMFRT 0.5 ML 30GX5/16
- GNP ULTRA COMFORT 1 ML SYRINGE
- GNP ULTRA COMFORT 3/10 ML SYR
- GS PEN NEEDLE 31G X 8MM
- HEALTHWISE INS 0.3 ML 30GX5/16"
- HEALTHWISE INS 0.3 ML 31GX5/16"
- HEALTHWISE INS 0.5 ML 30GX5/16"
- HEALTHWISE INS 0.5 ML 31GX5/16"
- HEALTHWISE INS 1 ML 30GX5/16"
- HEALTHWISE INS 1 ML 31GX5/16"
- HEALTHWISE PEN NEEDLE 31G 5MM
- HEALTHWISE PEN NEEDLE 31G 8MM
- HEALTHWISE PEN NEEDLE 32G 4MM
- HEALTHY ACCENTS PENTIP 5MM 31G
- HEALTHY ACCENTS PENTIP 6MM 31G
- HEALTHY ACCENTS PENTIP 8MM 31G
- HEALTHY ACCENTS PENTP 12MM 29G
- HEB INCONTROL ALCOHOL 70% PADS
- INCONTROL PEN NEEDLE 12MM 29G
- INCONTROL PEN NEEDLE 4MM 32G
- INCONTROL PEN NEEDLE 5MM 31G
- INCONTROL PEN NEEDLE 6MM 31G
- INCONTROL PEN NEEDLE 8MM 31G
- INSULIN 1 ML SYRINGE
- INSULIN 1/2 ML SYRINGE
- INSULIN 3/10 ML SYRINGE
- INSULIN SYR 0.3 ML 31GX1/4(1/2)
- INSULIN SYRIN 0.5 ML 28GX1/2" (OTC)
- INSULIN SYRIN 0.5 ML 29GX1/2" (OTC)
- INSULIN SYRIN 0.5 ML 30GX1/2" (RX)

- INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRING 0.5 ML 27G 1/2" INNER
- INSULIN SYRINGE 0.3 ML
- INSULIN SYRINGE 0.3 ML 31GX1/4
- INSULIN SYRINGE 0.5 ML
- INSULIN SYRINGE 0.5 ML 31GX1/4
- INSULIN SYRINGE 1 ML
- INSULIN SYRINGE 1 ML 27G 1/2" INNER
- INSULIN SYRINGE 1 ML 28GX1/2" (OTC)
- INSULIN SYRINGE 1 ML 30GX1/2" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 31GX1/4"
- INSULIN SYRINGE 1 ML 31GX5/16" SHORT NEEDLE,THIN II (OTC)
- INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE
- INSULIN U-500 SYRINGE-NEEDLE
- INSUPEN PEN NEEDLE 29GX1/2"
- INSUPEN PEN NEEDLE 31G 8MM
- INSUPEN PEN NEEDLE 31GX3/16"
- INSUPEN PEN NEEDLE 32G 4MM
- INSUPEN PEN NEEDLE 32G 6MM (RX)
- IV ANTISEPTIC WIPES
- KENDALL ALCOHOL 70% PREP PAD
- LISCO SPONGES 100/BAG
- MAGELLAN INSUL SYRINGE 0.3 ML
- MAGELLAN INSUL SYRINGE 0.5 ML
- MAGELLAN INSULIN SYR 0.3 ML
- MAGELLAN INSULIN SYR 0.5 ML
- MAGELLAN INSULIN SYRINGE 1 ML
- MAXI-COMFORT INS 0.5 ML 28G
- MAXI-COMFORT INS 1 ML 28GX1/2"
- MAXICOMFORT II PEN NDL 31GX6MM
- MAXICOMFORT INS 0.5 ML 27GX1/2"
- MAXICOMFORT INS 1 ML 27GX1/2"
- MAXICOMFORT PEN NDL 29G X 5MM
- MAXICOMFORT PEN NDL 29G X 8MM
- MICRODOT PEN NEEDLE 31GX6MM
- MICRODOT PEN NEEDLE 32GX4MM
- MICRODOT PEN NEEDLE 33GX4MM
- MICRODOT READYGARD NDL 31G 5MM OUTER
- MINI PEN NEEDLE 32G 5MM
- MINI PEN NEEDLE 32G 8MM
- MINI PEN NEEDLE 33G 5MM
- MINI PEN NEEDLE 33G 6MM
- MINI ULTRA-THIN II PEN NDL 31G STERILE
- MONOJECT 0.5 ML SYRN 28GX1/2"
- MONOJECT 1 ML SYRN 27X1/2"
- MONOJECT 1 ML SYRN 28GX1/2" (OTC)
- MONOJECT INSUL SYR U100 (OTC)
- MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)
- MONOJECT INSUL SYR U100 1 ML
- MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)
- MONOJECT INSULIN SYR 0.3 ML
- MONOJECT INSULIN SYR 0.3 ML (OTC)
- MONOJECT INSULIN SYR 0.5 ML
- MONOJECT INSULIN SYR 0.5 ML (OTC)
- MONOJECT INSULIN SYR 1 ML 3'S (OTC)
- MONOJECT INSULIN SYR U-100
- MONOJECT SYRINGE 0.3 ML
- MONOJECT SYRINGE 0.5 ML
- MONOJECT SYRINGE 1 ML
- NANO 2 GEN PEN NEEDLE 32G 4MM
- NANO PEN NEEDLE 32G 4MM
- NOVOFINE 32G NEEDLES
- NOVOFINE AUTOCOVER 30G NEEDLE
- NOVOFINE PLUS PEN NDL 32GX1/6"
- PEN NEEDLE 30G 5MM OUTER
- PEN NEEDLE 30G 8MM INNER
- PEN NEEDLE 30G X 5/16"
- PEN NEEDLE 31G X 1/4" HRI
- PEN NEEDLE 33G 4MM
- PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLES 12MM 29G 29GX12MM,STRL
- PEN NEEDLES 4MM 32G
- PEN NEEDLES 5MM 31G

31GX5MM,STRL,MINI (OTC)
- PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC)
- PENTIPS PEN NEEDLE 29G 1/2"
- PENTIPS PEN NEEDLE 31G 1/4"
- PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM
- PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM
- PENTIPS PEN NEEDLE 32G 1/4"
- PENTIPS PEN NEEDLE 32GX5/32"
- PIP PEN NEEDLE 31G X 5MM
- PIP PEN NEEDLE 32G X 4MM
- PREVENT PEN NEEDLE 31GX1/4"
- PREVENT PEN NEEDLE 31GX5/16"
- PRO COMFORT 0.5 ML 30GX1/2"
- PRO COMFORT 0.5 ML 30GX5/16"
- PRO COMFORT 0.5 ML 31GX5/16"
- PRO COMFORT 1 ML 30GX1/2"
- PRO COMFORT 1 ML 30GX5/16"
- PRO COMFORT 1 ML 31GX5/16"
- PRO COMFORT ALCOHOL 70% PADS
- PRO COMFORT PEN NDL 32G 8MM
- PRO COMFORT PEN NDL 32G X 1/4"
- PRO COMFORT PEN NDL 4MM 32G
- PRO COMFORT PEN NDL 5MM 32G
- PRO-COMFORT ALCOHOL 70% PADS
- PRODIGY INS SYR 1 ML 28GX1/2"
- PRODIGY SYRNG 0.5 ML 31GX5/16"
- PRODIGY SYRNGE 0.3 ML 31GX5/16"
- PURE CMFT SFTY PEN NDL 31G 5MM
- PURE CMFT SFTY PEN NDL 31G 6MM
- PURE CMFT SFTY PEN NDL 32G 4MM
- PURE COMFORT ALCOHOL 70% PADS
- PURE COMFORT PEN NDL 32G 4MM
- PURE COMFORT PEN NDL 32G 5MM
- PURE COMFORT PEN NDL 32G 6MM
- PURE COMFORT PEN NDL 32G 8MM
- RA ISOPROPYL ALCOHOL 70% WIPES
- RA STERILE PADS 2"X 2"
- RAYA SURE PEN NEEDLE 29G 12MM
- RAYA SURE PEN NEEDLE 31G 4MM
- RAYA SURE PEN NEEDLE 31G 5MM
- RAYA SURE PEN NEEDLE 31G 6MM
- RELION INS SYR 0.3 ML 31GX6MM
- RELION INS SYR 0.5 ML 31GX6MM
- RELION INS SYR 1 ML 31GX15/64"
- RELION PEN NEEDLE 32GX5/32"
- RELION SYRING 0.3 ML 31GX5/16" INNER
- RELION SYRING 0.5 ML 31GX5/16" INNER (OTC)
- SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10
- SAFETY PEN NEEDLE 31G 4MM
- SAFETY PEN NEEDLE 5MM X 31G
- SAFETY SYRINGE 0.5 ML 30G 1/2"
- SECURESAFE PEN NDL 30GX5/16" OUTER
- SECURESAFE PEN NEEDLE 31G 5MM OUTER
- SECURESAFE SYR 0.5 ML 29G 1/2" OUTER
- SECURESAFE SYRNG 1 ML 29G 1/2" OUTER
- SKY SAFETY PEN NEEDLE 30G 5MM
- SKY SAFETY PEN NEEDLE 30G 8MM
- SURE CMFT SFTY PEN NDL 31G 6MM
- SURE CMFT SFTY PEN NDL 32G 4MM
- SURE COMFORT 0.5 ML SYRINGE
- SURE COMFORT 1 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE
- SURE COMFORT 30G PEN NEEDLE
- SURE COMFORT ALCOHOL PREP PADS
- SURE COMFORT INS 0.3 ML 31GX1/4
- SURE COMFORT INS 0.5 ML 31GX1/4
- SURE COMFORT INS 1 ML 31GX1/4"
- SURE COMFORT PEN NDL 29GX1/2" 12.7MM
- SURE COMFORT PEN NDL 31G 5MM
- SURE COMFORT PEN NDL 31G 8MM
- SURE COMFORT PEN NDL 32G 4MM
- SURE COMFORT PEN NDL 32G 6MM
- SURE-FINE PEN NEEDLES 12.7MM

- SURE-FINE PEN NEEDLES 5MM
- SURE-FINE PEN NEEDLES 8MM
- SURE-JECT INSU SYR U100 0.3 ML
- SURE-JECT INSU SYR U100 0.5 ML
- SURE-JECT INSU SYR U100 1 ML
- SURE-JECT INSUL SYR U100 1 ML
- SURE-JECT INSULIN SYRINGE 1 ML
- SURE-PREP ALCOHOL PREP PADS
- TECHLITE 0.3 ML 29GX12MM (1/2)
- TECHLITE 0.3 ML 30GX8MM (1/2)
- TECHLITE 0.3 ML 31GX6MM (1/2)
- TECHLITE 0.3 ML 31GX8MM (1/2)
- TECHLITE 0.5 ML 30GX12MM (1/2)
- TECHLITE 0.5 ML 30GX8MM (1/2)
- TECHLITE 0.5 ML 31GX6MM (1/2)
- TECHLITE 0.5 ML 31GX8MM (1/2)
- TECHLITE INS SYR 1 ML 29GX12MM
- TECHLITE INS SYR 1 ML 30GX12MM
- TECHLITE INS SYR 1 ML 31GX6MM
- TECHLITE INS SYR 1 ML 31GX8MM
- TECHLITE PEN NEEDLE 29GX1/2"
- TECHLITE PEN NEEDLE 29GX3/8"
- TECHLITE PEN NEEDLE 31GX1/4"
- TECHLITE PEN NEEDLE 31GX3/16"
- TECHLITE PEN NEEDLE 31GX5/16"
- TECHLITE PEN NEEDLE 32GX1/4"
- TECHLITE PEN NEEDLE 32GX5/16"
- TECHLITE PEN NEEDLE 32GX5/32"
- TECHLITE PLUS PEN NDL 32G 4MM
- TERUMO INS SYRINGE U100-1 ML
- TERUMO INS SYRINGE U100-1/2 ML
- TERUMO INS SYRINGE U100-1/3 ML
- TERUMO INS SYRNG U100-1/2 ML
- THINPRO INS SYRIN U100-0.3 ML
- THINPRO INS SYRIN U100-0.5 ML
- THINPRO INS SYRIN U100-1 ML
- TOPFINE INSULN PEN NDL 32G 4MM
- TRUE CMFRT PRO 0.5 ML 30G 5/16"
- TRUE CMFRT PRO 0.5 ML 31G 5/16"
- TRUE CMFRT PRO 0.5 ML 32G 5/16"
- TRUE CMFT SFTY PEN NDL 31G 5MM
- TRUE CMFT SFTY PEN NDL 31G 6MM
- TRUE CMFT SFTY PEN NDL 32G 4MM
- TRUE COMFORT 0.5 ML 30G 1/2"
- TRUE COMFORT 0.5 ML 30G 5/16"
- TRUE COMFORT 0.5 ML 31G 5/16"
- TRUE COMFORT 0.5 ML 31GX5/16"
- TRUE COMFORT 1 ML 31GX5/16"
- TRUE COMFORT ALCOHOL 70% PADS
- TRUE COMFORT PEN NDL 31G 8MM
- TRUE COMFORT PEN NDL 31GX5MM
- TRUE COMFORT PEN NDL 31GX6MM
- TRUE COMFORT PEN NDL 32G 5MM
- TRUE COMFORT PEN NDL 32G 6MM
- TRUE COMFORT PEN NDL 32GX4MM
- TRUE COMFORT PEN NDL 33G 4MM
- TRUE COMFORT PEN NDL 33G 5MM
- TRUE COMFORT PEN NDL 33G 6MM
- TRUE COMFORT PRO 1 ML 30G 1/2"
- TRUE COMFORT PRO 1 ML 30G 5/16"
- TRUE COMFORT PRO 1 ML 31G 5/16"
- TRUE COMFORT PRO 1 ML 32G 5/16"
- TRUE COMFORT PRO ALCOHOL PADS
- TRUE COMFORT SFTY 1 ML 30G 1/2"
- TRUE COMFRT PRO 0.5 ML 30G 1/2"
- TRUE COMFRT SFTY 1 ML 30G 5/16"
- TRUE COMFRT SFTY 1 ML 31G 5/16"
- TRUE COMFRT SFTY 1 ML 32G 5/16"
- TRUE-CMFRT PRO PEN NDL 31G 5MM
- TRUE-CMFRT PRO PEN NDL 31G 6MM
- TRUE-CMFRT PRO PEN NDL 31G 8MM
- TRUE-CMFRT PRO PEN NDL 32G 4MM
- TRUEPLUS PEN NEEDLE 29GX1/2"
- TRUEPLUS PEN NEEDLE 31G X 1/4"
- TRUEPLUS PEN NEEDLE 31GX3/16"
- TRUEPLUS PEN NEEDLE 31GX5/16"
- TRUEPLUS PEN NEEDLE 32GX5/32"
- TRUEPLUS SYR 0.3 ML 29GX1/2"
- TRUEPLUS SYR 0.3 ML 30GX5/16"
- TRUEPLUS SYR 0.3 ML 31GX5/16"
- TRUEPLUS SYR 0.5 ML 28GX1/2"
- TRUEPLUS SYR 0.5 ML 29GX1/2"
- TRUEPLUS SYR 0.5 ML 30GX5/16"
- TRUEPLUS SYR 0.5 ML 31GX5/16"
- TRUEPLUS SYR 1 ML 28GX1/2"
- TRUEPLUS SYR 1 ML 29GX1/2"
- TRUEPLUS SYR 1 ML 30GX5/16"
- TRUEPLUS SYR 1 ML 31GX5/16"
- ULT CFT 0.3 ML 31GX5/16" (1/2) 1/2 UNIT
- ULTICAR INS 0.3 ML 31GX1/4(1/2)
- ULTICARE INS 0.3 ML 31GX1/4"
- ULTICARE INS 0.5 ML 31GX1/4"
- ULTICARE INS 1 ML 31GX1/4"

- ULTICARE INS SYR 1 ML 30GX1/2"
- ULTICARE PEN NEEDLE 31GX3/16"
- ULTICARE PEN NEEDLE 6MM 31G
- ULTICARE PEN NEEDLE 8MM 31G
- ULTICARE PEN NEEDLES 12MM 29G
- ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM
- ULTICARE PEN NEEDLES 6MM 32G
- ULTICARE SAFE PEN NDL 30G 8MM
- ULTICARE SAFE PEN NDL 5MM 30G
- ULTICARE SYR 0.3 ML 30GX1/2"
- ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 0.5 ML 30GX1/2"
- ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 1 ML 31GX5/16"
- ULTIGUARD SAFE 1 ML 30G 12.7MM
- ULTIGUARD SAFE0.3 ML 30G 12.7MM
- ULTIGUARD SAFE0.5 ML 30G 12.7MM
- ULTIGUARD SAFEPACK 1 ML 31G 8MM
- ULTIGUARD SAFEPACK 29G 12.7MM
- ULTIGUARD SAFEPACK 31G 5MM
- ULTIGUARD SAFEPACK 31G 6MM
- ULTIGUARD SAFEPACK 31G 8MM
- ULTIGUARD SAFEPACK 32G 4MM
- ULTIGUARD SAFEPACK 32G 6MM
- ULTIGUARD SAFEPK 0.3 ML 31G 8MM
- ULTIGUARD SAFEPK 0.5 ML 31G 8MM
- ULTILET ALCOHOL STERL SWAB
- ULTILET INSULIN SYRINGE 0.3 ML
- ULTILET INSULIN SYRINGE 0.5 ML
- ULTILET INSULIN SYRINGE 1 ML
- ULTILET PEN NEEDLE
- ULTILET PEN NEEDLE 4MM 32G
- ULTRA COMFORT 0.3 ML 29GX1/2"
- ULTRA COMFORT 0.3 ML SYRINGE
- ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G
- ULTRA COMFORT 0.5 ML 29GX1/2"
- ULTRA COMFORT 0.5 ML 31GX5/16"
- ULTRA COMFORT 0.5 ML SYRINGE
- ULTRA COMFORT 1 ML 29GX1/2"
- ULTRA COMFORT 1 ML 30GX5/16"
- ULTRA COMFORT 1 ML 31GX5/16"
- ULTRA COMFORT 1 ML SYRINGE
- ULTRA FLO 0.3 ML 30G 1/2" (1/2)
- ULTRA FLO 0.3 ML 30G 5/16"(1/2)
- ULTRA FLO 0.3 ML 31G 5/16"(1/2)
- ULTRA FLO PEN NEEDLE 31G 5MM
- ULTRA FLO PEN NEEDLE 31G 8MM
- ULTRA FLO PEN NEEDLE 32G 4MM
- ULTRA FLO PEN NEEDLE 33G 4MM
- ULTRA FLO PEN NEEDLES 12MM 29G
- ULTRA FLO SYR 0.3 ML 29GX1/2"
- ULTRA FLO SYR 0.3 ML 30G 5/16"
- ULTRA FLO SYR 0.3 ML 31G 5/16"
- ULTRA FLO SYR 0.5 ML 29G 1/2"
- ULTRA THIN PEN NDL 32G X 4MM
- ULTRA-FINE 0.3 ML 30G 12.7MM
- ULTRA-FINE 0.3 ML 31G 6MM (1/2)
- ULTRA-FINE 0.3 ML 31G 8MM (1/2)
- ULTRA-FINE 0.5 ML 30G 12.7MM
- ULTRA-FINE INS 0.5 ML 31G 6MM
- ULTRA-FINE INS SYR 1 ML 31G 6MM
- ULTRA-FINE INS SYR 1 ML 31G 8MM
- ULTRA-FINE PEN NDL 29G 12.7MM
- ULTRA-FINE PEN NEEDLE 31G 5MM
- ULTRA-FINE PEN NEEDLE 31G 8MM
- ULTRA-FINE PEN NEEDLE 32G 6MM
- ULTRA-FINE SYR 0.3 ML 31G 6MM
- ULTRA-FINE SYR 0.3 ML 31G 8MM
- ULTRA-FINE SYR 0.5 ML 31G 6MM
- ULTRA-FINE SYR 0.5 ML 31G 8MM
- ULTRA-FINE SYR 1 ML 30G 12.7MM
- ULTRA-THIN II 1 ML 31GX5/16"
- ULTRA-THIN II INS 0.3 ML 30G
- ULTRA-THIN II INS 0.3 ML 31G
- ULTRA-THIN II INS 0.5 ML 29G
- ULTRA-THIN II INS 0.5 ML 30G
- ULTRA-THIN II INS 0.5 ML 31G
- ULTRA-THIN II INS SYR 1 ML 29G
- ULTRA-THIN II INS SYR 1 ML 30G
- ULTRA-THIN II PEN NDL 29GX1/2"
- ULTRA-THIN II PEN NDL 31GX5/16
- ULTRACARE INS 0.3 ML 30GX5/16"
- ULTRACARE INS 0.3 ML 31GX5/16"
- ULTRACARE INS 0.5 ML 30GX1/2"
- ULTRACARE INS 0.5 ML 30GX5/16"
- ULTRACARE INS 0.5 ML 31GX5/16"
- ULTRACARE INS 1 ML 30G X 5/16"
- ULTRACARE INS 1 ML 30GX1/2"
- ULTRACARE INS 1 ML 31G X 5/16"
- ULTRACARE PEN NEEDLE 31GX1/4"

- ULTRACARE PEN NEEDLE 31GX3/16"
- ULTRACARE PEN NEEDLE 31GX5/16"
- ULTRACARE PEN NEEDLE 32GX1/4"
- ULTRACARE PEN NEEDLE 32GX3/16"
- ULTRACARE PEN NEEDLE 32GX5/32"
- ULTRACARE PEN NEEDLE 33GX5/32"
- UNIFINE OTC PEN NEEDLE 31G 5MM
- UNIFINE OTC PEN NEEDLE 32G 4MM
- UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL
- UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI
- UNIFINE PENTIPS 32G 4MM
- UNIFINE PENTIPS 32GX1/4"
- UNIFINE PENTIPS 33GX5/32"
- UNIFINE PENTIPS 6MM 31G
- UNIFINE PENTIPS 8MM 31G 31GX8MM, SHORT, STRL
- UNIFINE PENTIPS MAX 30GX3/16"
- UNIFINE PENTIPS PLUS 29GX1/2" 12MM
- UNIFINE PENTIPS PLUS 30GX3/16"
- UNIFINE PENTIPS PLUS 31G 5MM
- UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM
- UNIFINE PENTIPS PLUS 32GX5/32"
- UNIFINE PENTIPS PLUS 33GX5/32"
- UNIFINE PROTECT 30G 5MM
- UNIFINE PROTECT 30G 8MM
- UNIFINE PROTECT 32G 4MM
- UNIFINE SAFECONTROL 30G 5MM
- UNIFINE SAFECONTROL 30G 8MM
- UNIFINE SAFECONTROL 31G 5MM
- UNIFINE SAFECONTROL 31G 6MM
- UNIFINE SAFECONTROL 31G 8MM
- UNIFINE SAFECONTROL 32G 4MM
- UNIFINE ULTR PEN NDL 34G 3.5MM
- UNIFINE ULTRA PEN NDL 29G 12MM
- UNIFINE ULTRA PEN NDL 31G 5MM
- UNIFINE ULTRA PEN NDL 31G 6MM
- UNIFINE ULTRA PEN NDL 31G 8MM
- UNIFINE ULTRA PEN NDL 32G 4MM
- UNIFINE ULTRA PEN NDL 32G 6MM
- VANISHPOINT 0.5 ML 30GX1/2" SY OUTER
- VANISHPOINT INS 0.5 ML 30G 8MM OUTER
- VANISHPOINT INS 1 ML 30GX3/16"
- VANISHPOINT U-100 29X1/2 SYR
- VERIFINE INS SYR 1 ML 29G 1/2"
- VERIFINE PEN NEEDLE 29G 12MM
- VERIFINE PEN NEEDLE 31G 5MM
- VERIFINE PEN NEEDLE 31G X 6MM
- VERIFINE PEN NEEDLE 31G X 8MM
- VERIFINE PEN NEEDLE 32G 6MM
- VERIFINE PEN NEEDLE 32G X 4MM
- VERIFINE PEN NEEDLE 32G X 5MM
- VERIFINE PLUS PEN NDL 31G 5MM
- VERIFINE PLUS PEN NDL 31G 8MM
- VERIFINE PLUS PEN NDL 32G 4MM
- VERIFINE PLUS PEN NDL 32G 4MM-SHARPS CONTAINER
- VERIFINE SYRING 0.5 ML 29G 1/2"
- VERIFINE SYRING 1 ML 31G 5/16"
- VERIFINE SYRNG 0.3 ML 31G 5/16"
- VERIFINE SYRNG 0.5 ML 31G 5/16"
- VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY
- WEBCOL ALCOHOL PREPS 20'S,LARGE
- WM UNIFINE PENTIP PLUS 8MM 31G W/ SAFETY CLICK

PA Criteria	Criteria Details
Exclusion Criteria	ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN.
Required Medical Information	

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

INTERFERON FOR MS-AVONEX

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

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

INTERFERON FOR MS-BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

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

INTERFERON FOR MS-PLEGRIDY

Products Affected

- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML

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

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ISAVUCONAZONIUM

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INVASIVE ASPERGILLOSIS, INVASIVE MUCORMYCOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	PLAN YEAR
Other Criteria	INVASIVE ASPERGILLOSIS: TRIAL OF OR CONTRAINDICATION TO VORICONAZOLE. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

IVACAFTOR

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

IVOSIDENIB

Products Affected

- TIBSOVO

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

IXAZOMIB

Products Affected

- NINLARO

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

LAMOTRIGINE

Products Affected

- SUBVENITE ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	ALL INDICATIONS: CONTRAINDICATION TO OR UNABLE TO SWALLOW LAMOTRIGINE TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

LANREOTIDE

Products Affected

- *lanreotide subcutaneous syringe 120 mg/0.5 ml*
- SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 60 MG/0.2 ML, 90 MG/0.3 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	ACROMEGALY: INITIAL/RENEWAL: PLAN YEAR. GEP-NETS, CARCINOID SYNDROME: PLAN YEAR.
Other Criteria	ACROMEGALY: INITIAL: SERUM INSULIN-LIKE GROWTH FACTOR 1 (IGF-1) LEVEL (ADJUSTED FOR AGE) IS ELEVATED OR UNEQUIVOCAL WITH INADEQUATE SUPPRESSION OF GROWTH HORMONE AFTER A GLUCOSE LOAD. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

LAPATINIB

Products Affected

- *lapatinib*

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

LAROTRECTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	VITRAKVI ORAL SOLUTION: 1) TRIAL OF VITRAKVI CAPSULES, OR 2) UNABLE TO TAKE CAPSULE FORMULATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

LAZERTINIB

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

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

LECANEMAB-IRMB

Products Affected

- LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 360 MG/1.8 ML, 500 MG/2.5 ML (250MG/1.25MLX2)

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

LENALIDOMIDE

Products Affected

- *lenalidomide*

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

LENVATINIB

Products Affected

- LENVIMA

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

LETERMOVIR

Products Affected

- PREVYMIS ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

LEUPROLIDE

Products Affected

- *leuprolide subcutaneous kit*

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

LEUPROLIDE DEPOT

Products Affected

- *leuprolide acetate (3 month)*
- LUTRATE DEPOT (3 MONTH)

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

LEUPROLIDE MESYLATE

Products Affected

- CAMCEVI (6 MONTH)

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

LEUPROLIDE-ELIGARD

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)

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

LEUPROLIDE-LUPRON DEPOT

Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

LEUPROLIDE-LUPRON DEPOT-PED

Products Affected

- LUPRON DEPOT-PED (3 MONTH)
- LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CENTRAL PRECOCIOUS PUBERTY (CPP): INITIAL: FEMALES: ELEVATED LEVEL OF LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVEL OF LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	CPP: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CPP: INITIAL: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR BREAST DEVELOPMENT AND PUBIC HAIR GROWTH. MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR GENITAL DEVELOPMENT AND PUBIC HAIR GROWTH. RENEWAL: 1) TANNER STAGING AT INITIAL DIAGNOSIS HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

L-GLUTAMINE

Products Affected

- *glutamine (sickle cell)*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

LIDOCAINE OINTMENT

Products Affected

- *lidocaine topical ointment*

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

LIDOCAINE PATCH

Products Affected

- *dermacinrx lidocan 5% patch outer*
- *lidocaine topical adhesive patch,medicated 5 %*
- *lidocan iii*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) PAIN ASSOCIATED WITH POST-HERPETIC NEURALGIA, 2) NEUROPATHY DUE TO DIABETES MELLITUS, 3) CHRONIC BACK PAIN, OR 4) OSTEOARTHRITIS OF THE KNEE OR HIP.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine topical cream*

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

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

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

LOTILANER

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

LUMACAFTOR-IVACAFTOR

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

MACITENTAN

Products Affected

- *macitentan*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

MARIBAVIR

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYTOMEGALOVIRUS (CMV): PRESCRIBED BY OR IN CONSULTATION WITH A TRANSPLANT SPECIALIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	8 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MECASERMIN

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	GROWTH FAILURE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	GROWTH FAILURE: INITIAL: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF WRIST AND HAND. INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER GROWTH HORMONE MEDICATION. RENEWAL: IMPROVEMENT WHILE ON THERAPY (INCREASE IN HEIGHT OR INCREASE IN HEIGHT VELOCITY).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MECHLORETHAMINE

Products Affected

- VALCHLOR

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

MEPOLIZUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

METYROSINE

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PHEOCHROMOCYTOMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, ENDOCRINE SURGEON, OR HEMATOLOGIST-ONCOLOGIST.
Coverage Duration	PHEOCHROMOCYTOMA: PRE-OP SURGERY: 30 DAYS, TREATMENT: PLAN YEAR.
Other Criteria	PHEOCHROMOCYTOMA: INITIAL: HAS NON-METASTATIC PHEOCHROMOCYTOMA. PREOPERATIVE PREPARATION FOR SURGERY: USE IN COMBINATION WITH AN ALPHA-ADRENERGIC RECEPTOR BLOCKER. RENEWAL: MALIGNANT PHEOCHROMOCYTOMA: STABLE OR CLINICAL IMPROVEMENT WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

MIDAZOLAM

Products Affected

- NAYZILAM

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

MIDOSTAURIN

Products Affected

- RYDAPT

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

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CUSHINGS SYNDROME (CS): INITIAL: DIAGNOSIS CONFIRMED BY: 1) 24-HR URINE FREE CORTISOL (AT LEAST 2 TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (AT LEAST 2 TESTS TO CONFIRM).
Age Restrictions	
Prescriber Restrictions	CS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CS: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICOIDS. INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER AGENTS USED TO LOWER CORTISOL LEVELS FOR CS. RENEWAL: 1) CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE), 2) CONTINUES TO HAVE TOLERABILITY TO THERAPY, AND 3) CONTINUES TO NOT BE A CANDIDATE FOR SURGICAL TREATMENT OR HAS FAILED SURGERY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

MILTEFOSINE

Products Affected

- IMPAVIDO

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

MIRDAMETINIB

Products Affected

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

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

MODAFINIL

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

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

MOMELOTINIB

Products Affected

- OJJAARA

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

MORPHINE SOLUTION

Products Affected

- *morphine concentrate oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OPIOID TOLERANT: PLAN YEAR. HOSPICE, PALLIATIVE CARE OR END OF LIFE CARE: LIFETIME.
Other Criteria	1) OPIOID TOLERANT (I.E. PREVIOUS USE OF 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL PER HOUR, 30 MG ORAL OXYCODONE PER DAY, 8 MG ORAL HYDROMORPHONE PER DAY, 25 MG ORAL OXYMORPHONE PER DAY, 60 MG ORAL HYDROCODONE PER DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID) AND HAS TROUBLE SWALLOWING OPIOID TABLETS, CAPSULES, OR LARGE VOLUMES OF LIQUID, OR 2) ENROLLED IN HOSPICE OR PALLIATIVE CARE OR END OF LIFE CARE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NERANDOMILAST

Products Affected

- JASCAYD

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

NERATINIB

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	EARLY-STAGE (STAGE I-III) BREAST CANCER: MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NILOTINIB - TASIGNA

Products Affected

- *nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND MEDICATION IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NILOTINIB-DANZITEN

Products Affected

- DANZITEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): 1) PERFORMED MUTATIONAL ANALYSIS PRIOR TO INITIATION OF THERAPY, AND 2) THERAPY IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NINTEDANIB

Products Affected

- *nintedanib*
- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

NIRAPARIB

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: 1) ZEJULA WILL BE USED AS MONOTHERAPY, AND 2) ZEJULA IS STARTED NO LATER THAN 8 WEEKS AFTER THE MOST RECENT PLATINUM-CONTAINING REGIMEN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NIRAPARIB-ABIRATERONE

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC), METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NIROGACESTAT

Products Affected

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

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

NITISINONE

Products Affected

- *nitisinone*
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY TYROSINEMIA TYPE 1 (HT-1): INITIAL: DIAGNOSIS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE. RENEWAL: URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.
Age Restrictions	
Prescriber Restrictions	HT-1: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HT-1: INITIAL: ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED NITISINONE TABLETS OR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NIVOLUMAB

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NIVOLUMAB-HYALURONIDASE-NVHY

Products Affected

- OPDIVO QVANTIG

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

OFATUMUMAB SQ

Products Affected

- KESIMPTA PEN

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

OLAPARIB

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER: MEDICATION WILL BE USED AS MONOTHERAPY. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

OLEZARSEN

Products Affected

- TRYNGOLZA

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

OLUTASIDENIB

Products Affected

- REZLIDHIA

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

OMALIZUMAB

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

OMALIZUMAB-IGEC

Products Affected

- OMLYCLO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL OF AT LEAST 30 IU/ML. FOOD ALLERGY: 1) IGE SERUM LEVEL OF AT LEAST 30 IU/ML, AND 2) POSITIVE SKIN PRICK TEST TO AT LEAST ONE FOOD, OR POSITIVE MEDICALLY MONITORED FOOD CHALLENGE TO AT LEAST ONE FOOD.
Age Restrictions	
Prescriber Restrictions	INITIAL/RENEWAL: CHRONIC SPONTANEOUS URTICARIA (CSU): PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST. INITIAL: CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. FOOD ALLERGY: PRESCRIBED BY OR IN CONSULTATION WITH ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: CSU: 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE, AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA ON MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. CRSWNP: 1) A 56 DAY TRIAL OF ONE CLINICAL STANDARD OF CARE AGENT: A TOPICAL NASAL CORTICOSTEROID, 2) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 3) INADEQUATELY CONTROLLED DISEASE. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA. FOOD ALLERGY: CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE. CRSWNP: CLINICAL BENEFIT COMPARED TO BASELINE. ASTHMA: 1) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A)
	REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. FOOD ALLERGY: 1) PERSISTENT IGE-MEDIATED FOOD ALLERGY, AND 2) CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION.

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

OSILODROSTAT

Products Affected

- ISTURISA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CUSHINGS SYNDROME: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CUSHINGS SYNDROME: RENEWAL: 1) CONTINUED IMPROVEMENT OF CUSHINGS DISEASE/SYNDROME, AND 2) MAINTAINS TOLERABILITY TO ISTURISA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

OSIMERTINIB

Products Affected

- TAGRISSO

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

PACRITINIB

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

PALBOCICLIB

Products Affected

- IBRANCE

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

PASIREOTIDE DIASPARTATE

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CUSHINGS DISEASE (CD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CD: RENEWAL: 1) CONTINUED IMPROVEMENT OF CUSHINGS DISEASE, AND 2) MAINTAINED TOLERABILITY TO SIGNIFOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PAZOPANIB

Products Affected

- *pazopanib oral tablet 200 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	ADVANCED SOFT TISSUE SARCOMA (STS): NOT USED FOR ADIPOCYTIC STS OR GASTROINTESTINAL STROMAL TUMORS (GIST)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEGFILGRASTIM - APGF

Products Affected

- NYVEPRIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEGFILGRASTIM - CBQV

Products Affected

- UDENYCA ONBODY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	NON MYELOID MALIGNANCY: UDENYCA: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA. UDENYCA ONBODY: 1) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA, OR 2) BARRIER TO ACCESS (E.G., TRAVEL BARRIERS, UNABLE TO RETURN TO CLINIC FOR INJECTIONS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PEGINTERFERON ALFA-2A

Products Affected

- PEGASYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEPATITIS B: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, OR PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G., HEPATOLOGIST).
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEGVISOMANT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ACROMEGALY: INITIAL: SERUM INSULIN-LIKE GROWTH FACTOR 1 (IGF-1) LEVEL (ADJUSTED FOR AGE) IS ELEVATED OR UNEQUIVOCAL WITH INADEQUATE SUPPRESSION OF GROWTH HORMONE AFTER A GLUCOSE LOAD. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEMBROLIZUMAB

Products Affected

- KEYTRUDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEMBROLIZUMAB-BERAHYALURONIDASE ALFA-PMPH

Products Affected

- KEYTRUDA QLEX

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

PEMIGATINIB

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CHOLANGIOCARCINOMA, MYELOID/LYMPHOID NEOPLASMS: COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), WILL BE COMPLETED PRIOR TO INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PENICILLAMINE TABLET

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WILSONS DISEASE: 1) GENETIC TESTING CONFIRMING AN ATP7B MUTATION, 2) 24-HOUR URINARY COPPER EXCRETION (GREATER THAN 40 MICROGRAMS/24 HOURS), 3) LIVER BIOPSY WITH COPPER DRY WEIGHT GREATER THAN 75 MICROGRAMS/GRAM, OR 4) SERUM CERULOPLASMIN LEVEL OF LESS THAN 20 MG/DL. INITIAL: CYSTINURIA: HAS NEPHROLITHIASIS AND ONE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTINE, 2) PRESENCE OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) FAMILY HISTORY OF CYSTINURIA AND POSITIVE CYANIDE-NITROPRUSSIDE SCREENING.
Age Restrictions	
Prescriber Restrictions	WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. INITIAL: CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. RENEWAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) EXPERIENCED OR MAINTAINED IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT COMPARED TO BASELINE. CYSTINURIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PEXIDARTINIB

Products Affected

- TURALIO

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

PIMAVANSERIN

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

PIRFENIDONE

Products Affected

- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 534 mg, 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

PIRTOBRUTINIB

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

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

POMALIDOMIDE

Products Affected

- *pomalidomide*
- POMALYST

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

PONATINIB

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHRONIC MYELOID LEUKEMIA (CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND ICLUSIG IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

POSACONAZOLE TABLET

Products Affected

- *posaconazole oral tablet,delayed release (dr/ec)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE, PROPHYLAXIS: 6 MONTHS. TREATMENT: 12 WEEKS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PRALSETINIB

Products Affected

- GAVRETO

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

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TOXOPLASMOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	TOXOPLASMOSIS: INITIAL: 8 WEEKS, RENEWAL: 6 MOS.
Other Criteria	TOXOPLASMOSIS: RENEWAL: ONE OF THE FOLLOWING: (1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING), OR (2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENTLY TAKING AN ANTI-RETROVIRAL THERAPY IF HIV POSITIVE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

QUININE

Products Affected

- *quinine sulfate*

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

QUIZARTINIB

Products Affected

- VANFLYTA

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

REGORAFENIB

Products Affected

- STIVARGA

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

RELACORILANT

Products Affected

- LIFYORLI

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

RELUGOLIX

Products Affected

- ORGOVYX

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

REPOTRECTINIB

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

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

RESMETIROM

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

REVUMENIB

Products Affected

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

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

RIBOCICLIB

Products Affected

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

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

RIBOCICLIB-LETROZOLE

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

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

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

RILONACEPT

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

RIMEGEPANT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ACUTE MIGRAINE TREATMENT: 1) TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN) AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. EPISODIC MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RIOCIGUAT

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

RIPRETINIB

Products Affected

- QINLOCK

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

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ROPEGINTERFERON ALFA-2B-NJFT

Products Affected

- BESREMI
- BESREMI PEN

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

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RUXOLITINIB

Products Affected

- JAKAFI
- JAKAFI XR

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SAPROPTERIN

Products Affected

- *javygtor oral tablet,soluble*
- *sapropterin oral tablet,soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPERPHENYLALANINEMIA (HPA) WITH PHENYLKETONURIA (PKU): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A METABOLIC OR GENETIC DISEASE SPECIALIST.
Coverage Duration	INITIAL: 2 MONTHS. RENEWAL: PLAN YEAR.
Other Criteria	HPA WITH PKU: INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER AGENT INDICATED FOR THE TREATMENT OF PKU. RENEWAL: CONTINUES TO BENEFIT FROM TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SARGRAMOSTIM

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SARILUMAB

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SECUKINUMAB SQ

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SELEXIPAG

Products Affected

- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 100 MCG, 150 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SELINEXOR

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK)

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

SELPERCATINIB

Products Affected

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

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

SELUMETINIB

Products Affected

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

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

SEMAGLUTIDE - WEGOVY

Products Affected

- WEGOVY ORAL MG/0.75 ML
- WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SEVABERTINIB

Products Affected

- HYRNUO

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

SILDENAFIL TABLET

Products Affected

- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SODIUM OXYBATE-XYREM

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SOFOSBUVIR/VELPATASVIR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SOMATROPIN - NORDITROPIN

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SOMATROPIN - SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SONIDEGIB

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	LOCALLY ADVANCED BASAL CELL CARCINOMA (BCC): BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SONROTOCLAX

Products Affected

- BEQALZI
- BEQALZI STARTER PACK

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

SORAFENIB

Products Affected

- *sorafenib*

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

SOTATERCEPT-CSRK

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

SOTORASIB

Products Affected

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

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

SPARSENTAN

Products Affected

- FILSPARI

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

STIRIPENTOL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SUNITINIB

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO IMATINIB.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TADALAFIL - ADCIRCA, ALYQ

Products Affected

- *alyq*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

TADALAFIL-CIALIS

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA (BPH).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	BPH: 1) TRIAL OF ONE ALPHA BLOCKER (E.G., DOXAZOSIN, TERAZOSIN, TAMSULOSIN, ALFUZOSIN), AND 2) TRIAL OF ONE 5-ALPHA-REDUCTASE INHIBITOR (E.G., FINASTERIDE, DUTASTERIDE). APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TAFAMIDIS

Products Affected

- VYNDAMAX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CARDIOMYOPATHY ASSOCIATED WITH WILD TYPE OR HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (ATTR-CM): INITIAL: 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE, AND 2) DIAGNOSIS CONFIRMED BY (A) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF TC-99M-PYP, OR (B) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN.
Age Restrictions	
Prescriber Restrictions	ATTR-CM: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ATTR-CM: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER ATTR-CM TTR STABILIZERS (E.G., ACORAMIDIS)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TALAZOPARIB

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

TALETRECTINIB

Products Affected

- IBTROZI

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

TELOTRISTAT

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CARCINOID SYNDROME DIARRHEA: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST OR GASTROENTEROLOGIST
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TEPOTINIB

Products Affected

- TEPMETKO

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

TERIPARATIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	OSTEOPOROSIS: HAS NOT RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY, UNLESS REMAINS AT OR HAS RETURNED TO HAVING A HIGH RISK FOR FRACTURE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TESTOSTERONE

Products Affected

- *testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1 %*
- *(25 mg/2.5gram), 1 % (50 mg/5 gram)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MALE HYPOGONADISM: INITIAL/RENEWAL: 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED WITHIN THE PAST 12 MONTHS, AND 1) PSA LEVEL IS LESS THAN OR EQUAL TO 4 NG/ML, OR 2) PSA LEVEL IS GREATER THAN 4 NG/ML AND THE BENEFITS OF ONGOING THERAPY OUTWEIGH THE RISKS OF ELEVATED PSA. RENEWAL: IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TESTOSTERONE CYPIONATE - DEPO

Products Affected

- *testosterone cypionate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MALE HYPOGONADISM: INITIAL/RENEWAL: 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED WITHIN THE PAST 12 MONTHS, AND 1) PSA LEVEL IS LESS THAN OR EQUAL TO 4 NG/ML, OR 2) PSA LEVEL IS GREATER THAN 4 NG/ML AND THE BENEFITS OF ONGOING THERAPY OUTWEIGH THE RISKS OF ELEVATED PSA. RENEWAL: IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TESTOSTERONE ENANTHATE

Products Affected

- *testosterone enanthate*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

THALIDOMIDE

Products Affected

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

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

TIVOZANIB

Products Affected

- FOTIVDA

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

TOCILIZUMAB-AAZG IV

Products Affected

- TYENNE

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: RA, PJIA, SJIA, GCA: PLAN YEAR. CRS: 1 MONTH.

PA Criteria	Criteria Details
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOIDS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ IR, RINVOQ. RENEWAL: RA, PJIA, SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. GCA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TOCILIZUMAB-AAZG SQ

Products Affected

- TYENNE
- TYENNE AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOIDS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ IR, RINVOQ. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TOFACITINIB

Products Affected

- *tofacitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PSA, AS, PCJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TOLVAPTAN

Products Affected

- *tolvaptan (polycys kidney dis) oral tablet*
- *tolvaptan (polycys kidney dis) oral tablets, sequential*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD): INITIAL: CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI, OR ULTRASOUND.
Age Restrictions	
Prescriber Restrictions	ADPKD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ADPKD: INITIAL: DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS). RENEWAL: HAS NOT PROGRESSED TO ESRD/DIALYSIS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TOPICAL TRETINOIN

Products Affected

- ALTRENO
- *tretinoin topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

TOVORAFENIB

Products Affected

- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION
- OJEMDA ORAL TABLET

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

TRAMETINIB SOLUTION

Products Affected

- MEKINIST ORAL RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA, MELANOMA, METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC), LOCALLY ADVANCED OR METASTATIC ANAPLASTIC THYROID CANCER (ATC), UNRESECTABLE OR METASTATIC SOLID TUMOR, LOW-GRADE GLIOMA (LGG): UNABLE TO SWALLOW MEKINIST TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TRAMETINIB TABLET

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

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

TRASTUZUMAB-DKST

Products Affected

- OGIVRI

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

TRASTUZUMAB-HYALURONIDASE-OYSK

Products Affected

- HERCEPTIN HYLECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	ADJUVANT BREAST CANCER, METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: HERZUMA, OGIVRI, ONTRUZANT, TRAZIMERA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TRAZODONE

Products Affected

- RALDESY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	MAJOR DEPRESSIVE DISORDER (MDD): CONTRAINDICATION TO OR UNABLE TO SWALLOW TRAZODONE TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TREPROSTINIL-YUTREPIA

Products Affected

- YUTREPIA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

TRIENTINE CAPSULE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WILSONS DISEASE: 1) GENETIC TESTING CONFIRMING AN ATP7B MUTATION, 2) 24-HOUR URINARY COPPER EXCRETION (GREATER THAN 40 MICROGRAMS/24 HOURS), 3) LIVER BIOPSY WITH COPPER DRY WEIGHT GREATER THAN 75 MICROGRAMS/GRAM, OR 4) SERUM CERULOPLASMIN LEVEL OF LESS THAN 20 MG/DL.
Age Restrictions	
Prescriber Restrictions	WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	WILSONS DISEASE: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: PENICILLAMINE TABLET.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TRIFLURIDINE/TIPIRACIL

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

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

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

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

UBROGEPANT

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ACUTE MIGRAINE TREATMENT: 1) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED AGENT: A TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

UPADACITINIB

Products Affected

- RINVOQ
- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

USTEKINUMAB-AAUZ IV

Products Affected

- OTULFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

USTEKINUMAB-AAUZ SQ

Products Affected

- OTULFI

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

USTEKINUMAB-AEKN IV

Products Affected

- SELARSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

USTEKINUMAB-AEKN SQ

Products Affected

- SELARSDI

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

USTEKINUMAB-KFCE IV

Products Affected

- YESINTEK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

USTEKINUMAB-KFCE SQ

Products Affected

- YESINTEK

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

VALBENAZINE

Products Affected

- INGREZZA
- INGREZZA INITIATION PK(TARDIV)
- INGREZZA SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TARDIVE DYSKINESIA (TD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST. CHOREA ASSOCIATED WITH HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	PLAN YEAR
Other Criteria	TD: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CURRENTLY STABLE ON CAPRELSA REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VEDOLIZUMAB

Products Affected

- ENTYVIO
- ENTYVIO PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	MELANOMA: ZELBORAF WILL BE USED ALONE OR IN COMBINATION WITH COTELLIC
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VENETOCLAX

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

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

VEPDEGESTRANT

Products Affected

- VEPPANU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ADVANCED OR METASTATIC BREAST CANCER: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGY SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ADVANCED OR METASTATIC BREAST CANCER: INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER SELECTIVE ESTROGEN RECEPTOR DEGRADER (SERD). RENEWAL: DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS SHOWN BY A PARTIAL OR COMPLETE RESPONSE OR STABLE DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VERICIGUAT

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEART FAILURE (HF): INITIAL/RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HF: INITIAL: HIGH-RISK WITH WORSENING HF AS EVIDENCED BY HOSPITALIZATION FOR HF OR NEED FOR INTRAVENOUS DIURETICS. INITIAL/RENEWAL: 1) NO CONCURRENT USE WITH RIOCIGUAT OR PDE-5 INHIBITORS, AND 2) HISTORY OF AND CONTINUATION OF, OR CONTRAINDICATION OR INTOLERANCE TO, ONE AGENT FROM ANY OF THE FOLLOWING GUIDELINE-DIRECTED MEDICAL THERAPY (GDMT) MEDICATION CLASSES: (A) ACE INHIBITOR, ARB, OR ARNI, (B) BETA BLOCKER, (C) ALDOSTERONE ANTAGONIST, (D) SGLT-2 INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VIGABATRIN

Products Affected

- *vigabatrin*
- *vigadrone*
- *vigpoder*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: CPS: TRIAL OF OR CONTRAINDICATION TO TWO ANTIEPILEPTIC AGENTS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VIMSELTINIB

Products Affected

- ROMVIMZA

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

VISMODEGIB

Products Affected

- ERIVEDGE

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

VONOPRAZAN

Products Affected

- VOQUEZNA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

VORASIDENIB

Products Affected

- VORANIGO

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

VORICONAZOLE SUSPENSION

Products Affected

- *voriconazole oral suspension for reconstitution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CANDIDA INFECTIONS: 3 MOS. CONTINUATION OF THERAPY, ALL OTHER INDICATIONS: PLAN YEAR.
Other Criteria	CANDIDA INFECTIONS: CONTRAINDICATION TO OR UNABLE TO SWALLOW FLUCONAZOLE TABLETS. ALL INDICATIONS EXCEPT ESOPHAGEAL CANDIDIASIS: UNABLE TO SWALLOW TABLETS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ZANUBRUTINIB

Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	MANTLE CELL LYMPHOMA: INTOLERANCE TO CALQUENCE. CHRONIC LYMPHOCYTIC LEUKEMIA, SMALL LYMPHOCYTIC LYMPHOMA: INTOLERANCE TO CALQUENCE OR IMBRUVICA. WALDENSTROMS MACROGLOBULINEMIA: NO STEP REQUIRED.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ZIDESAMTINIB

Products Affected

- JIDEYTRO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Review
Required Medical Information	PA Criteria: Pending CMS Review
Age Restrictions	PA Criteria: Pending CMS Review
Prescriber Restrictions	PA Criteria: Pending CMS Review
Coverage Duration	PA Criteria: Pending CMS Review
Other Criteria	PA Criteria: Pending CMS Review
Indications	PA Criteria: Pending CMS Review
Off Label Uses	PA Criteria: Pending CMS Review
Part B Prerequisite	PA Criteria: Pending CMS Review
Prerequisite Therapy Required	PA Criteria: Pending CMS Review

ZIFTOMENIB

Products Affected

- KOMZIFTI

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

ZONGERTINIB

Products Affected

- HERNEXEOS

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

ZURANOLONE

Products Affected

- ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 DAYS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

INDEX

1ST TIER UNIFINE PENTP 5MM 31G ... 157
1ST TIER UNIFINE PNTIP 4MM 32G ... 157
1ST TIER UNIFINE PNTIP 6MM 31G ... 157
1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT ... 157
1ST TIER UNIFINE PNTP 29GX1/2" ... 157
1ST TIER UNIFINE PNTP 31GX3/16 ... 157
1ST TIER UNIFINE PNTP 32GX5/32 ... 157
abigale ... 131
abiraterone oral tablet 250 mg ... 3
abirtega ... 3
ACTIMMUNE ... 170
adalimumab-aaty ... 8
adalimumab-aaty(cf) ai crohns ... 8
ADEMPAS ... 269
ADVOCATE INS 0.3 ML 30GX5/16" ... 157
ADVOCATE INS 0.3 ML 31GX5/16" ... 157
ADVOCATE INS 0.5 ML 30GX5/16" ... 157
ADVOCATE INS 0.5 ML 31GX5/16" ... 157
ADVOCATE INS 1 ML 31GX5/16" ... 157
ADVOCATE INS SYR 1 ML 30GX5/16 ... 157
ADVOCATE PEN NEEDLE 32G 4MM ... 157
ADVOCATE PEN NEEDLE 4MM 33G ... 157
ADVOCATE PEN NEEDLES 5MM 31G ... 157
ADVOCATE PEN NEEDLES 8MM 31G ... 157
AIMOVIG AUTOINJECTOR ... 99
AKEEGA ... 219
ALCOHOL PADS ... 157
ALECENSA ... 11
ALTRENO ... 320
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG ... 46
ALUNBRIG ORAL TABLETS,DOSE PACK ... 46
alyq ... 299
ambrisentan ... 13
AQINJECT PEN NEEDLE 31G 5MM ... 157
AQINJECT PEN NEEDLE 32G 4MM ... 157
ARCALYST ... 267
ARIKAYCE ... 14
armodafinil ... 22
ASSURE ID DUO PRO NDL 31G 5MM ... 157
ASSURE ID DUO-SHIELD 30GX3/16" ... 157
ASSURE ID DUO-SHIELD 30GX5/16" ... 157
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2" ... 157
ASSURE ID PEN NEEDLE 30GX5/16" ... 157
ASSURE ID PRO PEN NDL 30G 5MM ... 157
ASSURE ID SYR 0.5 ML 31GX15/64" ... 157
ASSURE ID SYR 1 ML 31GX15/64" ... 157
AUGTYRO ORAL CAPSULE 160 MG, 40 MG ... 261
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG ... 73
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG ... 73
AUSTEDO XR TITRATION KT(WK1-4) ... 73
AUTOKEEPER SAF PEN NDL 30G 8MM ... 157
AVMAPKI ... 30
AVMAPKI-FAKZYNJA ... 30
AVONEX INTRAMUSCULAR PEN INJECTOR KIT ... 167
AVONEX INTRAMUSCULAR SYRINGE KIT ... 167
AYVAKIT ... 29
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG ... 98
BD AUTOSHIELD DUO NDL 5MMX30G ... 157
BD ECLIPSE 30GX1/2" SYRINGE ... 157
BD INS SYR 0.3 ML 8MMX31G(1/2) ... 157
BD INS SYR UF 0.3 ML 12.7MMX30G ... 157
BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE ... 157
BD INSULIN SYR 1 ML 27GX12.7MM ... 157
BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE ... 157
BD SAFETGLD INS 0.3 ML 29G 13MM ... 157
BD SAFETYGLD INS 0.3 ML 31G 8MM 157
BD SAFETYGLD INS 0.5 ML 30G 8MM 157
BD SAFETYGLD INS 1 ML 29G 13MM ... 157
BD SAFETYGLID INS 1 ML 6MMX31G 157
BD SAFETYGLIDE SYRINGE 27GX5/8 157
BD SAFTYGLD INS 0.3 ML 6MMX31G 157
BD SAFTYGLD INS 0.5 ML 29G 13MM 157
BD SAFTYGLD INS 0.5 ML 6MMX31G 157

BD SINGLE USE SWAB 157
BD UF MICRO PEN NEEDLE 6MMX32G 157
BD UF MINI PEN NEEDLE 5MMX31G . 157
BD UF NANO PEN NEEDLE 4MMX32G 157
BD UF ORIG PEN NDL 12.7MMX29G ... 157
BD UF SHORT PEN NEEDLE 8MMX31G 157
BD VEO INS 0.3 ML 6MMX31G (1/2) 157
BD VEO INS SYRING 1 ML 6MMX31G 157
BD VEO INS SYRN 0.3 ML 6MMX31G . 157
BD VEO INS SYRN 0.5 ML 6MMX31G . 157
bendamustine intravenous recon soln 25 mg 39
BENLYSTA SUBCUTANEOUS 36
BEQALZI 292
BEQALZI STARTER PACK 292
BESREMI 272
BESREMI PEN 272
betaine 41
BETASERON SUBCUTANEOUS KIT 168
bexarotene 42
BORDERED GAUZE 2"X2" 157
bortezomib injection 44
BOSULIF ORAL CAPSULE 100 MG, 50 MG 45
BOSULIF ORAL TABLET 100 MG, 500 MG 45
bosutinib oral tablet 100 mg, 400 mg, 500 mg 45
BRAFTOVI 92
BRUKINSA ORAL CAPSULE 356
BRUKINSA ORAL TABLET 356
butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg 129
butalbital-acetaminophen-caff oral tablet .. 128
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG 51
CALQUENCE (ACALABRUTINIB MAL) 5
CAMCEVI (6 MONTH) 186
CAPRELSA ORAL TABLET 100 MG, 300 MG 343
CAREFINE PEN NEEDLE 12.7MM 29G HRI 157
CAREFINE PEN NEEDLE 4MM 32G 157
CAREFINE PEN NEEDLE 5MM 32G 157
CAREFINE PEN NEEDLE 6MM 31G HRI 157
CAREFINE PEN NEEDLE 8MM 30G HRI 157
CAREFINE PEN NEEDLES 6MM 32G ... 157
CAREFINE PEN NEEDLES 8MM 31G ... 157
CARETOUCH ALCOHOL 70% PREP PAD 157
CARETOUCH PEN NEEDLE 29G 12MM 157
CARETOUCH PEN NEEDLE 31GX1/4" . 157
CARETOUCH PEN NEEDLE 31GX3/16" 157
CARETOUCH PEN NEEDLE 31GX5/16" 157
CARETOUCH PEN NEEDLE 32GX3/16" 157
CARETOUCH PEN NEEDLE 32GX5/32" 157
CARETOUCH SYR 0.3 ML 31GX5/16" .. 157
CARETOUCH SYR 0.5 ML 30GX5/16" .. 157
CARETOUCH SYR 0.5 ML 31GX5/16" .. 157
CARETOUCH SYR 1 ML 28GX5/16" 157
CARETOUCH SYR 1 ML 29GX5/16" 157
CARETOUCH SYR 1 ML 30GX5/16" 157
CARETOUCH SYR 1 ML 31GX5/16" 157
carglumic acid 55
CAYSTON 34
CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE 157
CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND 157
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY) 50
COMFORT EZ 0.3 ML 31G 15/64" 157
COMFORT EZ 0.5 ML 31G 15/64" 157
COMFORT EZ INS 0.3 ML 30GX1/2" 157
COMFORT EZ INS 0.3 ML 30GX5/16" ... 157
COMFORT EZ INS 1 ML 31G 15/64" 157
COMFORT EZ INS 1 ML 31GX5/16" 157
COMFORT EZ INSULIN SYR 0.3 ML 157
COMFORT EZ INSULIN SYR 0.5 ML 157
COMFORT EZ PEN NEEDLE 12MM 29G 157

COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO 157
COMFORT EZ PEN NEEDLES 4MM 33G 157
COMFORT EZ PEN NEEDLES 5MM 31G MINI 157
COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI 157
COMFORT EZ PEN NEEDLES 5MM 33G 157
COMFORT EZ PEN NEEDLES 6MM 31G 157
COMFORT EZ PEN NEEDLES 6MM 32G 157
COMFORT EZ PEN NEEDLES 6MM 33G 157
COMFORT EZ PEN NEEDLES 8MM 31G SHORT 157
COMFORT EZ PEN NEEDLES 8MM 32G 157
COMFORT EZ PEN NEEDLES 8MM 33G 157
COMFORT EZ PLS PEN NDL 32G 4MM 157
COMFORT EZ PRO PEN NDL 30G 8MM 157
COMFORT EZ PRO PEN NDL 31G 4MM 157
COMFORT EZ PRO PEN NDL 31G 5MM 157
COMFORT EZ SYR 0.3 ML 29GX1/2" 157
COMFORT EZ SYR 0.5 ML 28GX1/2" 157
COMFORT EZ SYR 0.5 ML 29GX1/2" 157
COMFORT EZ SYR 0.5 ML 30GX1/2" 157
COMFORT EZ SYR 1 ML 27G 12.7MM . 157
COMFORT EZ SYR 1 ML 28GX1/2" 157
COMFORT EZ SYR 1 ML 29GX1/2" 157
COMFORT EZ SYR 1 ML 30GX1/2" 157
COMFORT EZ SYR 1 ML 30GX5/16" 157
COMFORT POINT PEN NDL 31GX1/3" . 157
COMFORT POINT PEN NDL 31GX1/6" . 157
COMFORT TOUCH PEN NDL 31G 4MM 157
COMFORT TOUCH PEN NDL 31G 5MM 157
COMFORT TOUCH PEN NDL 31G 6MM 157
COMFORT TOUCH PEN NDL 31G 8MM 157
COMFORT TOUCH PEN NDL 32G 4MM 157
COMFORT TOUCH PEN NDL 32G 5MM 157
COMFORT TOUCH PEN NDL 32G 6MM 157
COMFORT TOUCH PEN NDL 32G 8MM 157
COMFORT TOUCH PEN NDL 33G 4MM 157
COMFORT TOUCH PEN NDL 33G 5MM 157
COMFORT TOUCH PEN NDL 33G 6MM 157
COPIKTRA 83
CORTROPHIN GEL INJECTION 59
COSENTYX (2 SYRINGES) 278
COSENTYX PEN (2 PENS) 278
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML 278
COSENTYX UNOREADY PEN 278
COTELLIC 58
CRESEMBA ORAL 171
CURITY ALCOHOL PREPS 2 PLY,MEDIUM 157
CURITY GAUZE PADS 157
CURITY GAUZE SPONGES (12 PLY)-200/BAG 157
dalfampridine 65
DANZITEN 216
dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg 68
DAURISMO ORAL TABLET 100 MG, 25 MG 122
deferasirox oral granules in packet 70
deferasirox oral tablet 70
DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII 157
DERMACEA GAUZE 2"X2" SPONGE 8 PLY 157
DERMACEA NON-WOVEN 2"X2" SPNGE 157
dermacinrx lidocan 5% patch outer 193
DIACOMIT ORAL CAPSULE 250 MG, 500 MG 297

DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG.....297
diclofenac sodium topical solution in metered-dose pump.....75
dihydroergotamine nasal.....76
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg.....77
diphenoxylate-atropine oral tablet.....140
dipyridamole oral.....130
dronabinol oral capsule..... 80
DROPLET 0.3 ML 29G 12.7MM(1/2) OUTER.....157
DROPLET 0.3 ML 30G 12.7MM(1/2) OUTER.....157
DROPLET 0.5 ML 29GX12.5MM(1/2).....157
DROPLET 0.5 ML 30GX12.5MM(1/2).....157
DROPLET INS 0.3 ML 29GX12.5MM.....157
DROPLET INS 0.3 ML 30G 8MM(1/2) OUTER.....157
DROPLET INS 0.3 ML 30GX12.5MM.....157
DROPLET INS 0.3 ML 31G 6MM(1/2) OUTER.....157
DROPLET INS 0.3 ML 31G 8MM(1/2) OUTER.....157
DROPLET INS 0.5 ML 29G 12.7MM OUTER.....157
DROPLET INS 0.5 ML 30G 12.7MM OUTER.....157
DROPLET INS 0.5 ML 30GX6MM(1/2)..157
DROPLET INS 0.5 ML 30GX8MM(1/2)..157
DROPLET INS 0.5 ML 31GX6MM(1/2)..157
DROPLET INS 0.5 ML 31GX8MM(1/2)..157
DROPLET INS SYR 0.3 ML 30GX6MM.157
DROPLET INS SYR 0.3 ML 30GX8MM.157
DROPLET INS SYR 0.3 ML 31GX6MM.157
DROPLET INS SYR 0.3 ML 31GX8MM.157
DROPLET INS SYR 0.5 ML 30G 8MM OUTER.....157
DROPLET INS SYR 0.5 ML 31G 6MM OUTER.....157
DROPLET INS SYR 0.5 ML 31G 8MM OUTER.....157
DROPLET INS SYR 1 ML 29G 12.7MM OUTER.....157
DROPLET INS SYR 1 ML 30G 12.5MM.157
DROPLET INS SYR 1 ML 30G 6MM.....157
DROPLET INS SYR 1 ML 30G 8MM OUTER.....157
DROPLET INS SYR 1 ML 31G 6MM OUTER.....157
DROPLET INS SYR 1 ML 31G 8MM.....157
DROPLET MICRON 34G X 9/64".....157
DROPLET PEN NEEDLE 29G 10MM.....157
DROPLET PEN NEEDLE 29G 12MM.....157
DROPLET PEN NEEDLE 30G 8MM.....157
DROPLET PEN NEEDLE 31G 5MM.....157
DROPLET PEN NEEDLE 31G 6MM.....157
DROPLET PEN NEEDLE 31G 8MM.....157
DROPLET PEN NEEDLE 32G 4MM.....157
DROPLET PEN NEEDLE 32G 5MM.....157
DROPLET PEN NEEDLE 32G 6MM.....157
DROPLET PEN NEEDLE 32G 8MM.....157
DROPSAFE ALCOHOL 70% PREP PADS.....157
DROPSAFE INS SYR 0.3 ML 31G 6MM 157
DROPSAFE INS SYR 0.3 ML 31G 8MM 157
DROPSAFE INS SYR 0.5 ML 31G 6MM 157
DROPSAFE INS SYR 0.5 ML 31G 8MM 157
DROPSAFE INSUL SYR 1 ML 31G 6MM.....157
DROPSAFE INSUL SYR 1 ML 31G 8MM.....157
DROPSAFE INSULN 1 ML 29G 12.5MM 157
DROPSAFE PEN NEEDLE 31G 4MM.....157
DROPSAFE PEN NEEDLE 31G 5MM.....157
DROPSAFE PEN NEEDLE 31G 8MM.....157
DROPSAFE PEN NEEDLE 31GX1/4"..... 157
droxidopa.....81
DUPIXENT PEN.....82
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML.....82
EASY CMFT SFTY PEN NDL 31G 5MM157
EASY CMFT SFTY PEN NDL 31G 6MM157
EASY CMFT SFTY PEN NDL 32G 4MM157
EASY COMFORT 0.3 ML 31G 1/2".....157
EASY COMFORT 0.3 ML 31G 5/16".....157
EASY COMFORT 0.5 ML 30GX1/2".....157
EASY COMFORT 0.5 ML 31GX5/16".....157
EASY COMFORT 0.5 ML 32GX5/16".....157
EASY COMFORT 0.5 ML SYRINGE.....157
EASY COMFORT 1 ML 31GX5/16".....157

EASY COMFORT 1 ML 32GX5/16".....157
EASY COMFORT ALCOHOL 70% PAD 157
EASY COMFORT INSULIN 1 ML SYR..157
EASY COMFORT PEN NDL 29G 4MM..157
EASY COMFORT PEN NDL 29G 5MM..157
EASY COMFORT PEN NDL 31GX1/4"..157
EASY COMFORT PEN NDL 31GX3/16" 157
EASY COMFORT PEN NDL 31GX5/16" 157
EASY COMFORT PEN NDL 32GX5/32" 157
EASY COMFORT PEN NDL 33G 4MM..157
EASY COMFORT PEN NDL 33G 5MM..157
EASY COMFORT PEN NDL 33G 6MM..157
EASY COMFORT SYR 0.5 ML 29G 8MM.....157
EASY COMFORT SYR 1 ML 29G 8MM.157
EASY COMFORT SYR 1 ML 30GX1/2".157
EASY GLIDE INS 0.3 ML 31GX6MM.... 157
EASY GLIDE INS 0.5 ML 31GX6MM.... 157
EASY GLIDE INS 1 ML 31GX6MM..... 157
EASY GLIDE PEN NEEDLE 4MM 33G..157
EASY TOUCH 0.3 ML 30G 8MM(1/2).... 157
EASY TOUCH 0.3 ML 31G 6MM(1/2).... 157
EASY TOUCH 0.3 ML 31G 8MM(1/2).... 157
EASY TOUCH 0.3 ML SYR 30GX1/2"....157
EASY TOUCH 0.5 ML SYR 27GX1/2"....157
EASY TOUCH 0.5 ML SYR 29GX1/2"....157
EASY TOUCH 0.5 ML SYR 30GX1/2"....157
EASY TOUCH 0.5 ML SYR 30GX5/16... 157
EASY TOUCH 1 ML SYR 29GX1/2".....157
EASY TOUCH 1 ML SYR 30GX1/2".....157
EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED..... 157
EASY TOUCH AUTO 0.5 ML 30G 6MM 157
EASY TOUCH AUTO 0.5 ML 30G 8MM 157
EASY TOUCH AUTORET 1 ML 30G 6MM.....157
EASY TOUCH AUTORET 1 ML 30G 8MM.....157
EASY TOUCH FLIPLOK 1 ML 27GX0.5 157
EASY TOUCH INS 0.3 ML 30G 8MM.....157
EASY TOUCH INS 0.3 ML 31G 8MM.....157
EASY TOUCH INS 0.5 ML 30G 8MM.....157
EASY TOUCH INS 0.5 ML 31G 6MM.....157
EASY TOUCH INS 0.5 ML 31G 8MM.....157
EASY TOUCH INS 1 ML 27G 1/2".....157
EASY TOUCH INS 1 ML 28G 12.7MM...157
EASY TOUCH INS SYR 1 ML 30G 8MM 157
EASY TOUCH INS SYR 1 ML 31G 6MM 157
EASY TOUCH INS SYR 1 ML 31G 8MM 157
EASY TOUCH INSULIN 1 ML 29GX1/2 157
EASY TOUCH INSULIN 1 ML 30GX1/2 157
EASY TOUCH INSULIN SYR 1 ML..... 157
EASY TOUCH INSULIN SYR 1 ML RETRACTABLE..... 157
EASY TOUCH INSULN 1 ML 29GX1/2" 157
EASY TOUCH INSULN 1 ML 30GX1/2" 157
EASY TOUCH INSULN 1 ML 30GX5/16157
EASY TOUCH INSULN 1 ML 31GX5/16157
EASY TOUCH LUER LOK INSUL 1 ML157
EASY TOUCH PEN NEEDLE 29GX1/2" 157
EASY TOUCH PEN NEEDLE 30GX5/16 157
EASY TOUCH PEN NEEDLE 31GX1/4" 157
EASY TOUCH PEN NEEDLE 31GX3/16 157
EASY TOUCH PEN NEEDLE 31GX5/16 157
EASY TOUCH PEN NEEDLE 32GX1/4" 157
EASY TOUCH PEN NEEDLE 32GX3/16 157
EASY TOUCH PEN NEEDLE 32GX5/32 157
EASY TOUCH SAF PEN NDL 29G 5MM 157
EASY TOUCH SAF PEN NDL 29G 8MM 157
EASY TOUCH SAF PEN NDL 30G 5MM 157
EASY TOUCH SAF PEN NDL 30G 8MM 157
EASY TOUCH SYR 0.5 ML 28G 12.7MM.....157
EASY TOUCH SYR 0.5 ML 29G 12.7MM.....157
EASY TOUCH SYR 1 ML 27G 16MM.... 157
EASY TOUCH UNI-SLIP SYR 1 ML.....157
EASYLIFE ALCOHOL 70% PADS.....157
EASYLIFE INS PEN NDL 29G 12MM.... 157
EASYLIFE INS PEN NDL 31G 4MM..... 157
EASYLIFE INS PEN NDL 31G 5MM..... 157
EASYLIFE INS PEN NDL 31G 6MM..... 157
EASYLIFE INS PEN NDL 31G 8MM..... 157
EASYLIFE INS PEN NDL 32G 4MM..... 157
EASYLIFE INS PEN NDL 32G 5MM..... 157
EASYLIFE INS PEN NDL 32G 6MM..... 157

EASYLIFE INS PEN NDL 32G 8MM..... 157
EASYLIFE INS PEN NDL 33G 4MM..... 157
EASYLIFE INS PEN NDL 33G 5MM..... 157
EASYLIFE INS PEN NDL 33G 6MM..... 157
EASYLIFE INS PEN NDL 33G 8MM..... 157
EASYLIFE INS SYR 0.5 ML 30G 8MM.. 157
EASYLIFE INS SYR 1 ML 30G 8MM..... 157
EASYLIFE INS SYR 1 ML 31G 8MM..... 157
EASYLIFE SAFTY PEN NDL 31G 4MM 157
EASYLIFE SAFTY PEN NDL 31G 5MM 157
EASYLIFE SYR 1 ML 30G 12.7MM..... 157
EASYTOUCH SAF PEN NDL 30G 6MM 157
ELIGARD..... 187
ELIGARD (3 MONTH)..... 187
ELIGARD (4 MONTH)..... 187
ELIGARD (6 MONTH)..... 187
eltrombopag olamine oral powder in packet 12.5 mg, 25 mg..... 90
eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg..... 90
EMBRACE PEN NEEDLE 29G 12MM.... 157
EMBRACE PEN NEEDLE 30G 5MM..... 157
EMBRACE PEN NEEDLE 30G 8MM..... 157
EMBRACE PEN NEEDLE 31G 5MM..... 157
EMBRACE PEN NEEDLE 31G 6MM..... 157
EMBRACE PEN NEEDLE 31G 8MM..... 157
EMBRACE PEN NEEDLE 32G 4MM..... 157
EMGALITY PEN..... 117
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML, 300 MG/3 ML (100 MG/ML X 3)..... 117
ENBREL MINI..... 101
ENBREL SUBCUTANEOUS SOLUTION 101
ENBREL SUBCUTANEOUS SYRINGE. 101
ENBREL SURECLICK..... 101
ENSACOVE ORAL CAPSULE 100 MG, 25 MG..... 93
ENTYVIO..... 344
ENTYVIO PEN..... 344
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG..... 287
EPCLUSA ORAL TABLET..... 287
EPIDIOLEX..... 52
ERIVEDGE..... 352
ERLEADA ORAL TABLET 240 MG, 60 MG..... 19
erlotinib oral tablet 100 mg, 150 mg, 25 mg..... 100
estradiol-norethindrone acet..... 131
everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg..... 103
everolimus (antineoplastic) oral tablet for suspension..... 104
EXEL U100 0.3 ML 29GX1/2"..... 157
EXEL U100 0.3 ML 30GX5/16"..... 157
EXXUA..... 120
FASENRA..... 40
FASENRA PEN..... 40
fentanyl citrate buccal lozenge on a handle 108
FILSPARI..... 296
fingolimod..... 113
FINTEPLA..... 107
FOTIVDA..... 312
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG..... 115
FT STERILE PADS 2" X 2"..... 157
GAUZE PAD TOPICAL BANDAGE 2 X 2 "..... 157
GAVRETO..... 254
gefitinib..... 119
GILOTRIF..... 10
glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml..... 123
glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml..... 123
glutamine (sickle cell)..... 191
glyburide..... 133
glyburide micronized..... 133
glyburide-metformin..... 134
GNP ALCOHOL SWAB STERILE, TWO PLY..... 157
GNP PEN NEEDLE 31G 5MM..... 157
GNP PEN NEEDLE 32G 6MM..... 157
GNP SIMPLI PEN NEEDLE 32G 4MM... 157
GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT..... 157
GNP ULT CMFRT 0.5 ML 29GX1/2"..... 157
GNP ULTR CMFRT 0.5 ML 30GX5/16... 157
GNP ULTRA COMFORT 1 ML SYRINGE..... 157

GNP ULTRA COMFORT 3/10 ML SYR..157
GOMEKLI ORAL CAPSULE 1 MG, 2 MG.....209
GOMEKLI ORAL TABLET FOR SUSPENSION.....209
GS PEN NEEDLE 31G X 8MM.....157
HADLIMA.....9
HADLIMA PUSHTOUCH.....9
HADLIMA(CF).....9
HADLIMA(CF) PUSHTOUCH.....9
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT.....48
HEALTHWISE INS 0.3 ML 30GX5/16".. 157
HEALTHWISE INS 0.3 ML 31GX5/16".. 157
HEALTHWISE INS 0.5 ML 30GX5/16".. 157
HEALTHWISE INS 0.5 ML 31GX5/16".. 157
HEALTHWISE INS 1 ML 30GX5/16"..... 157
HEALTHWISE INS 1 ML 31GX5/16"..... 157
HEALTHWISE PEN NEEDLE 31G 5MM157
HEALTHWISE PEN NEEDLE 31G 8MM157
HEALTHWISE PEN NEEDLE 32G 4MM157
HEALTHY ACCENTS PENTIP 5MM 31G.....157
HEALTHY ACCENTS PENTIP 6MM 31G.....157
HEALTHY ACCENTS PENTIP 8MM 31G.....157
HEALTHY ACCENTS PENTP 12MM 29G.....157
HEB INCONTROL ALCOHOL 70% PADS.....157
HERCEPTIN HYLECTA.....325
HERNEXEOS.....359
HUMIRA PEN.....7
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML.....7
HUMIRA(CF).....7
HUMIRA(CF) PEN.....7
HUMIRA(CF) PEN CROHNS-UC-HS.....7
HUMIRA(CF) PEN PEDIATRIC UC.....7
HUMIRA(CF) PEN PSOR-UV-ADOL HS...7
HYRNUO.....284
IBRANCE.....235
IBTROZI.....303
icatibant.....146
ICLUSIG.....252
IDHIFA.....91
imatinib oral tablet 100 mg, 400 mg.....149
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG.....145
IMBRUVICA ORAL SUSPENSION.....145
IMBRUVICA ORAL TABLET.....145
IMKELDI.....150
IMPAVIDO.....208
INCONTROL PEN NEEDLE 12MM 29G 157
INCONTROL PEN NEEDLE 4MM 32G..157
INCONTROL PEN NEEDLE 5MM 31G..157
INCONTROL PEN NEEDLE 6MM 31G..157
INCONTROL PEN NEEDLE 8MM 31G..157
INCRELEX.....200
indomethacin oral capsule.....141
infliximab.....153
INGREZZA.....342
INGREZZA INITIATION PK(TARDIV)..342
INGREZZA SPRINKLE.....342
INLURIYO.....151
INLYTA ORAL TABLET 1 MG, 5 MG.....32
INQOVI.....69
INREBIC.....106
INSULIN 1 ML SYRINGE.....157
INSULIN 1/2 ML SYRINGE.....157
INSULIN 3/10 ML SYRINGE.....157
INSULIN SYR 0.3 ML 31GX1/4(1/2).....157
INSULIN SYRIN 0.5 ML 28GX1/2" (OTC).....157
INSULIN SYRIN 0.5 ML 29GX1/2" (OTC).....157
INSULIN SYRIN 0.5 ML 30GX1/2" (RX)157
INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC).....157
INSULIN SYRING 0.5 ML 27G 1/2" INNER.....157
INSULIN SYRINGE 0.3 ML.....157
INSULIN SYRINGE 0.3 ML 31GX1/4.....157
INSULIN SYRINGE 0.5 ML.....157
INSULIN SYRINGE 0.5 ML 31GX1/4.....157
INSULIN SYRINGE 1 ML.....157
INSULIN SYRINGE 1 ML 27G 1/2" INNER.....157
INSULIN SYRINGE 1 ML 28GX1/2" (OTC).....157
INSULIN SYRINGE 1 ML 30GX1/2" SHORT NEEDLE (OTC).....157

INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC) 157
INSULIN SYRINGE 1 ML 31GX1/4" 157
INSULIN SYRINGE 1 ML 31GX5/16" SHORT NEEDLE,THIN II (OTC) 157
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE 157
INSULIN U-500 SYRINGE-NEEDLE 157
INSUPEN PEN NEEDLE 29GX1/2" 157
INSUPEN PEN NEEDLE 31G 8MM 157
INSUPEN PEN NEEDLE 31GX3/16" 157
INSUPEN PEN NEEDLE 32G 4MM 157
INSUPEN PEN NEEDLE 32G 6MM (RX) 157
ISTURISA ORAL TABLET 1 MG, 5 MG 232
ITOVEBI ORAL TABLET 3 MG, 9 MG .. 152
IV ANTISEPTIC WIPES 157
IWILFIN 84
JAKAFI 274
JAKAFI XR 274
JASCAYD 213
javygtor oral tablet,soluble 275
JAYPIRCA ORAL TABLET 100 MG, 50 MG 250
JIDEYTRO 357
KALYDECO 172
KENDALL ALCOHOL 70% PREP PAD . 157
KERENDIA 111
KESIMPTA PEN 224
ketorolac oral 135
KEVZARA 277
KEYTRUDA 242
KEYTRUDA QLEX 243
KINERET 17
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 265
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3) 264
KOMZIFTI 358
KOSELUGO ORAL CAPSULE 10 MG, 25 MG 282
KOSELUGO ORAL CAPSULE, SPRINKLE 5 MG, 7.5 MG 282
KRAZATI 6
lanreotide subcutaneous syringe 120 mg/0.5 ml 176
lapatinib 177
LAZCLUZE ORAL TABLET 240 MG, 80 MG 179
lenalidomide 181
LENVIMA 182
LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 360 MG/1.8 ML, 500 MG/2.5 ML (250MG/1.25MLX2) 180
LEUKINE INJECTION RECON SOLN ... 276
leuprolide acetate (3 month) 185
leuprolide subcutaneous kit 184
lidocaine topical adhesive patch,medicated 5 % 193
lidocaine topical ointment 192
lidocaine-prilocaine topical cream 194
lidocan iii 193
LIFYORLI 259
LISCO SPONGES 100/BAG 157
LIVTENCITY 199
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG 329
LORBRENA ORAL TABLET 100 MG, 25 MG 195
LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG 295
LUPRON DEPOT 188
LUPRON DEPOT (3 MONTH) 188
LUPRON DEPOT (4 MONTH) 188
LUPRON DEPOT (6 MONTH) 188
LUPRON DEPOT-PED (3 MONTH) 189
LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT 189
LUTRATE DEPOT (3 MONTH) 185
LYNPARZA 225
LYTGOBI 116
macitentan 198
MAGELLAN INSUL SYRINGE 0.3 ML .. 157
MAGELLAN INSUL SYRINGE 0.5 ML .. 157
MAGELLAN INSULIN SYR 0.3 ML 157
MAGELLAN INSULIN SYR 0.5 ML 157
MAGELLAN INSULIN SYRINGE 1 ML 157
MAXICOMFORT II PEN NDL 31GX6MM 157
MAXICOMFORT INS 0.5 ML 27GX1/2" 157

MAXI-COMFORT INS 0.5 ML 28G.....157
MAXICOMFORT INS 1 ML 27GX1/2"... 157
MAXI-COMFORT INS 1 ML 28GX1/2"..157
MAXICOMFORT PEN NDL 29G X 5MM
..... 157
MAXICOMFORT PEN NDL 29G X 8MM
..... 157
megestrol 400 mg/10 ml susp cup outer..... 142
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml).....142
megestrol oral tablet.....142
MEKINIST ORAL RECON SOLN..... 322
MEKINIST ORAL TABLET 0.5 MG, 2 MG.....323
MEKTOVI.....43
metyrosine.....203
MICRODOT PEN NEEDLE 31GX6MM..157
MICRODOT PEN NEEDLE 32GX4MM..157
MICRODOT PEN NEEDLE 33GX4MM..157
MICRODOT READYGARD NDL 31G 5MM OUTER.....157
mifepristone oral tablet 300 mg..... 206
mimvey.....131
MINI PEN NEEDLE 32G 5MM.....157
MINI PEN NEEDLE 32G 8MM.....157
MINI PEN NEEDLE 33G 5MM.....157
MINI PEN NEEDLE 33G 6MM.....157
MINI ULTRA-THIN II PEN NDL 31G STERILE..... 157
modafinil oral tablet 100 mg, 200 mg..... 210
MODEYSO..... 79
MONOJECT 0.5 ML SYRN 28GX1/2".....157
MONOJECT 1 ML SYRN 27X1/2".....157
MONOJECT 1 ML SYRN 28GX1/2" (OTC).....157
MONOJECT INSUL SYR U100 (OTC)....157
MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC).....157
MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)..... 157
MONOJECT INSUL SYR U100 1 ML..... 157
MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC).....157
MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)..... 157
MONOJECT INSULIN SYR 0.3 ML..... 157
MONOJECT INSULIN SYR 0.3 ML (OTC).....157
MONOJECT INSULIN SYR 0.5 ML..... 157
MONOJECT INSULIN SYR 0.5 ML (OTC).....157
MONOJECT INSULIN SYR 1 ML 3'S (OTC).....157
MONOJECT INSULIN SYR U-100.....157
MONOJECT SYRINGE 0.3 ML.....157
MONOJECT SYRINGE 0.5 ML.....157
MONOJECT SYRINGE 1 ML.....157
morphine concentrate oral solution..... 212
MOUNJARO.....126
NANO 2 GEN PEN NEEDLE 32G 4MM. 157
NANO PEN NEEDLE 32G 4MM.....157
NAYZILAM.....204
NERLYNX..... 214
NIKTIMVO INTRAVENOUS SOLUTION 10 MG/ML.....31
nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg..... 215
NINLARO..... 174
nintedanib.....217
nitisinone..... 221
NIVESTYM.....110
NORDITROPIN FLEXPRO..... 289
NOVOFINE 32G NEEDLES..... 157
NOVOFINE AUTOCOVER 30G NEEDLE.....157
NOVOFINE PLUS PEN NDL 32GX1/6"..157
NUBEQA.....67
NUCALA SUBCUTANEOUS AUTO-INJECTOR..... 202
NUCALA SUBCUTANEOUS RECON SOLN.....202
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML..... 202
NUPLAZID..... 248
NURTEC ODT.....268
NYVEPRIA.....238
ODOMZO.....291
OFEV.....217
OGIVRI..... 324
OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG..... 220
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION.....321

OJEMDA ORAL TABLET 321
OJJAARA 211
OMLYCLO 229
ONAPGO 20
ONUREG 33
OPDIVO 222
OPDIVO QVANTIG 223
ORFADIN ORAL SUSPENSION 221
ORGOVYX 260
ORILISSA ORAL TABLET 150 MG, 200 MG 86
ORKAMBI ORAL TABLET 197
ORSERDU ORAL TABLET 345 MG, 86 MG 85
OSENVELT 72
OTEZLA 21
OTEZLA STARTER 21
OTEZLA XR 21
OTEZLA XR INITIATION 21
OTULFI 333, 335
OZEMPIC ORAL 125
OZEMPIC SUBCUTANEOUS 125
paroxetine hcl 143
pazopanib oral tablet 200 mg, 400 mg 237
PEGASYS 240
PEMAZYRE 244
PEN NEEDLE 30G 5MM OUTER 157
PEN NEEDLE 30G 8MM INNER 157
PEN NEEDLE 30G X 5/16" 157
PEN NEEDLE 31G X 1/4" HRI 157
PEN NEEDLE 33G 4MM 157
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2" 157
PEN NEEDLES 12MM 29G 29GX12MM,STRL 157
PEN NEEDLES 4MM 32G 157
PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC) 157
PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC) 157
penicillamine oral tablet 245
PENTIPS PEN NEEDLE 29G 1/2" 157
PENTIPS PEN NEEDLE 31G 1/4" 157
PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM 157
PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM 157
PENTIPS PEN NEEDLE 32G 1/4" 157
PENTIPS PEN NEEDLE 32GX5/32" 157
phenobarbital 136
PIP PEN NEEDLE 31G X 5MM 157
PIP PEN NEEDLE 32G X 4MM 157
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) 12
pirfenidone oral capsule 249
pirfenidone oral tablet 267 mg, 534 mg, 801 mg 249
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML 169
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML 169
pomalidomide 251
POMALYST 251
posaconazole oral tablet,delayed release (dr/ec) 253
PREMPHASE 132
PREMPRO 132
PREVENT PEN NEEDLE 31GX1/4" 157
PREVENT PEN NEEDLE 31GX5/16" 157
PREVYMIS ORAL TABLET 183
PRO COMFORT 0.5 ML 30GX1/2" 157
PRO COMFORT 0.5 ML 30GX5/16" 157
PRO COMFORT 0.5 ML 31GX5/16" 157
PRO COMFORT 1 ML 30GX1/2" 157
PRO COMFORT 1 ML 30GX5/16" 157
PRO COMFORT 1 ML 31GX5/16" 157
PRO COMFORT ALCOHOL 70% PADS 157
PRO COMFORT PEN NDL 32G 8MM 157
PRO COMFORT PEN NDL 32G X 1/4" ... 157
PRO COMFORT PEN NDL 4MM 32G 157
PRO COMFORT PEN NDL 5MM 32G 157
PRO-COMFORT ALCOHOL 70% PADS 157
PRODIGY INS SYR 1 ML 28GX1/2" 157
PRODIGY SYRNG 0.5 ML 31GX5/16" ... 157
PRODIGY SYRNGE 0.3 ML 31GX5/16" . 157
promethazine oral tablet 137
PURE CMFT SFTY PEN NDL 31G 5MM 157
PURE CMFT SFTY PEN NDL 31G 6MM 157
PURE CMFT SFTY PEN NDL 32G 4MM 157

PURE COMFORT ALCOHOL 70% PADS 157
PURE COMFORT PEN NDL 32G 4MM .. 157
PURE COMFORT PEN NDL 32G 5MM .. 157
PURE COMFORT PEN NDL 32G 6MM .. 157
PURE COMFORT PEN NDL 32G 8MM .. 157
pyrimethamine 255
QINLOCK 270
quinine sulfate 256
QULIPTA 27
RA ISOPROPYL ALCOHOL 70% WIPES 157
RA STERILE PADS 2"X 2" 157
RALDESY 326
RASONQUE 66
RAYA SURE PEN NEEDLE 29G 12MM . 157
RAYA SURE PEN NEEDLE 31G 4MM ... 157
RAYA SURE PEN NEEDLE 31G 5MM ... 157
RAYA SURE PEN NEEDLE 31G 6MM ... 157
RELION INS SYR 0.3 ML 31GX6MM 157
RELION INS SYR 0.5 ML 31GX6MM 157
RELION INS SYR 1 ML 31GX15/64" 157
RELION PEN NEEDLE 32GX5/32" 157
RELION SYRING 0.3 ML 31GX5/16" INNER 157
RELION SYRING 0.5 ML 31GX5/16" INNER (OTC) 157
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML 97
RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG 281
REVCOVI 88
REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG 263
REZDIFFRA 262
REZLIDHIA 227
REZUROCK 37
RINVOQ 332
RINVOQ LQ 332
ROMVIMZA 351
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG 94
ROZLYTREK ORAL PELLETS IN PACKET 95
RUBRACA 273
RYBELSUS 125
RYBREVANT 16
RYBREVANT FASPRO 15
RYDAPT 205
SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10 157
SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10 157
SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10 157
SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10 157
SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10 157
SAFETY PEN NEEDLE 31G 4MM 157
SAFETY PEN NEEDLE 5MM X 31G 157
SAFETY SYRINGE 0.5 ML 30G 1/2" 157
SAPHNELO PEN 18
sapropterin oral tablet,soluble 275
SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG 23
scopolamine base 139
SECURESAFE PEN NDL 30GX5/16" OUTER 157
SECURESAFE PEN NEEDLE 31G 5MM OUTER 157
SECURESAFE SYR 0.5 ML 29G 1/2" OUTER 157
SECURESAFE SYRNG 1 ML 29G 1/2" OUTER 157
SELARSDI 336, 338
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG 290
SIGNIFOR 236
sildenafil (pulm.hypertension) oral tablet .. 285
SIRTURO 35
SKY SAFETY PEN NEEDLE 30G 5MM . 157
SKY SAFETY PEN NEEDLE 30G 8MM . 157
SKYRIZI 271
sodium oxybate 286
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 60 MG/0.2 ML, 90 MG/0.3 ML 176
SOMAVERT 241
sorafenib 293
STIVARGA 258

STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML 24
SUBVENITE ORAL SUSPENSION 175
sunitinib malate 298
SURE CMFT SFTY PEN NDL 31G 6MM 157
SURE CMFT SFTY PEN NDL 32G 4MM 157
SURE COMFORT 0.5 ML SYRINGE 157
SURE COMFORT 1 ML SYRINGE 157
SURE COMFORT 3/10 ML SYRINGE 157
SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE 157
SURE COMFORT 30G PEN NEEDLE 157
SURE COMFORT ALCOHOL PREP PADS 157
SURE COMFORT INS 0.3 ML 31GX1/4 . 157
SURE COMFORT INS 0.5 ML 31GX1/4 . 157
SURE COMFORT INS 1 ML 31GX1/4" ... 157
SURE COMFORT PEN NDL 29GX1/2" 12.7MM 157
SURE COMFORT PEN NDL 31G 5MM .. 157
SURE COMFORT PEN NDL 31G 8MM .. 157
SURE COMFORT PEN NDL 32G 4MM .. 157
SURE COMFORT PEN NDL 32G 6MM .. 157
SURE-FINE PEN NEEDLES 12.7MM 157
SURE-FINE PEN NEEDLES 5MM 157
SURE-FINE PEN NEEDLES 8MM 157
SURE-JECT INSU SYR U100 0.3 ML 157
SURE-JECT INSU SYR U100 0.5 ML 157
SURE-JECT INSU SYR U100 1 ML 157
SURE-JECT INSUL SYR U100 1 ML 157
SURE-JECT INSULIN SYRINGE 1 ML .. 157
SURE-PREP ALCOHOL PREP PADS 157
SYMPAZAN 57
TABRECTA 54
tadalafil oral tablet 2.5 mg, 5 mg 300
TAFINLAR ORAL CAPSULE 62
TAFINLAR ORAL TABLET FOR SUSPENSION 63
TAGRISSO 233
TALZENNA 302
TARPEYO 47
TAVNEOS 28
TECHLITE 0.3 ML 29GX12MM (1/2) 157
TECHLITE 0.3 ML 30GX8MM (1/2) 157
TECHLITE 0.3 ML 31GX6MM (1/2) 157
TECHLITE 0.3 ML 31GX8MM (1/2) 157
TECHLITE 0.5 ML 30GX12MM (1/2) 157
TECHLITE 0.5 ML 30GX8MM (1/2) 157
TECHLITE 0.5 ML 31GX6MM (1/2) 157
TECHLITE 0.5 ML 31GX8MM (1/2) 157
TECHLITE INS SYR 1 ML 29GX12MM . 157
TECHLITE INS SYR 1 ML 30GX12MM . 157
TECHLITE INS SYR 1 ML 31GX6MM ... 157
TECHLITE INS SYR 1 ML 31GX8MM ... 157
TECHLITE PEN NEEDLE 29GX1/2" 157
TECHLITE PEN NEEDLE 29GX3/8" 157
TECHLITE PEN NEEDLE 31GX1/4" 157
TECHLITE PEN NEEDLE 31GX3/16" 157
TECHLITE PEN NEEDLE 31GX5/16" 157
TECHLITE PEN NEEDLE 32GX1/4" 157
TECHLITE PEN NEEDLE 32GX5/16" 157
TECHLITE PEN NEEDLE 32GX5/32" 157
TECHLITE PLUS PEN NDL 32G 4MM ... 157
TEPMETKO 305
teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml) 306
TERUMO INS SYRINGE U100-1 ML 157
TERUMO INS SYRINGE U100-1/2 ML .. 157
TERUMO INS SYRINGE U100-1/3 ML .. 157
TERUMO INS SYRNG U100-1/2 ML 157
testosterone cypionate 308
testosterone enanthate 309
testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %) 307
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram) 307
tetrabenazine 310
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG 311
THINPRO INS SYRIN U100-0.3 ML 157
THINPRO INS SYRIN U100-0.5 ML 157
THINPRO INS SYRIN U100-1 ML 157
TIBSOVO 173
tofacitinib 317
tolvaptan (polycys kidney dis) oral tablet ... 319
tolvaptan (polycys kidney dis) oral tablets, sequential 319
TOPFINE INSULN PEN NDL 32G 4MM 157
torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg 103
TREMFYA INTRAVENOUS 127
TREMFYA ONE-PRESS 127

TREMFYA PEN INDUCTION PK(2PEN) 127
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML 127
TREMFYA SUBCUTANEOUS SYRINGE 127
tretinoin topical cream 320
trientine oral capsule 250 mg 328
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL 89
TRIKAFTA ORAL TABLETS, SEQUENTIAL 89
TRUE CMFRT PRO 0.5 ML 30G 5/16" 157
TRUE CMFRT PRO 0.5 ML 31G 5/16" 157
TRUE CMFRT PRO 0.5 ML 32G 5/16" 157
TRUE CMFT SFTY PEN NDL 31G 5MM 157
TRUE CMFT SFTY PEN NDL 31G 6MM 157
TRUE CMFT SFTY PEN NDL 32G 4MM 157
TRUE COMFORT 0.5 ML 30G 1/2" 157
TRUE COMFORT 0.5 ML 30G 5/16" 157
TRUE COMFORT 0.5 ML 31G 5/16" 157
TRUE COMFORT 0.5 ML 31GX5/16" 157
TRUE COMFORT 1 ML 31GX5/16" 157
TRUE COMFORT ALCOHOL 70% PADS 157
TRUE COMFORT PEN NDL 31G 8MM .. 157
TRUE COMFORT PEN NDL 31GX5MM 157
TRUE COMFORT PEN NDL 31GX6MM 157
TRUE COMFORT PEN NDL 32G 5MM .. 157
TRUE COMFORT PEN NDL 32G 6MM .. 157
TRUE COMFORT PEN NDL 32GX4MM 157
TRUE COMFORT PEN NDL 33G 4MM .. 157
TRUE COMFORT PEN NDL 33G 5MM .. 157
TRUE COMFORT PEN NDL 33G 6MM .. 157
TRUE COMFORT PRO 1 ML 30G 1/2" ... 157
TRUE COMFORT PRO 1 ML 30G 5/16" . 157
TRUE COMFORT PRO 1 ML 31G 5/16" . 157
TRUE COMFORT PRO 1 ML 32G 5/16" . 157
TRUE COMFORT PRO ALCOHOL PADS 157
TRUE COMFORT SFTY 1 ML 30G 1/2" . 157
TRUE COMFRT PRO 0.5 ML 30G 1/2" ... 157
TRUE COMFRT SFTY 1 ML 30G 5/16" .. 157
TRUE COMFRT SFTY 1 ML 31G 5/16" .. 157
TRUE COMFRT SFTY 1 ML 32G 5/16" .. 157
TRUE-CMFRT PRO PEN NDL 31G 5MM 157
TRUE-CMFRT PRO PEN NDL 31G 6MM 157
TRUE-CMFRT PRO PEN NDL 31G 8MM 157
TRUE-CMFRT PRO PEN NDL 32G 4MM 157
TRUEPLUS PEN NEEDLE 29GX1/2" 157
TRUEPLUS PEN NEEDLE 31G X 1/4" ... 157
TRUEPLUS PEN NEEDLE 31GX3/16" ... 157
TRUEPLUS PEN NEEDLE 31GX5/16" ... 157
TRUEPLUS PEN NEEDLE 32GX5/32" ... 157
TRUEPLUS SYR 0.3 ML 29GX1/2" 157
TRUEPLUS SYR 0.3 ML 30GX5/16" 157
TRUEPLUS SYR 0.3 ML 31GX5/16" 157
TRUEPLUS SYR 0.5 ML 28GX1/2" 157
TRUEPLUS SYR 0.5 ML 29GX1/2" 157
TRUEPLUS SYR 0.5 ML 30GX5/16" 157
TRUEPLUS SYR 0.5 ML 31GX5/16" 157
TRUEPLUS SYR 1 ML 28GX1/2" 157
TRUEPLUS SYR 1 ML 29GX1/2" 157
TRUEPLUS SYR 1 ML 30GX5/16" 157
TRUEPLUS SYR 1 ML 31GX5/16" 157
TRULICITY 124
TRUQAP 53
TRYNGOLZA 226
TUKYSA ORAL TABLET 150 MG, 50 MG 330
TURALIO 247
TYENNE 313, 315
TYENNE AUTOINJECTOR 315
TYMLOS 1
UBRELVY 331
UDENYCA ONBODY 239
ULT CFT 0.3 ML 31GX5/16" (1/2) 1/2 UNIT 157
ULTICAR INS 0.3 ML 31GX1/4(1/2) 157
ULTICARE INS 0.3 ML 31GX1/4" 157
ULTICARE INS 0.5 ML 31GX1/4" 157
ULTICARE INS 1 ML 31GX1/4" 157
ULTICARE INS SYR 1 ML 30GX1/2" 157
ULTICARE PEN NEEDLE 31GX3/16" 157
ULTICARE PEN NEEDLE 6MM 31G 157
ULTICARE PEN NEEDLE 8MM 31G 157
ULTICARE PEN NEEDLES 12MM 29G . 157

ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM 157
ULTICARE PEN NEEDLES 6MM 32G ... 157
ULTICARE SAFE PEN NDL 30G 8MM .. 157
ULTICARE SAFE PEN NDL 5MM 30G .. 157
ULTICARE SYR 0.3 ML 30GX1/2" 157
ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL 157
ULTICARE SYR 0.5 ML 30GX1/2" 157
ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL 157
ULTICARE SYR 1 ML 31GX5/16" 157
ULTIGUARD SAFE 1 ML 30G 12.7MM . 157
ULTIGUARD SAFE0.3 ML 30G 12.7MM 157
ULTIGUARD SAFE0.5 ML 30G 12.7MM 157
ULTIGUARD SAFEPACK 1 ML 31G 8MM 157
ULTIGUARD SAFEPACK 29G 12.7MM 157
ULTIGUARD SAFEPACK 31G 5MM 157
ULTIGUARD SAFEPACK 31G 6MM 157
ULTIGUARD SAFEPACK 31G 8MM 157
ULTIGUARD SAFEPACK 32G 4MM 157
ULTIGUARD SAFEPACK 32G 6MM 157
ULTIGUARD SAFEPK 0.3 ML 31G 8MM 157
ULTIGUARD SAFEPK 0.5 ML 31G 8MM 157
ULTILET ALCOHOL STERL SWAB 157
ULTILET INSULIN SYRINGE 0.3 ML ... 157
ULTILET INSULIN SYRINGE 0.5 ML ... 157
ULTILET INSULIN SYRINGE 1 ML 157
ULTILET PEN NEEDLE 157
ULTILET PEN NEEDLE 4MM 32G 157
ULTRA COMFORT 0.3 ML 29GX1/2" 157
ULTRA COMFORT 0.3 ML SYRINGE ... 157
ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G 157
ULTRA COMFORT 0.5 ML 29GX1/2" 157
ULTRA COMFORT 0.5 ML 31GX5/16" .. 157
ULTRA COMFORT 0.5 ML SYRINGE ... 157
ULTRA COMFORT 1 ML 29GX1/2" 157
ULTRA COMFORT 1 ML 30GX5/16" 157
ULTRA COMFORT 1 ML 31GX5/16" 157
ULTRA COMFORT 1 ML SYRINGE 157
ULTRA FLO 0.3 ML 30G 1/2" (1/2) 157
ULTRA FLO 0.3 ML 30G 5/16"(1/2) 157
ULTRA FLO 0.3 ML 31G 5/16"(1/2) 157
ULTRA FLO PEN NEEDLE 31G 5MM ... 157
ULTRA FLO PEN NEEDLE 31G 8MM ... 157
ULTRA FLO PEN NEEDLE 32G 4MM ... 157
ULTRA FLO PEN NEEDLE 33G 4MM ... 157
ULTRA FLO PEN NEEDLES 12MM 29G 157
ULTRA FLO SYR 0.3 ML 29GX1/2" 157
ULTRA FLO SYR 0.3 ML 30G 5/16" 157
ULTRA FLO SYR 0.3 ML 31G 5/16" 157
ULTRA FLO SYR 0.5 ML 29G 1/2" 157
ULTRA THIN PEN NDL 32G X 4MM 157
ULTRACARE INS 0.3 ML 30GX5/16" 157
ULTRACARE INS 0.3 ML 31GX5/16" 157
ULTRACARE INS 0.5 ML 30GX1/2" 157
ULTRACARE INS 0.5 ML 30GX5/16" 157
ULTRACARE INS 0.5 ML 31GX5/16" 157
ULTRACARE INS 1 ML 30G X 5/16" 157
ULTRACARE INS 1 ML 30GX1/2" 157
ULTRACARE INS 1 ML 31G X 5/16" 157
ULTRACARE PEN NEEDLE 31GX1/4" .. 157
ULTRACARE PEN NEEDLE 31GX3/16" 157
ULTRACARE PEN NEEDLE 31GX5/16" 157
ULTRACARE PEN NEEDLE 32GX1/4" .. 157
ULTRACARE PEN NEEDLE 32GX3/16" 157
ULTRACARE PEN NEEDLE 32GX5/32" 157
ULTRACARE PEN NEEDLE 33GX5/32" 157
ULTRA-FINE 0.3 ML 30G 12.7MM 157
ULTRA-FINE 0.3 ML 31G 6MM (1/2) 157
ULTRA-FINE 0.3 ML 31G 8MM (1/2) 157
ULTRA-FINE 0.5 ML 30G 12.7MM 157
ULTRA-FINE INS 0.5 ML 31G 6MM 157
ULTRA-FINE INS SYR 1 ML 31G 6MM 157
ULTRA-FINE INS SYR 1 ML 31G 8MM 157
ULTRA-FINE PEN NDL 29G 12.7MM 157
ULTRA-FINE PEN NEEDLE 31G 5MM .. 157
ULTRA-FINE PEN NEEDLE 31G 8MM .. 157
ULTRA-FINE PEN NEEDLE 32G 6MM .. 157
ULTRA-FINE SYR 0.3 ML 31G 6MM 157
ULTRA-FINE SYR 0.3 ML 31G 8MM 157
ULTRA-FINE SYR 0.5 ML 31G 6MM 157
ULTRA-FINE SYR 0.5 ML 31G 8MM 157
ULTRA-FINE SYR 1 ML 30G 12.7MM ... 157
ULTRA-THIN II 1 ML 31GX5/16" 157
ULTRA-THIN II INS 0.3 ML 30G 157
ULTRA-THIN II INS 0.3 ML 31G 157

ULTRA-THIN II INS 0.5 ML 29G..... 157
ULTRA-THIN II INS 0.5 ML 30G..... 157
ULTRA-THIN II INS 0.5 ML 31G..... 157
ULTRA-THIN II INS SYR 1 ML 29G..... 157
ULTRA-THIN II INS SYR 1 ML 30G..... 157
ULTRA-THIN II PEN NDL 29GX1/2"..... 157
ULTRA-THIN II PEN NDL 31GX5/16..... 157
UNIFINE OTC PEN NEEDLE 31G 5MM 157
UNIFINE OTC PEN NEEDLE 32G 4MM 157
UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL..... 157
UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI..... 157
UNIFINE PENTIPS 32G 4MM..... 157
UNIFINE PENTIPS 32GX1/4"..... 157
UNIFINE PENTIPS 33GX5/32"..... 157
UNIFINE PENTIPS 6MM 31G..... 157
UNIFINE PENTIPS 8MM 31G 31GX8MM, SHORT, STRL..... 157
UNIFINE PENTIPS MAX 30GX3/16"..... 157
UNIFINE PENTIPS PLUS 29GX1/2" 12MM..... 157
UNIFINE PENTIPS PLUS 30GX3/16"..... 157
UNIFINE PENTIPS PLUS 31G 5MM..... 157
UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM..... 157
UNIFINE PENTIPS PLUS 32GX5/32"..... 157
UNIFINE PENTIPS PLUS 33GX5/32"..... 157
UNIFINE PROTECT 30G 5MM..... 157
UNIFINE PROTECT 30G 8MM..... 157
UNIFINE PROTECT 32G 4MM..... 157
UNIFINE SAFECONTROL 30G 5MM..... 157
UNIFINE SAFECONTROL 30G 8MM..... 157
UNIFINE SAFECONTROL 31G 5MM..... 157
UNIFINE SAFECONTROL 31G 6MM..... 157
UNIFINE SAFECONTROL 31G 8MM..... 157
UNIFINE SAFECONTROL 32G 4MM..... 157
UNIFINE ULTR PEN NDL 34G 3.5MM.. 157
UNIFINE ULTRA PEN NDL 29G 12MM 157
UNIFINE ULTRA PEN NDL 31G 5MM.. 157
UNIFINE ULTRA PEN NDL 31G 6MM.. 157
UNIFINE ULTRA PEN NDL 31G 8MM.. 157
UNIFINE ULTRA PEN NDL 32G 4MM.. 157
UNIFINE ULTRA PEN NDL 32G 6MM.. 157
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 100 MCG, 150 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG..... 279
UPTRAVI ORAL TABLETS,DOSE PACK..... 279
VALCHLOR..... 201
VALTOCO..... 74
VANFLYTA..... 257
VANISHPOINT 0.5 ML 30GX1/2" SY OUTER..... 157
VANISHPOINT INS 0.5 ML 30G 8MM OUTER..... 157
VANISHPOINT INS 1 ML 30GX3/16"..... 157
VANISHPOINT U-100 29X1/2 SYR..... 157
VELSIPITY..... 102
VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG..... 347
VENCLEXTA STARTING PACK..... 347
VEOZAH..... 109
VEPPANU..... 348
VERIFINE INS SYR 1 ML 29G 1/2"..... 157
VERIFINE PEN NEEDLE 29G 12MM..... 157
VERIFINE PEN NEEDLE 31G 5MM..... 157
VERIFINE PEN NEEDLE 31G X 6MM... 157
VERIFINE PEN NEEDLE 31G X 8MM... 157
VERIFINE PEN NEEDLE 32G 6MM..... 157
VERIFINE PEN NEEDLE 32G X 4MM... 157
VERIFINE PEN NEEDLE 32G X 5MM... 157
VERIFINE PLUS PEN NDL 31G 5MM... 157
VERIFINE PLUS PEN NDL 31G 8MM... 157
VERIFINE PLUS PEN NDL 32G 4MM... 157
VERIFINE PLUS PEN NDL 32G 4MM-SHARPS CONTAINER..... 157
VERIFINE SYRING 0.5 ML 29G 1/2"..... 157
VERIFINE SYRING 1 ML 31G 5/16"..... 157
VERIFINE SYRNG 0.3 ML 31G 5/16"..... 157
VERIFINE SYRNG 0.5 ML 31G 5/16"..... 157
VERQUVO..... 349
VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY..... 157
VERZENIO..... 2
vigabatrin..... 350
vigadrone..... 350
vigpoder..... 350
VITRAKVI ORAL CAPSULE 100 MG, 25 MG..... 178

VITRAKVI ORAL SOLUTION 178
VIZIMPRO 64
VONJO 234
VOQUEZNA 353
VORANIGO 354
voriconazole oral suspension for reconstitution 355
VOSEVI 288
VOWST 105
VUMERITY 78
VYALEV 114
VYNDAMAX 301
WEBCOL ALCOHOL PREPS 20'S,LARGE 157
WEGOVY ORAL 283
WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML 283
WELIREG 38
WINREVAIR 294
WM UNIFINE PENTIP PLUS 8MM 31G W/ SAFETY CLICK 157
XALKORI ORAL CAPSULE 60
XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG 61
XDEMVY 196
XERMELO 304
XIFAXAN ORAL TABLET 200 MG, 550 MG 266
XOLAIR 228
XOSPATA 121
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK) 280
XTANDI ORAL CAPSULE 96
XTANDI ORAL TABLET 40 MG, 80 MG 96
YESINTEK 339, 341
YONSA 4
yulithira oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg 103
YUTREPIA 327
ZEJULA 218
ZELBORAF 346
ZENBEXUS 144
ZTALMY 118
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG 360
ZYDELIG 148
ZYKADIA 56
ZYMFENTRA 155