

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

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**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 կյտեր: Չանգահարեք **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 ដូចជាឯកសារសរសេរជាអក្សរធំ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ព ក៏អាចរកបានផងដែរ។ 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**). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ໃຫ້ໂທຫາເບີ **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 hlou 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**). ਅਪਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬੋਲ 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 serbisyon ng 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.

**2026 Alameda Medicare**  
**2026 Prior Authorization Criteria**  
CURRENT AS OF 01/01/2026

## ACITRETIN

### Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a dermatologist or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For prophylaxis of skin cancer in patients with previously treated skin cancers who have undergone an organ transplantation the request will be approved. For psoriasis: the patient has documented trial of, contraindication to, or medical reason for not using at least 2 of the treatment options listed: topical steroids, tazarotene, methotrexate, and cyclosporine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ACL INHIBITORS

## Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years or older
Prescriber Restrictions	Prescriber must be a cardiologist or specialist in the treatment of lipid disorders
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C), 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin. In addition to the initial criteria above if the new start is for the diagnosis of hyperlipidemia, the following are required: 1) Member has a diagnosis of heterozygous familial hypercholesterolemia (FH) OR primary hyperlipidemia, 2) Member has tried ezetimibe at a maximum tolerated dose and LDL-C is not at goal, or documentation has been provided that the patient is not able to tolerate ezetimibe. In addition to the initial criteria above if the new start is for cardiovascular risk reduction, the following are required: 1) Member has established cardiovascular disease (documented history of coronary artery disease, symptomatic peripheral artery disease, and/or cerebrovascular atherosclerotic disease, 2) Member does not have established cardiovascular disease but is considered high risk (one of the following): Diabetes Mellitus (Type 1 or Type 2) in females over 65 years of age or males over 60 years of age OR a Reynolds Risk score greater than 30% or a SCORE Risk score greater than 7.5% over 10 years OR a coronary artery calcium score greater than 400 Agaston units at any time in the past, 3) Member has a fasting LDL-C greater than or equal to 70 mg/dL. For

<b>PA Criteria</b>	<b>Criteria Details</b>
	continuation of therapy or reauthorization requests for all indications: Documentation provided that the member has obtained clinical benefit from medication (e.g., LDL-C lowering from baseline)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ACTEMRA

## Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For pJIA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For sJIA, Giant Cell Arteritis and Systemic Sclerosis-Associated Interstitial Lung Disease: Approve
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ADALIMUMAB

## Products Affected

- *adalimumab-fkjp (2 pen)*
- *adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml*
- SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML
- SIMLANDI (1 SYRINGE)
- SIMLANDI (2 PEN)
- SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen. For Crohns Disease: Trial of, medical reason for not using (i.e. severe Crohns disease), or contraindication to 1 of the following: mercaptopurine, azathioprine, sulfasalazine, methotrexate injection or corticosteroid (e.g., prednisone, methylprednisolone). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine), azathioprine or a corticosteroid (i.e. prednisone, methylprednisolone). For PsA, psoriasis, Hidradenitis Suppurativa, or Uveitis: approve.
Indications	All Medically-accepted Indications.



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ADEMPAS

## Products Affected

- ADEMPAS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with Phosphodiesterase Inhibitors used for Pulmonary Hypertension or Other Soluble Guanylate Cyclase Stimulators.
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1)- Initial: [Note: documentation required] (1) PAH was confirmed by right heart catheterization AND (2) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg AND (3) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND (4) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. Continuation of therapy: patient has positive clinical response to treatment. Chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) - Initial: [Note: documentation required] (1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA) OR (2) patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. Continuation of therapy: patient has positive clinical response to treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ALPHA-1 PROTEINASE INHIBITORS

## Products Affected

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG
- GLASSIA
- PROLASTIN-C INTRAVENOUS SOLUTION
- ZEMAIRA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of hereditary alpha1-antitrypsin deficiency as evident by pretreatment serum AAT levels below 11 micromol/L and progressive FEV1 or FVC decline demonstrating symptomatic lung disease.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for Glassia or Aralast NP, the patient has a documented medical reason (such as trial, intolerance or contraindication) for not using Prolastin-C or Zemaira to treat their medical condition.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ALYFTREK

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with Trikafta, Kalydeco, Orkambi, or Symdeko. Patients with unknown CFTR gene mutations.
<b>Required Medical Information</b>	Documentation of CFTR gene that is responsive to vanzacaftor-tezacaftor-deutivacaftor treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a provider who specializes in treatment of CF.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Cystic Fibrosis (CF) - Initial: patient must have at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive to the requested medication. Continuation of therapy: approve.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# AMBRISENTAN

## Products Affected

- ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1)- Initial: [Note: documentation required] (1) PAH was confirmed by right heart catheterization AND (2) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg AND (3) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND (4) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. Continuation of therapy: patient has positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# ANTINEOPLASTIC AGENTS

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## Products Affected

- *abiraterone acetate*
- ABIRTEGA
- AKEEGA
- ALECENSA
- ALUNBRIG
- AUGTYRO
- AVMAPKI FAKZYNJA CO-PACK
- AYVAKIT
- BALVERSA
- *bexarotene*
- BOSULIF
- BRAFTOVI ORAL CAPSULE 75 MG
- BRUKINSA
- CABOMETYX
- CALQUENCE ORAL TABLET
- CAPRELSA
- COMETRIQ (100 MG DAILY DOSE)  
ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE)  
ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)
- COPIKTRA
- COTELLIC
- DANZITEN
- *dasatinib*
- DAURISMO
- ENSACOVE
- ERIVEDGE
- ERLEADA
- *erlotinib hcl*
- EULEXIN
- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble*
- FOTIVDA
- FRUZAQLA
- GAVRETO
- *gefitinib*
- GILOTRIF
- GOMEKLI
- IBRANCE
- IBTROZI
- ICLUSIG
- IDHIFA
- *imatinib mesylate oral*
- IMKELDI
- INLYTA
- INQOVI
- INREBIC
- ITOVEBI
- IWILFIN
- JAYPIRCA
- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KOSELUGO
- KRAZATI
- *lapatinib ditosylate*
- LAZCLUZE
- *lenalidomide*
- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)
- LEUKERAN
- LONSURF
- LORBRENA
- LUMAKRAS
- LYNPARZA ORAL TABLET
- LYTGobi (12 MG DAILY DOSE)
- LYTGobi (16 MG DAILY DOSE)
- LYTGobi (20 MG DAILY DOSE)
- MEKINIST
- MEKTOVI
- *mercaptopurine oral suspension*
- NERLYNX
- *nilotinib d-tartrate*
- *nilotinib hcl*

Formulary ID 26313

Last Updated: 09/2025

- *nilutamide*
- NINLARO
- NUBEQA
- ODOMZO
- OGSIVEO
- OJEMDA
- OJJAARA
- ONUREG
- ORGOVYX
- ORSERDU
- *pazopanib hcl*
- PEMAZYRE
- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)
- POMALYST
- QINLOCK
- RETEVMO ORAL TABLET
- REVLIMID
- REVUFORJ
- REZLIDHIA
- ROMVIMZA
- ROZLYTREK
- RUBRACA
- RYDAPT
- SCEMBLIX
- SOLTAMOX
- *sorafenib tosylate*
- STIVARGA
- *sunitinib malate*
- TABLOID
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA
- TAZVERIK
- TEPMETKO
- THALOMID ORAL CAPSULE 100 MG, 50 MG
- TIBSOVO
- *toremifene citrate*
- *tretinoin oral*
- TRUQAP
- TUKYSA
- TURALIO ORAL CAPSULE 125 MG
- VANFLYTA
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI
- VIZIMPRO
- VONJO
- VORANIGO
- WELIREG
- XALKORI
- XOSPATA
- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 40 MG
- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (80 MG TWICE WEEKLY)
- XTANDI
- YONSA
- ZEJULA ORAL TABLET
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be an oncologist or specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No



# APOMORPHINE

## Products Affected

- apomorphine hcl subcutaneous*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with serotonin 5-HT3 receptor antagonists.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If diagnosis is Parkinson's, the patient must have a documented trial of, contraindication to, or medical reason for not using two alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# AQNEURSA

## Products Affected

- AQNEURSA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) The member has a documented diagnosis of Niemann-Pick disease type C (NPC) AND 2) Documentation of genetic testing identifying disease-causing alleles in NPC1 or NPC2 AND 3) Documentation of disease-related neurological symptoms (e.g., developmental delay/regression, ataxia, cataplexy, seizures, motor-function decline, tremors, dysphagia) For reauthorization: Documentation that member has had positive response to therapy (e.g., stabilization in neurological status, decrease in functional Scale for Assessment and Rating of Ataxia [fSARA] score).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# ARCALYST

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## Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For deficiency of interleukin-1 receptor antagonist, documented trial of, contraindication to, or medical reason for not using Kineret. For continuation of therapy or reauthorization: Documentation has been provided that patient has clinically benefited from medication.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ARIKAYCE

## Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Mycobacterium avium complex (MAC): (1) Documented diagnosis of MAC lung disease as verified by failure to achieve at least 2 negative sputum cultures following 6 consecutive months of a combination antibacterial drug regimen AND (2) Provider attestation that medication is being used as part of a combination antibacterial drug regimen.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or an infectious disease specialist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# ARISTADA

## Products Affected

- ARISTADA INITIO 441 MG/1.6ML, 662 MG/2.4ML, 882
- ARISTADA INTRAMUSCULAR MG/3.2ML
- PREFILLED SYRINGE 1064 MG/3.9ML,

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure of, contraindication, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using at least two of the following: Abilify Maintena, Abilify Asimtufii, Invega Sustenna, Invega Trinza, Invega Hafyera, or Risperidone Microspheres ER.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# AUVELITY

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## Products Affected

- AUVELITY

PA Criteria	Criteria Details
Exclusion Criteria	Seizure disorder
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using to two generic antidepressants.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# AZTREONAM LYSINE

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## Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist, infectious disease specialist, or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# BENLYSTA

## Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a rheumatologist, nephrologist, or specialist in the treatment of autoimmune disorders.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts for systemic lupus erythematosus (SLE): concurrent use of two of the following or medical reason for not using glucocorticoids, azathioprine, methotrexate, mycophenolate, or hydroxychloroquine, chloroquine, and cyclophosphamide. For continuation of therapy or reauthorization for SLE: documentation of clinical response to therapy (i.e. fewer flares that required steroid treatment, lower average daily oral prednisone dose, improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits, etc.) For new starts for lupus nephritis (LN): concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization for LN: Documentation of improvement in renal function (i.e. reduction in UPCR).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No



PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	No

# BESREMI

## Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, or specialist for submitted diagnosis.
Coverage Duration	The request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using Pegasys
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# BOSENTAN

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## Products Affected

- bosentan oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# CAMZYOS

## Products Affected

- CAMZYOS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For all new starts, documentation of ALL of the following must be provided: 1) Diagnosis of symptomatic New York Heart Association (NYHA) class II or III obstructive hypertrophic cardiomyopathy (oHCM) AND 2) Patient has a left ventricular ejection fraction (LVEF) greater than or equal to 55% AND 3) Assessment of Valsalva left ventricular outflow tract (LVOT) gradient AND 4) Trial of, medical reason for not using or contraindication to BOTH of the following: Beta blockers (i.e. metoprolol, propranolol, atenolol) AND Non-dihydropyridine calcium channel blockers (i.e. verapamil, diltiazem) AND 5) Prescriber attests that patient is not using moderate to strong CYP2C19 or CYP3A4 inhibitors or inducers. For continuation of therapy or reauthorization, all of the following must be provided: 1) Documentation of clinical benefit as evidenced by an improvement from baseline in oHCM symptoms (i.e., improvement in fatigue, chest pain, shortness of breath, LVOT, peak oxygen consumption, etc.) OR improvement or no worsening of NYHA functional class AND 2) Member must also have a left ventricular ejection fraction (LVEF) greater than or equal to 50%.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# CARGLUMIC ACID

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## Products Affected

- carglumic acid oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# CASPOFUNGIN

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## Products Affected

- *caspofungin acetate*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# CERDELGA

## Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with undetermined CYP2D6 metabolizer status.
Required Medical Information	Patient's CYP2D6 metabolizer status, as determined by an FDA approved test. For reauthorization, documentation has been provided that patient has obtained clinical benefit from medication (e.g. increased platelet count, improvement in anemia, PFTs, improvement in radiographic scans, improved quality of life).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a specialist in treatment of Gaucher's disease.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No



# CGRP ANTAGONISTS

## Products Affected

- AIMOVIG
- EMGALITY
- EMGALITY (300 MG DOSE)
- NURTEC
- QULIPTA
- UBRELVY
- ZAVZPRET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For acute migraine new starts - for Ubrelvy and Nurtec requests, must have trial of, contraindication to or medical reason for not using a triptan. For Zavzpret requests, must have trial of, contraindication to or medical reason for not using Ubrelvy or Nurtec. For migraine prophylaxis new starts - 1) at least 4 migraine days per month or one or more severe migraine attacks lasting for greater than 12 hours despite use of abortive therapy (e.g. triptans or NSAIDs) and 2) trial of, contraindication to, or medical reason for not using at least two of the following agents: a beta adrenergic blocker, an anti-epileptic agent, a tricyclic antidepressant, or a serotonin-norepinephrine reuptake inhibitor. For Emgality requests for episodic cluster headache new starts - must have trial of, contraindication to, or a medical reason for not using verapamil for at least 4 weeks at minimum effective doses. For continuation of therapy or reauthorization - For acute migraine (Nurtec, Ubrelvy, Zavzpret), must show documentation of improvement in migraine symptoms (pain, photophobia, phonophobia). For migraine prevention (Nurtec, Emgality, Qulipta, Aimovig), must show documentation of improvement in migraine symptoms. For episodic cluster headache treatment, must show documentation of reduction in frequency of headaches.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# CHOLBAM

## Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: Patient has documented diagnosis of either: 1) bile acid synthesis disorder due to a single enzyme defect or 2) peroxisomal disorders. For continuation of therapy or reauthorization: prescriber attests: 1) the patient has clinical improvement with therapy (i.e. liver function tests) AND 2) there is no evidence of biliary obstruction or cholestasis
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, or metabolic specialist
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# CIBINQO

## Products Affected

- CIBINQO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For atopic dermatitis: Trial of, contraindication to, or medical reason for not using Rinvoq
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# CIMZIA

## Products Affected

- CIMZIA (2 SYRINGE)
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG
- CIMZIA-STARTER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, an adalimumab product, Cosentyx, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For Crohn's Disease: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an adalimumab product or an ustekinumab product or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: approve. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Tremfya, an ustekinumab product, Enbrel, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, an ustekinumab product, Tremfya, Xeljanz, Enbrel, or an adalimumab product, or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. Polyarticular juvenile idiopathic arthritis (pJIA) - Initial: trial of, medical reason for not using, or contraindication to 2 of the following:

<b>PA Criteria</b>	<b>Criteria Details</b>
	Enbrel, an adalimumab product, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# CORLANOR

## Products Affected

- CORLANOR ORAL SOLUTION
- ivabradine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	New starts for chronic heart failure must have all of the following: 1) LVEF of 35% or less 2) Sinus rhythm and have resting heart rate greater than or equal to 70 bpm. For pediatric patients with heart failure due to dilated cardiomyopathy: approve.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not receiving a beta blocker.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# CORTROPHIN

## Products Affected

- CORTROPHIN
- CORTROPHIN GEL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	New starts for MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, edematous state (e.g. nephrotic syndrome without uremia), and respiratory diseases: trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for ophthalmic disease: trial of, contraindication to, or medical reason for not using oral or ophthalmic corticosteroids. Continuation of therapy or reauthorization for MS exacerbation: documentation of symptom improvement and current use of a multiple sclerosis disease modifying agent for maintenance therapy. Continuation of therapy or reauthorization for all other conditions: documented evidence of response to treatment and symptom improvement.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	MS exacerbation: 1 month. Other conditions: new start for 3 months and reauth end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# COSENTYX

## Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX INTRAVENOUS
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SENSOREADY PEN
- COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML
- COSENTYX UNOREADY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	1) Documented diagnosis of ankylosing spondylitis, non-radiographic axial spondyloarthritis, plaque psoriasis, psoriatic arthritis, enthesitis-related arthritis, rheumatoid arthritis or hidradenitis suppurativa. 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# CRESEMBA

## Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of medically accepted indication.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or oncologist
Coverage Duration	Request will be authorized for 3 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# CYSTAGON

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## Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# CYSTARAN

## Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis for cystinosis with corneal cystine crystal accumulation.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or metabolic disease specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# DALFAMPRIDINE ER

## Products Affected

- dalfampridine er*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	History of seizure or moderate/severe renal impairment (CrCl less than or equal to 50 mL/min).
<b>Required Medical Information</b>	For new starts: 1) Attestation that creatinine clearance (CrCl) greater than 50 mL/min was confirmed prior to initiation of therapy, AND 2) Documentation has been provided that member is ambulatory (able to walk at least 25 feet) and has a documented walking impairment, AND 3) For appropriate indications, member is currently being treated with a disease modifying agent (e.g. immunomodulator, interferon, etc.) or has a medical reason why member is unable to use a disease modifying agent for their condition. For continuation of therapy or re-authorization requests: 1) Member must experience improvement in walking from baseline due to use of dalfampridine ER.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a neurologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# DEFERASIROX

## Products Affected

- deferasirox*
- deferasirox granules*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Creatinine clearance less than 40 mL/min or platelet counts less than 50,000/mm <sup>3</sup> .
<b>Required Medical Information</b>	For all indications: platelet count greater than or equal to 50,000/mm <sup>3</sup> (within 30 days). For chronic iron overload due to transfusions: serum ferritin concentration greater than 1000 mcg/L (lab result within 30 days). For chronic iron overload in non-transfusion-dependent thalassemia syndromes: serum ferritin concentration greater than 300 mcg/L (lab result within 30 days).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For deferasirox granules oral packets, the member must have medical reason for not using deferasirox tablets or oral soluble tablets.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# DEFERIPRONE

## Products Affected

- *deferiprone*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: 1) serum ferritin level above 1,000 mcg/L and absolute neutrophil count (ANC) greater than $1.5 \times 10^9/L$ within 30 days of request, and 2) Trial of, contraindication to, or medical reason for not using deferasirox tablets. For continuation of therapy or reauthorization, decrease in serum ferritin from baseline.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# DIACOMIT

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## Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For members 2 years and older: Trial of, contraindication to, or medical reason for not using one generic anticonvulsant for appropriate indications. For members under 2 years old: Approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# DIHYDROERGOTAMINE NASAL

## Products Affected

- dihydroergotamine mesylate nasal*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: Member has a diagnosis of migraine headaches with or without aura. Prescriber attestation that it will be used for the acute treatment of migraine. For continuation of therapy or reauthorization: Documentation or provider attestation of positive clinical response (e.g., improvement in pain, photophobia, phonophobia).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Requests will be authorized for 12 weeks.
Other Criteria	Trial of, contraindication to, or medical reason (e.g. intolerance or hypersensitivity) for not using a triptan (e.g., rizatriptan, sumatriptan).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# DOPTelet

## Products Affected

- DOPTelet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for chronic liver disease and chronic immune thrombocytopenia (chronic ITP): documented baseline platelet count of less than 50,000/mcL.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with hematologist, hepatologist or surgeon.
Coverage Duration	For thrombocytopenia with CLD getting procedure: 5 days. For chronic ITP: remainder of contract year
Other Criteria	For chronic ITP: trial of, contraindication to, or medical reason for not using a corticosteroid. For thrombocytopenia with chronic liver disease (CLD): approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# DOXEPIN CREAM

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## Products Affected

- doxepin hcl external*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 1 month.
Other Criteria	Trial of, contraindication to, or medical reason for not using a topical corticosteroid or topical calcineurin inhibitor.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# DUPIXENT

## Products Affected

- DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic spontaneous urticaria (CSU) - Initial: patient has inadequate symptomatic relief despite trial of two weeks of a second-generation oral antihistamine (unless contraindicated). Continuation of therapy: patient has positive clinical response to treatment. Bullous pemphigoid - Initial: patient has had trial of, contraindication to, or medical reason for not using a topical corticosteroid, oral corticosteroid, or an immunosuppressive agent. Continuation of therapy: patient has positive clinical response to treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial therapy only: prescribed by or in consultation with specialist for submitted diagnosis.
<b>Coverage Duration</b>	AD - Initial: 4 months, PN & CSU - Initial: 6 months, All others: end of contract year.
<b>Other Criteria</b>	Atopic dermatitis (AD) in patients 6 months of age and older - Initial: (1) patient has diagnosis of moderate to severe AD, AND (2) has had trial of, contraindication to, or medical reason for not using either a topical corticosteroid or topical calcineurin inhibitor. Continuation of therapy: patient has positive clinical response to treatment. Asthma with eosinophilic phenotype - Initial: (1) patient has baseline blood eosinophil count greater than or equal to 150 cells per microliter, AND (2) asthma remains inadequately controlled despite current treatment with or medical reasons for not using BOTH (i) medium to high dose inhaled corticosteroid AND (ii) additional controller (i.e. leukotriene modifier, long acting beta-2-agonist, long acting muscarinic antagonist, and sustained released theophylline). Asthma, oral corticosteroid dependent - Initial: asthma remains inadequately controlled despite current treatment with or medical reasons for not using BOTH (i) high dose inhaled corticosteroid AND (ii) additional controller (i.e. leukotriene modifier, long acting beta-2-agonist, long acting muscarinic antagonist, and sustained released theophylline).

PA Criteria	Criteria Details
	<p>Asthma with eosinophilic phenotype or oral corticosteroid dependent - Continuation of therapy: clinical improvement in asthma control (i.e. reduction in frequency and/or severity of exacerbations and symptoms OR reduction in daily maintenance oral corticosteroid dose). Chronic rhinosinusitis with nasal polyps (CRSwNP) - Initial: (1) Dupixent is used as add-on maintenance treatment, AND (2) patient has a trial of, contraindication to, or medical reason for not using nasal corticosteroids. Continuation of therapy: patient has positive clinical response to treatment. Prurigo nodularis (PN): attestation is provided confirming diagnosis. Eosinophilic esophagitis (EoE) - Initial: (1) diagnosis has been confirmed by esophageal biopsy AND (2) patient weighs at least 15 kilograms AND (3) patient experienced an inadequate treatment response, intolerance, or has a contraindication to a topical or oral corticosteroid (i.e. fluticasone propionate or budesonide). Continuation of therapy: patient has positive clinical response to treatment. Chronic Obstructive Pulmonary Disease (COPD) - Initial: (1) documented diagnosis of COPD with an eosinophilic phenotype, AND (2) Dupixent is used as an add-on maintenance treatment, AND (3) documentation that patient's COPD is inadequately controlled. Continuation of therapy: patient has positive clinical response to treatment.</p>
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# EGRIFTA

## Products Affected

- EGRIFTA SV
- EGRIFTA WR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of active antiretroviral therapy for at least 8 weeks.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# EMSAM

## Products Affected

- EMSAM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with SSRIs, SNRIs, clomipramine and imipramine, meperidine, tramadol, methadone, pentazocine, and propoxyphene, and the antitussive agent dextromethorphan or carbamazepine
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For new starts: Trial of, contraindication to, or medical reason for not using two generic antidepressants.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ENBREL

## Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For PsA or psoriasis: approve. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen. Continuation of therapy: patient has been receiving Enbrel for a minimum of 4 months and has positive clinical response to treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# ENDARI

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## Products Affected

- *l-glutamine oral packet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation that two or more painful sickle cell crises have occurred in the past 12 months.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using hydroxyurea for at least three months.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ENTYVIO

## Products Affected

- ENTYVIO PEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ulcerative colitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an ustekinumab product, Tremfya, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# EPIDIOLEX

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## Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# EPRONTIA

## Products Affected

- EPRONTIA
- topiramate oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	The request will be authorized until the end of the contract year.
Other Criteria	Documented trial of, contraindication to, or medical reason for not using topiramate sprinkle capsule or topiramate oral tablet.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ERYTHROPOIETIN STIMULATING AGENTS

## Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE
- EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML
- PROCIT
- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for all indications: Hgb within compendia range for treatment of the requested medical condition. For continuation of therapy or re-authorization: Hgb must not exceed 10 g/dL (anemia related to cancer), 11 g/dL (anemia of CKD), 12 g/dL (zidovudine-related anemia in members with HIV and ribavirin-induced anemia), 13 g/dL (elective, noncardiac, nonvascular surgery needing red blood cell allogeneic transfusion reduction).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# ERZOFRI

## Products Affected

- ERZOFRI INTRAMUSCULAR MG/1.5ML, 351 MG/2.25ML, 39  
SUSPENSION PREFILLED SYRINGE MG/0.25ML, 78 MG/0.5ML  
117 MG/0.75ML, 156 MG/ML, 234

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral paliperidone or oral risperidone without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For schizophrenia: trial and failure of, contraindication, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using at least two of the following: Abilify Maintena, Abilify Asimtufii, Risperidone Microsphere, Invega Sustenna, Invega Trinza, and Invega Hafyera. For schizoaffective disorder: trial and failure of, contraindication, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using Invega Sustenna.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# EUCRISA

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## Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a dermatologist, immunologist or an allergist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For patients 2 years of age and older: Trial of, contraindication to, or medical reason for not using topical tacrolimus or pimecrolimus. For patients less than 2 years of age: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# EVRYSDI

## Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts, all of the following must be included: 1) Documentation of genetic testing confirming diagnosis AND 2) Documentation of baseline motor function or motor milestone achievement [e.g. CHOP Infant Test of Neuromuscular Disorders (CHOP-INTEND) or Hammersmith Infant Neurological Examination (HINE) for Type 1 or Hammersmith Functional Motor Scale Expanded Scores (HFMSE), or Total Motor Function Measure 32 (MFM-32) for Type II and Type III, or 6 minute walk test in subjects able to walk]. For continuation of therapy or reauthorization, documentation of clinical response has been submitted (e.g. improvement in motor function/motor milestone achievement scores using CHOP-INTEND or HFMSE, MFM-32, 6 minute walk test or HINE improvement in more categories of motor milestones than worsening).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No



# FABHALTA

## Products Affected

- FABHALTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with another complement inhibitor for the treatment of PNH (i.e. Empaveli, Soliris, or Ultomiris).
<b>Required Medical Information</b>	PNH - Initial: patient has documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by (1) flow cytometry analysis confirming presence of PNH clones AND (2) patient has signs and symptoms of PNH (i.e. anemia, abdominal pain, dyspnea, kidney disease, pulmonary hypertension, hemolysis/hemoglobinuria, etc.). Continuation of therapy: patient has documented positive clinical response to treatment (i.e. decrease in LDH, increased or stabilization of hemoglobin levels, reduction in transfusions, increased reticulocyte count, etc.). Reduction of proteinuria in adults with immunoglobulin A (IgA) nephropathy - Initial: patient has documented diagnosis of IgA nephropathy AND IgA nephropathy at risk of rapid disease progression (i.e. clinical evidence of rapid disease progression generally a urine protein-to-creatinine ratio or UPCR greater or equal to 1.5g/g OR other clinically relevant tests). Continuation of therapy: patient has documented positive clinical response to treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist, nephrologist or oncologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

Formulary ID 26313

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# FASENRA

## Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for severe asthma with an eosinophilic phenotype: 1)Baseline blood eosinophil count greater than or equal to 150 cells per microliter AND 2) symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with an additional controller medication (ie. long-acting B2 agonist). Continuation of therapy or re-authorization for severe asthma with an eosinophilic phenotype: clinical benefit from use of the drug. New starts for eosinophilic granulomatosis with polyangiitis (EGPA)- Initial: patient has a documented history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10 percent AND trial of, contraindication to, or medical reason for not using one of the following medications: cyclophosphamide or methotrexate. Continuation of therapy: patient has a beneficial response to treatment with the requested drug (i.e. a reduction in the frequency of relapses, decrease in the daily oral corticosteroid dose, or no active vasculitis).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Formulary ID 26313  
Last Updated: 09/2025

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# FILSPARI

## Products Affected

- FILSPARI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Coadministration with renin-angiotensin-aldosterone system (RAAS) inhibitors, endothelin receptor antagonists, or aliskiren
<b>Required Medical Information</b>	For new starts: Documentation is provided that the member has diagnosis of primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression. Member has an estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m(2) and proteinuria. For continuation of therapy or reauthorization: Documentation of positive clinical response (ie. decrease in urine protein-to-creatinine ratio (UPCR)).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist.
<b>Coverage Duration</b>	New starts will be authorized for 9 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# FINTEPLA

## Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# FIRDAPSE

## Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
Exclusion Criteria	History of seizures.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# FLUCYTOSINE

## Products Affected

- flucytosine oral*

PA Criteria	Criteria Details
Exclusion Criteria	Complete dihydropyrimidine dehydrogenase (DPD) enzyme deficiency
Required Medical Information	Attestation member is taking in combination with amphotericin B.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# GALAFOLD

## Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed must be a geneticist, cardiologist, nephrologist or specialist experienced in the treatment of Fabry disease.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No



# GATTEX

## Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: attestation of 1) Colonoscopy and upper gastrointestinal endoscopy with removal of polyps within six months prior to starting treatment for adults or 2) Fecal occult blood testing within six months prior to starting treatment for pediatric patients and 3) Baseline laboratory assessments (bilirubin, alkalinephosphatase, lipase, and amylase). For continuation of therapy or reauthorization: Documentation is provided that the member has obtained a clinical benefit (e.g. reduction in parenteral fluid volume, reduction in number of days receiving parenteral nutrition).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# GLP-1 AGONISTS

## Products Affected

- *liraglutide*
- MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)
- RYBELSUS
- TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	The member has an indication of weight loss/obesity only or type 1 diabetes. The member has concurrent use of any GLP-1 receptor agonist.
<b>Required Medical Information</b>	The member has a documented diagnosis via chart notes of type 2 diabetes.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Diabetes: patient has diagnosis of type 2 diabetes mellitus. All other indications: patient must have medically accepted indication.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# GNRH AGONISTS

## Products Affected

- ELIGARD
- FIRMAGON (240 MG DOSE)
- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG
- *leuprolide acetate (3 month)*
- *leuprolide acetate injection*
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)
- LUTRATE DEPOT
- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Fibroids and endometriosis: 6 months. All other indications: end of contract year.
Other Criteria	If the medication request is for the treatment of prostate cancer and if the request is for any other GnRH agonist other than Eligard or leuprolide, the patient must have a documented trial of, contraindication to, or medical reason for not using Eligard or leuprolide to treat their prostate cancer.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# GOCOVRI

## Products Affected

- GOCOVRI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts: trial of, contraindication to, or medical reason for not using generic amantadine. Continuation of therapy or reauthorization: Member demonstrates clinical benefit (i.e. improvement in levodopa-induced dyskinesia or decreased off episodes).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# GROWTH HORMONES

## Products Affected

- GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE
- GENOTROPIN SUBCUTANEOUS CARTRIDGE
- NGENLA
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED
- SKYTROFA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for growth hormone deficiency: Documentation showing bone age testing, height, weight, and Growth Hormone Stimulation Test results OR Insulin Growth Factor 1 level. For continuation of therapy or reauthorization for growth hormone deficiency: documentation (medical records) showing positive response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an endocrinologist or nephrologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts for growth hormone deficiency: 1) If the request is not for Genotropin, trial of, contraindication to, or medical reason for not using Genotropin. For requests for all other medically accepted indications other than growth hormone deficiency, the request will be approved for products other than Skytrofa.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# HEREDITARY ANGIOEDEMA AGENTS

## Products Affected

- CINRYZE
- HAEGARDA
- ORLADEYO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an allergist, immunologist, rheumatologist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For continuation of therapy or reauthorization: Documentation has been provided that patient has clinically benefited from medication.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# HIGH RISK MEDICATION

## Products Affected

- *benztropine mesylate oral*
- *cypheptadine hcl oral*
- *diphenoxylate-atropine oral liquid*
- *diphenoxylate-atropine oral tablet 2.5-0.025 mg*
- *dipyridamole oral*
- *ergotamine-caffeine*
- *glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg*
- *glyburide-metformin oral tablet 5-500 mg*
- *guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg*
- *guanfacine hcl oral*
- *hydroxyzine hcl oral syrup*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate oral*
- *indomethacin oral capsule 25 mg, 50 mg*
- *ketorolac tromethamine oral*
- *nifedipine oral*
- *promethazine hcl oral solution 6.25 mg/5ml*
- *promethazine hcl oral syrup*
- *promethazine hcl oral tablet*
- *promethazine hcl rectal suppository 12.5 mg, 25 mg*
- *promethazine-phenylephrine*
- *promethazine rectal suppository 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	No



# HIGH RISK MEDICATION - PROTECTED CLASS DRUGS

## Products Affected

- *amitriptyline hcl oral*
- *amoxapine*
- *clomipramine hcl oral*
- *nortriptyline hcl oral*
- *perphenazine-amitriptyline*
- *phenobarbital oral elixir 20 mg/5ml*
- *phenobarbital oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# HIGH RISK MEDICATION, BUTALBITAL

## Products Affected

- *bac (butalbital-acetamin-caff)*
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-apap-cafeine oral capsule 50-325-40 mg*
- *butalbital-apap-cafeine oral solution*
- *butalbital-apap-cafeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *butalbital-aspirin-cafeine oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using an oral NSAID.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# HIGH RISK MEDICATION, MEGESTROL

## Products Affected

- *megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 625 mg/5ml*
- *megestrol acetate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# HIGH RISK MEDICATION, SHORT TERM MUSCLE RELAXANT

## Products Affected

- *carisoprodol oral*
- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*
- *metaxalone oral tablet 800 mg*
- *methocarbamol oral tablet 500 mg, 750 mg*
- *orphenadrine citrate er*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.
<b>Age Restrictions</b>	Prior authorization only applies to members 65 years old or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	New starts will be authorized for 30 days. Continuation of therapy or reauth will be for 90 days.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# HIGH RISK MEDICATION, SLEEP AGENTS

## Products Affected

- *eszopiclone*
- *temazepam*
- *zaleplon oral capsule 10 mg, 5 mg*
- *zolpidem tartrate er*
- *zolpidem tartrate oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored. For zolpidem immediate release 10mg and zolpidem ER: trial of or medical reason for not using zolpidem immediate release 5mg.
<b>Age Restrictions</b>	Prior authorization only applies to members 65 years old or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# HYFTOR

## Products Affected

- HYFTOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: documentation of diagnosis of tuberous sclerosis with facial angiofibroma. For continuation of therapy or reauthorization: documentation that the member has experienced a clinical benefit from treatment (e.g. improvement in size and color of angiofibroma).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or provider who specializes in the treatment of genetic or dermatologic disorders.
Coverage Duration	New starts: 3 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# ICATIBANT

## Products Affected

- *icatibant acetate subcutaneous solution*  
*prefilled syringe*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an immunologist, allergist, rheumatologist, or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# ILARIS

## Products Affected

- ILARIS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test)
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For sJIA: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No



# ILUMYA

## Products Affected

- ILUMYA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an ustekinumab product, Tremfya, Enbrel, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# IMBRUVICA

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts for treatment of graft-versus-host disease (GVHD): Trial of, contraindication to, or medical reason for not using a systemic corticosteroid. For continuation of therapy of for treatment of GVHD: documentation of clinical benefit from use of the drug (i.e. symptom improvement, reduction in corticosteroid dose). For all other indications, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# IMPAVIDO

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## Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis with one of the following: (a) Visceral leishmaniasis due to <i>Leishmania donovani</i> , (b) Cutaneous leishmaniasis due to <i>Leishmania braziliensis</i> , <i>Leishmania guyanensis</i> , or <i>Leishmania panamensis</i> , (c) Mucosal leishmaniasis due to <i>Leishmania braziliensis</i> .
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 28 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# INCRELEX

## Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# JAKAFI

## Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts for treatment of graft-versus-host disease (GVHD): Trial of, contraindication to, or medical reason for not using a systemic corticosteroid. For continuation of therapy of for treatment of GVHD: documentation of clinical benefit from use of the drug (i.e. symptom improvement, reduction in corticosteroid dose). For all other indications, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# KALYDECO

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## Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Orkambi, Symdeko, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# KERENDIA

## Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Documentation of diagnosis of chronic kidney disease due to type 2 diabetes mellitus AND 2) Documentation of serum potassium levels less than or equal to 5 mEq/L AND 3) eGFR greater than or equal to 25ml/min/1.73 m2 AND 4) Documentation that member is taking Kerendia in combination with an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) at maximum tolerated doses or documentation has been provided that the member is unable to tolerate ACEi or ARB AND 4) Documented trial of, contraindication to, or medical reason for not using a sodium-glucose cotransporter-2 (SGLT2) inhibitor. For continuation of therapy or reauthorization: 1) Documentation of serum potassium levels less than or equal to 5.5 mEq/L AND 2) Documentation that member is taking Kerendia in combination with an ACEi or ARB at maximum tolerated doses or documentation has been provided that the member is unable to tolerate ACEi or ARB.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes



# KEVZARA

## Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For polymyalgia rheumatica (PMR): Trial of, medical reason for not using, or contraindication to corticosteroids. For pJIA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# KINERET

## Products Affected

- KINERET SUBCUTANEOUS  
SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For cryopyrin-associated periodic syndromes or deficiency of interleukin-1 receptor antagonist: Approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# LEQSELVI

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## Products Affected

- LEQSELVI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation of confirmed diagnosis and other causes of hair loss have been ruled out.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# LITFULO

## Products Affected

- LITFULO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Initial: (1) documented diagnosis via chart notes of severe alopecia areata AND (2) patient is not receiving in combination with either of the following: (i) Targeted immunomodulator (i.e. Olumiant, Enbrel, Cimzia, Simponi, Orencia, adalimumab, Xeljanz, Rinvoq) OR (ii) potent immunosuppressant. Continuation of therapy: documentation of positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation of confirmed diagnosis and other causes of hair loss have been ruled out.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# LIVMARLI

## Products Affected

- LIVMARLI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Trial of, contraindication to, or medical reason for not using both of the following: cholestyramine AND rifampin. 2) Prescriber attests that the member has cholestasis 3) Baseline serum bile acid level is provided. 4) Documentation of patients weight. For continuation of therapy or reauthorization: 1) Documentation submitted indicating the member has had all of the following: an improvement in pruritis (e.g. improved observed scratching, decreased sleep disturbances/nighttime awakenings due to scratching, etc.) AND reduction in serum bile acid level from baseline. 2) Prescriber attests that patient has had no evidence of hepatic decompensation (e.g. variceal hemorrhage, ascites, hepatic encephalopathy, portal hypertension, etc.). 3) Documentation of patients weight.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# LIVTENCITY

## Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Cytomegalovirus (CMV): (1) Documented diagnosis of CMV infection AND (2) Member is a recipient of one of the following: (a) hematopoietic stem cell transplant, (b) solid organ transplant AND (3) patient has tried and failed treatment with valganciclovir, ganciclovir, cidofovir, or foscarnet AND (4) patient weighs greater than or equal to 35 kg.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a transplant, oncologist, or infectious disease specialist.
Coverage Duration	Request will be authorized for 8 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# LODOCO

## Products Affected

- LODOCO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be, or in consultation with a specialist in the treatment of cardiovascular disease, such as a cardiologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation that patient has established atherosclerotic disease or multiple risk factors for cardiovascular disease AND documentation that patient does not have pre-existing blood dyscrasias (ex. leukopenia, thrombocytopenia) and patient does not have renal failure (CrCl less than 15 ml/min) or severe hepatic impairment
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# LUCEMYRA

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## Products Affected

- *lofexidine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	Patient must have trial of, contraindication to, or medical reason for not using clonidine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# LUPKYNIS

## Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with cyclophosphamide.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be rheumatologist, nephrologist, or other specialist in the treatment of autoimmune disorders.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Documentation of urine protein/creatinine ratio (UPCR), 2) Documentation that the member has a baseline eGFR greater than 45 mL/min/1.73m <sup>2</sup> or that benefit outweighs risk of using this medication at current eGFR, and 3) Concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization: Documentation of improvement in renal function (i.e. reduction in UPCR or no confirmed decrease from baseline eGFR greater than or equal to 20%).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# LYBALVI

## Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with opioids.
Required Medical Information	Attestation from the provider that the member has had an opioid-free period of a minimum of 7 days after last use of shorting-acting opioids and 14 days from last use of long-acting opioids before initiating Lybalvi.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documented trial of, contraindication to, or medical reason for not using at least two generic antipsychotics, one of which must be generic olanzapine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# MAVYRET

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## Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Detectable HCV RNA viral load prior to treatment within 6 months of request. In addition, documentation of treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 8-16 weeks as per AASLD-IDSA guidance.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# METHOTREXATE ORAL SOLUTION

## Products Affected

- JYLAMVO
- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist, a rheumatologist, a dermatologist, or other appropriate specialist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Polyarticular Juvenile Idiopathic Arthritis (pJIA) - Initial: (1) patient had been diagnosed with pJIA AND (2) patient had tried, intolerant or has medical reason for not using at least one non-steroidal anti-inflammatory agents (NSAIDs) AND methotrexate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# METHYLTESTOSTERONE

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## Products Affected

- *methyltestosterone oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# METYROSINE

## Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of one of the following: 1) Concurrent use of alpha adrenergic blockers, 2) Medical reason for being unable to use an alpha adrenergic blocker, OR 3) Patient is not a candidate for surgical resection and requires long term treatment with metyrosine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# MIFEPRISTONE

## Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	For all members patient must not be currently on simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozone, quinidine, sirolimus, and tacrolimus.
<b>Required Medical Information</b>	Reviewer will verify available claim history to confirm member is not taking simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozone, quinidine, sirolimus or tacrolimus concurrently with mifepristone.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be an endocrinologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# MIGLUSTAT

## Products Affected

- miglustat*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For new starts, documentation of diagnosis for mild to moderate type 1 Gaucher disease. For continuation of therapy or reauthorization: documentation of clinical benefit from use of the drug (i.e. increased platelet count, improvement in anemia, PFT's, improvement in radiographic scans, improved quality of life).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a specialist in treatment of Gaucher's disease
<b>Coverage Duration</b>	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No



# MULTIPLE SCLEROSIS AGENTS

## Products Affected

- BAFIERTAM
- BETASERON SUBCUTANEOUS KIT
- *dimethyl fumarate oral capsule delayed release 120 mg, 240 mg*
- *dimethyl fumarate starter pack oral capsule delayed release therapy pack*
- *fingolimod hcl*
- *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml*
- KESIMPTA
- MAVENCLAD (10 TABS)
- MAVENCLAD (4 TABS)
- MAVENCLAD (5 TABS)
- MAVENCLAD (6 TABS)
- MAVENCLAD (7 TABS)
- MAVENCLAD (8 TABS)
- MAVENCLAD (9 TABS)
- MAYZENT
- MAYZENT STARTER PACK
- PONVORY
- PONVORY STARTER PACK
- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- TASCENSO ODT
- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for glatiramer, Glatopa, or dimethyl fumarate, the request will be approved. If the member is over 17 years of age and the request is not for glatiramer, Glatopa, or dimethyl fumarate for multiple sclerosis, the member must have a documented trial of, contraindication to or a medical reason for not using 2 of the following dimethyl fumarate, glatiramer, Glatopa, teriflunomide, or fingolimod. If the request is for

PA Criteria	Criteria Details
	<p> fingolimod and the member is 17 years of age or younger, the request will be approved. </p>
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# MYFEMBREE

## Products Affected

- MYFEMBREE

PA Criteria	Criteria Details
Exclusion Criteria	Patient has history of osteoporosis or hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an OB, gynecologist or reproductive endocrinologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts for menorrhagia: Trial of, contraindication to, or medical reason for not using an estrogen-progestin contraceptive therapy. For new starts if one of the following drugs has been tried previously, a trial of estrogen-progestin contraceptive therapy is not required: gonadotropin-releasing hormone (GnRH) agonists or tranexamic acid. New starts for endometriosis: Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years, and 2) Documentation has been provided that the member has obtained clinical benefit from medication (e.g. reduced menstrual bleeding from baseline, pain relief).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# NASAL ANTISEIZURE AGENTS

## Products Affected

- NAYZILAM
- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML
- VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML
- VALTOCO 5 MG DOSE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Nayzilam: 12 years of age or older. Valtoco: 6 years of age or older. Libervant: Between 2 to 5 years of age.
Prescriber Restrictions	Initial therapy only: prescribed by or in consultation with a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# NITISINONE

## Products Affected

- nitisinone*
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a geneticist, metabolic specialist, hepatologist, or liver transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Hereditary Tyrosinemia Type 1 (HT-1): diagnosis was confirmed by genetic testing confirming a mutation of the FAH gene OR elevated levels of succinylacetone.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# NON-AMPHETAMINE CENTRAL NERVOUS SYSTEM AGENTS

## Products Affected

- *armodafinil*
- *modafinil oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# NUCALA

## Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for severe asthma: 1) Baseline blood eosinophil count greater than or equal to 150 cells per microliter AND 2) symptoms with equal to or greater than 1 exacerbations in the previous 12 months requiring additional medical treatment, (e.g. oral systemic steroids) while on a high-dose inhaled corticosteroid with an additional controller medication (ie. long-acting B2 agonist) AND 3) the patient has a documented trial of, contraindication to, or medical reason for not using both Dupixent and Fasenra. New starts for eosinophilic granulomatosis with polyangiitis (EGPA): 1) trial of, contraindication to, or medical reason for not using one of the following medications: cyclophosphamide or methotrexate AND 2) the patient has a documented trial of, contraindication to, or medical reason for not using Fasenra. New starts for hypereosinophilic syndrome without an identifiable non-hematologic secondary cause: 1) 2 or more flares within the past 12 months AND 2) trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for chronic rhinosinusitis with nasal polyps: 1) trial of, contraindication to, or medical reason for not using nasal corticosteroids OR member has had prior surgery for nasal polyps AND 2) the patient has a documented trial of, contraindication to, or medical reason for not using both Dupixent and Xolair. Continuation of therapy or re-authorization for all indications: clinical benefit from use of the drug.



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# NUEDEXTA

## Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Complete atrioventricular (AV) block without implanted pacemaker, or at high risk of complete AV block. History of heart failure. Concomitant use with MAOIs or use of MAOIs within 14 days. Concomitant use with drugs containing quinidine, quinine, or mefloquine. History of quinine-, mefloquine-, dextromethorphan/quinidine-, or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome. Non-Part D indications.
<b>Required Medical Information</b>	Confirmation diagnosis is for Part D indication.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or psychiatrist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# NUPLAZID

## Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	Patient has a history of dementia-related psychosis.
Required Medical Information	For hallucinations and delusions associated with Parkinson's disease psychosis: documented diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# OCALIVA

## Products Affected

- OCALIVA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Members with decompensated cirrhosis, a prior decompensation event, compensated cirrhosis who have evidence of portal hypertension, or complete biliary obstruction.
<b>Required Medical Information</b>	For new starts: 1) Attestation that the member has failed at least a 12 month trial of ursodiol, or has a medical reason (e.g. intolerance, hypersensitivity) for being unable to tolerate ursodiol AND 2) lab results for baseline ALT/AST, alkaline phosphatase (ALP), and bilirubin within 90 days of request AND 3) patient has no evidence of cirrhosis OR patient has compensated cirrhosis without evidence of portal hypertension. For continuation of therapy or reauthorization: Documentation that the member has responded to Ocaliva (e.g. improved biochemical markers (e.g., ALP, bilirubin, GGT, AST, ALT levels)) AND patient has no cirrhosis OR patient has compensated cirrhosis without evidence of portal hypertension.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a gastroenterologist, hepatologist, or transplant specialist.
<b>Coverage Duration</b>	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# OCTREOTIDE

## Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*
- *octreotide acetate intramuscular*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for acromegaly: pt meets one of the following (1) inadequate response to surgery and/or radiotherapy OR (2) pt is not an appropriate candidate for surgery and/or radiotherapy OR (3) pt is experiencing negative effects due to tumor size (ex: optic nerve compression). Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# OFEV

## Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or lung transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For a diagnosis of idiopathic pulmonary fibrosis: 1) Documentation of disease as demonstrated on a high resolution CT scan or through lung biopsy and 2) Documented trial of, contraindication to, or medical reason for not using pirfenidone. For a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD): documented trial of, contraindication to, or medical reason for not using mycophenolate mofetil or cyclophosphamide. For a diagnosis of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype: documentation is provided confirming diagnosis.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# OPSUMIT

## Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group I - Initial: [Note: documentation required] (1) PAH was confirmed by right heart catheterization AND (2) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg AND (3) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg AND (4) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. Continuation of therapy: patient has positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using sildenafil.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ORAL ANTIPSYCHOTICS

## Products Affected

- CAPLYTA
- COBENFY
- COBENFY STARTER PACK
- FANAPT
- FANAPT TITRATION PACK A
- FANAPT TITRATION PACK B ORAL TABLET
- FANAPT TITRATION PACK C ORAL TABLET
- OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG
- VRAYLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For schizophrenia, manic or mixed episodes associated with bipolar I disorder, major depressive disorder associated with bipolar I or II disorder, adjunctive treatment of major depressive disorder, irritability associated with autistic disorder or treatment of Tourette's disorder: trial of, contraindication to, or medical reason for not using two generic antipsychotics. If the request is for Vraylar for major depressive disorder: provider attestation that the member is concurrently using an antidepressant.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No



PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# ORENCIA

## Products Affected

- ORENCIA CLICKJECT
- ORENCIA INTRAVENOUS
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For pJIA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an ustekinumab product, Tremfya, Xeljanz, Enbrel, Cosentyx, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For acute graft versus host disease: Attestation member is taking in combination with a calcineurin inhibitor and methotrexate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# ORIAHNN

## Products Affected

- ORIAHNN

PA Criteria	Criteria Details
Exclusion Criteria	Patient has history of osteoporosis or hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an OB, gynecologist or reproductive endocrinologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: Trial of, contraindication to, or medical reason for not using an estrogen-progestin contraceptive therapy. For new starts if one of the following drugs has been tried previously, a trial of estrogen-progestin contraceptive therapy is not required: gonadotropin-releasing hormone (GnRH) agonists or tranexamic acid. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years, and 2) Documentation has been provided that the member has obtained clinical benefit from medication (e.g. reduced menstrual bleeding from baseline).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ORILISSA

## Products Affected

- ORILISSA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patient has osteoporosis or severe hepatic impairment.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be an OB or gynecologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years for 150mg tablet or 6 months for 200mg tablet, and 2) Documentation has been provided that the member has obtained clinical benefit from the medication.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ORKAMBI

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## Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Symdeko, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to lumacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# OTEZLA

## Products Affected

- OTEZLA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For moderate to severe psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an ustekinumab product, Tremfya, Enbrel, or an adalimumab product, or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an ustekinumab product, Tremfya, Xeljanz, Enbrel, Cosentyx, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy. For Behcet's Syndrome or mild psoriasis: Approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# OXERVATE

## Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	Treatment duration greater than 16 weeks per affected eye(s).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an ophthalmologist or an optometrist.
Coverage Duration	Initial: 8 weeks. Continuation of therapy: additional 8 weeks.
Other Criteria	Initial: confirmed diagnosis. Continuation of therapy: patient has previously received less than or equal to 8 weeks of treatment per affected eye(s) and the patient has a recurrence of neurotrophic keratitis.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No



# OXYCODONE ER

## Products Affected

- OXYCONTIN ORAL TABLET ER 12 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG  
 HOUR ABUSE-DETERRENT 10 MG, 15 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Members being treated for active cancer diagnoses, sickle cell diagnoses, those in hospice care, or receiving palliative care will be excluded from the concurrent benzodiazepine and muscle relaxant therapy requirement. For new starts, ALL of the following are required: (1) Member has documented history of receiving an immediate-release opioid, (2) Member has a documented trial of, contraindication to, or medical reason for not using long-acting morphine sulfate, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products. For continuing therapy, ALL of the following are required: (1) Member's pain has been assessed within the last 6 months, (2) Member has demonstrated clinical improvement in pain and function on current medication regimen, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# PCSK9 INHIBITORS

## Products Affected

- REPATHA
- REPATHA SURECLICK
- REPATHA PUSHTRONEX SYSTEM

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and labs.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For ALL diagnoses (including primary hyperlipidemia) for new starts, documentation of the following: 1) Two fasting lipid panel reports within the past 12 months with abnormal LDL cholesterol results (above 70mg/dL) after treatment for a minimum of 3 months with a high potency statin (atorvastatin and rosuvastatin) and ezetimibe, or a medical reason (contraindication or intolerance) has been provided as to why the patient is unable to use these therapies, and 2) If patient experiences statin intolerance, trial of statin re-challenge with maximally tolerated dose of statins with continued abnormal LDL cholesterol results (above 70mg/dL) or with attestation of return of side effects. For familial hypercholesterolemia (FH), documentation of one of the following: 1) genetic testing confirming FH diagnosis, 2) a clinical diagnosis of 'definite' FH using the Dutch Lipid Clinic Diagnostic criteria, OR Simon-Broome Diagnostic criteria, OR American Heart Association criteria. For ASCVD, additional documentation of history of acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. For ALL diagnoses for continuation of therapy or reauthorization: documentation of improvement in LDL from new start.
Indications	All Medically-accepted Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# PEGINTERFERON

## Products Affected

- PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML
- PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For Hepatitis C: 1) Labs within 3 months of request: liver function tests and detectable HCV RNA viral load. 2) Documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. For Hepatitis B: 1) Labs within 3 months of request: ALT/AST, and 2) HBeAg status. For polycythemia vera, approve.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, infectious disease doctor or transplant specialist.
Coverage Duration	Request will be authorized for 24 to 48 weeks as defined by compendia.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# PENICILLAMINE

## Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product, or Xeljanz. For other indications, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# PERSERIS

## Products Affected

- PERSERIS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure of, contraindication, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using at least two of the following: Abilify Maintena, Abilify Asimtufii, Invega Sustenna, Invega Trinza, Invega Hafyera, or Risperidone Microspheres ER.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# PHENOXYBENZAMINE

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## Products Affected

- *phenoxybenzamine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using doxazosin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# PIRFENIDONE

## Products Affected

- *pirfenidone*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For idiopathic pulmonary fibrosis, documentation of all of the following: 1) confirmation of diagnosis on high resolution CT scan or through lung biopsy AND 2) FVC greater than or equal to 50% of the predicted value.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or lung transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# POSACONAZOLE

## Products Affected

- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist, a transplant specialist, or an oncologist.
Coverage Duration	28 days for oropharyngeal candidiasis, end of contract year for other indications
Other Criteria	For treatment of oropharyngeal candidiasis: trial of, contraindication to, or medical reason for not using fluconazole or itraconazole. For prophylaxis of invasive aspergillus infections due to being severely immunocompromised: trial of, contraindication to, or medical reason for not using voriconazole.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# PRETOMANID

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## Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	MDR-TB that is not treatment-intolerant or nonresponsive to standard therapy
Required Medical Information	Documentation of use in combination with bedaquiline and linezolid.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 26 weeks.
Other Criteria	Documentation of prior trial of or medical reason for not using first-line TB regimen containing isoniazid and rifampin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# PREVYMIS

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## Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, infectious disease, or transplant specialist.
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# PROMACTA

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic immune (idiopathic) thrombocytopenia (ITP): Documented baseline platelet count less than 30,000 cells/ microL. For severe aplastic anemia: Documentation of baseline platelet count less than 20,000 cells/microL OR platelet count less than 30,000 cells/microL with bleeding OR reticulocyte count less than 20,000 cells/microL OR absolute neutrophil count less than 500 cells/microL. For thrombocytopenia in patients with Hepatitis C infection: documented baseline platelet count less than 75,000 cells/microL.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For chronic immune (idiopathic) thrombocytopenia (ITP): Trial of, contraindication to, or medical reason for not using glucocorticosteroids. For severe aplastic anemia: Trial of, contraindication to, or medical reason for not using at least one immunosuppressive agent.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# PYRUKYND

## Products Affected

- PYRUKYND
- PYRUKYND TAPER PACK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: 1) documentation of diagnosis and 2) baseline hemoglobin level. For continuation of therapy or reauthorization: documentation of clinical improvement (e.g. reduction in number of blood transfusions, or increase or stabilization in hemoglobin level). If the criteria are not met, may authorize up to 14 days of a Pyrukynd Taper Pack to allow for tapering.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist.
Coverage Duration	New starts: 6 mo. Cont of therapy or reauth: end of contract yr. Denial: 14 days for dose tapering.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# RADICAVA

## Products Affected

- RADICAVA ORS
- RADICAVA ORS STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	For new starts: 1) documentation of ALS functional rating scale (ALSFRS-R) score and 2) documentation that the member has been on riluzole, is beginning therapy as an adjunct to treatment with Radicava, or provider has provided a medical reason why patient is unable to use riluzole. For continuation of therapy or reauthorization: documentation from provider of clinical stabilization in symptoms (e.g. stabilization of ALS functional rating scale (ALSFRS-R) score).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# RAVICTI

## Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a geneticist, metabolic specialist, gastroenterologist, hepatologist, or liver transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using sodium phenylbutyrate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# RECORLEV

## Products Affected

- RECORLEV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using ketoconazole tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# REGRANEX

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## Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 20 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# RELISTOR

## Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For opioid induced constipation, chronic non-cancer pain: Patient must have documented trial of or medical reason for not using the following: 1) lubiprostone, AND 2) lactulose AND 3) Movantik. Additionally, patient must have a medical reason for not being able to use oral Relistor in order to receive Relistor injection. For opioid-induced constipation, in patients with advanced illness or pain caused by active cancer requiring opioid dosage escalation for palliative care: Approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# REVCovi

## Products Affected

- REVCovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient has diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID) confirmed by one of the following: 1) documentation of deficiency or absence of adenosine deaminase OR 2) genetic testing revealing mutations in both alleles of the ADA1 gene
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an immunologist, geneticist, hematologist, oncologist, or provider who specializes in the treatment of ADA-SCID or related disorders.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# REXULTI

## Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For schizophrenia: trial of, contraindication to, or medical reason for not using two generic antipsychotics. For major depressive disorder: trial of, contraindication to, or medical reason for not using two generic antidepressants. For agitation due to dementia: 1) patient has documented diagnosis of Alzheimer's disease AND 2) medication will not be used on an "as needed" basis
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# REZDIFFRA

## Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patients with decompensated cirrhosis.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hepatologist, gastroenterologist, endocrinologist or specialist in the treatment of liver disease.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Initial therapy: (1) documented diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis, (2) documentation of stage F2 to F3 fibrosis as confirmed by a biopsy or a non-invasive test (NIT), (3) the drug is being prescribed at an FDA approved dose according to the member's weight and (4) prescriber attestation to providing lifestyle counseling on nutrition, exercise and avoiding excessive alcohol intake. For reauthorization: (1) the member has shown clinical benefit from the medication (e.g., the resolution of steatohepatitis and no worsening of liver fibrosis, or at least one stage improvement in liver fibrosis and no worsening of steatohepatitis), (2) the member continues to have a fibrosis stage of 3 or less and (3) the drug continues to be prescribed at an FDA approved dose according to the member's weight.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	No

# REZUROCK

## Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, or transplant specialist.
Coverage Duration	New starts: 3 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	For new starts: documented trial of, contraindication to, or medical reason for not using at least two lines of systemic immunosuppressive therapy (e.g. corticosteroids, tacrolimus, mycophenolate mofetil, Imbruvica, or Jakafi), one of which must be a systemic corticosteroid. For continuation of therapy or re-authorization: documentation of clinical benefit from use of the drug (i.e. symptom improvement, reduction in corticosteroid dose).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# RUFINAMIDE

## Products Affected

- *rufinamide oral suspension*
- *rufinamide oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	History of familial Short QT syndrome
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one alternative generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# RYKINDO

## Products Affected

- RYKINDO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using at least two of the following: Abilify Maintena, Abilify Asimtufii, Invega Sustenna, Invega Trinza, or Risperidone Microspheres ER.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# RYLAZE

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## Products Affected

- RYLAZE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist, hematologist, or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# SAPROPTERIN

## Products Affected

- sapropterin dihydrochloride oral packet*
- sapropterin dihydrochloride oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: documentation of elevated baseline phenylalanine levels. Continuation of therapy or reauthorization: prescriber attests the member has improvement in phenylalanine levels from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# SECUADO

## Products Affected

- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using to one generic antipsychotics.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# SEROSTIM

## Products Affected

- SEROSTIM SUBCUTANEOUS  
SOLUTION RECONSTITUTED 4 MG, 5  
MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a HIV specialist, gastroenterologist, nutritional support specialist or ID specialist.
Coverage Duration	Request will be authorized for 12 weeks.
Other Criteria	For initial starts for HIV wasting/cachexia: 1) Member must be on anti-retroviral therapy and 2) Trial of, contraindication to or medical reason for not using megestrol or dronabinol and 3) Alternative causes of wasting have been ruled out (diarrhea, malignancies, inadequate caloric intake, etc)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# SIGNIFOR

## Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Member is not a candidate for surgery or surgery was not curative.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# SILDENAFIL ORAL

## Products Affected

- sildenafil citrate oral suspension reconstituted*
- sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Documentation of concurrent nitrate or Adempas use.
<b>Required Medical Information</b>	Pulmonary Arterial Hypertension: Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas. Secondary Raynaud's phenomenon- Initial: [Note: documentation required] (1) diagnosis of secondary Raynaud's phenomenon AND (2) diagnosis of primary condition which Raynaud's phenomenon is secondary to (e.g., lupus, scleroderma, rheumatoid arthritis, Sjogren's syndrome, thyroid disease). Continuation of therapy: patient has positive clinical response to treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a pulmonologist, cardiologist, or rheumatologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For sildenafil suspension: Documentation of trial of, contraindication to, or medical reason for not using sildenafil tablet.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes



# SILIQ

## Products Affected

- SILIQ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an ustekinumab product, Tremfya, Enbrel, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# SIMPONI

## Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, an adalimumab product, Cosentyx, or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an ustekinumab product, Cosentyx, Tremfya, Xeljanz, Enbrel, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For UC: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: an adalimumab product, an ustekinumab product, Tremfya, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# SIRTURO

## Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) that the member is currently taking 3 additional antimycobacterial drugs in combination to treat MDR-TB.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 24 weeks.
Other Criteria	Documentation of prior trial of or medical reason for not using first-line TB regimen containing isoniazid and rifampin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# SODIUM OXYBATE

## Products Affected

- sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a sleep specialist, pulmonologist, or neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For somnolence associated with narcolepsy: trial of, contraindication to, or medical reason for not using a CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.). For cataplexy associated with narcolepsy, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# SODIUM PHENYLBUTYRATE

## Products Affected

- sodium phenylbutyrate oral powder 3 gm/tsp*
- sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a geneticist, metabolic specialist, gastroenterologist, hepatologist, or liver transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# SOFOSBUVIR/VELPATASVIR

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## Products Affected

- SOFOSBUVIR-VELPATASVIR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Detectable HCV RNA viral load prior to treatment within 6 months of request. In addition, documentation of treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 12-24 weeks based on AASLD-IDSA guidelines
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# SOMAVERT

## Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for acromegaly: pt meets one of the following (1) inadequate response to surgery and/or radiotherapy OR (2) pt is not an appropriate candidate for surgery and/or radiotherapy OR (3) pt is experiencing negative effects due to tumor size (ex: optic nerve compression). Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No



# SOTYKTU

## Products Affected

- SOTYKTU

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For moderate to severe psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an ustekinumab product, Tremfya, Enbrel, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# SUCRAID

## Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: documentation of diagnosis of congenital sucrase-isomaltase deficiency. For continuation of therapy or reauthorization: Prescriber attests that member has obtained a clinical benefit (e.g. fewer total stools, greater number of hard and formed stools, fewer watery and soft stools, decrease in breath hydrogen output)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# SYMDEKO

## Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Orkambi, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to tezacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# SYNAREL

## Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), OR gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# TADALAFIL

## Products Affected

- *tadalafil (pah)*
- TADLIQ

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For Tadliq: Documentation of trial of, contraindication to, or medical reason for not using tadalafil tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# TADALAFIL, BPH

## Products Affected

- tadalafil oral tablet 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of erectile dysfunction
Required Medical Information	Diagnosis of Benign prostatic hyperplasia (BPH) required AND trial of, contraindication to, or medical reason for not using an alpha blocker (e.g. tamsulosin, terazosin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# TALTZ

## Products Affected

- TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML, 40 MG/0.5ML, 80 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, an adalimumab product, Cosentyx, or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: approve. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to 2 of the following therapies: an ustekinumab product, Tremfya, Enbrel, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an ustekinumab product, Cosentyx, Tremfya, Xeljanz, Enbrel, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes



# TARPEYO

## Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: documentation is required that the member has 1) Diagnosis of primary immunoglobulin A nephropathy (IgAN) and 2) at risk of disease progression. Member has an estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m(2) and proteinuria. For continuation of therapy: documentation that member has been on Tarpeyo for less than 9 months. For reauthorizations: Requests will not be allowed as the safety and efficacy of subsequent courses of Tarpeyo have not been established.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	Request will be authorized for 9 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# TASIMELTEON

## Products Affected

- HETLIOZ LQ
- tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts of non-24 hour sleep-wake cycle: 1) Member is totally blind with no perception of light, 2) diagnosis of non-24 confirmed by a physiologic circadian phase marker (ex: dim light melatonin onset, assessment of core body temp or measurement of urinary melatonin levels) OR actigraphy with evaluation of sleep logs. For continuation of therapy or reauthorization: documentation of clinical benefit from use of the drug. For night-time sleep disturbances in Smith-Magenis Syndrome (SMS): approve
Age Restrictions	N/A
Prescriber Restrictions	Provider is a sleep specialist or neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# TAVNEOS

## Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist or hematologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Prescriber attests that Tavneos will be prescribed in combination with corticosteroids AND cyclophosphamide unless there is documented trial of, contraindication to, or medical reason for not using these therapies. 2) Documentation of baseline Birmingham Vasculitis Activity Score (BVAS) score 3) Prescriber attestation that the patient will have liver function tests before treatment (ALT, AST, alkaline phosphate, and total bilirubin) and every 4 weeks after start of therapy for the first 6 months of treatment 4) Prescriber attestation that the patient has been screened for and does not have active hepatitis B virus (HBV) infection at baseline. For continuation of therapy or reauthorization: 1) Documentation of remission (BVAS score of 0) OR improvement in BVAS score 2) Prescriber attestation that patient has no abnormality in liver function tests (abnormality: ALT or AST greater than 3 times the upper limit of normal and bilirubin greater than 2 times the upper limit of normal) 3) Prescriber attestation that patient has no active HBV infection.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# TEPEZZA

## Products Affected

- TEPEZZA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of moderate to severe active thyroid eye disease (TED) as evidenced by one or more of the following: a) eyelid retraction greater than or equal to 2 mm, b) moderate or severe soft tissue involvement, c) exophthalmos greater than or equal to 3 mm above normal for race and sex or d) periodic or constant diplopia OR Documentation of chronic TED with one or more of the following: a) a 3 mm or greater increase in exophthalmos from before diagnosis of TED, b) exophthalmos greater than or equal to 3 mm above normal for race and sex.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an ophthalmologist or endocrinologist
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	For active TED: member has had a trial and failure, contraindication to, or medical reason for not using oral or IV glucocorticoids.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# TERIPARATIDE

## Products Affected

- BONSITY
- teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation showing patient falls into one of the following categories: a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or patient has had an osteoporotic fracture or patient has T-scores from -1.5 to -2.5 at the femoral neck or spine, and a 10-year probability of hip fracture greater than or equal to 3% or a 10-year probability of any major osteoporosis-related fracture greater than or equal to 20% based on the United States-adapted FRAX model.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	In addition, the following criteria is also applicable: 1) Trial of, medical reason for not using, or contraindication to an oral bisphosphonate and Prolia and 2) therapy does not exceed the therapy maximum of 2 years.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# THIOLA

## Products Affected

- tiopronin oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# TIGECYCLINE

## Products Affected

- *tigecycline*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	(1) Patient must have documented diagnosis of one of the following infections: (a) complicated skin and skin structure infection, (b) complicated intraabdominal infection, (c) community-acquired pneumonia AND (2) Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using preferred first-line antibiotics.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# TOBI PODHALER

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## Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient has documented diagnosis of both: 1) cystic fibrosis AND 2) pseudomonas aeruginosa
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# TOLVAPTAN

## Products Affected

- *tolvaptan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with strong CYP3A4 inhibitors (i.e. clarithromycin, ketoconazole, itraconazole, ritonavir, lopinavir-ritonavir, indinavir-ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, conivaptan, and telithromycin).
<b>Required Medical Information</b>	Reviewer will verify available patient claim history to confirm patient is not using a strong CYP3A4 inhibitor (i.e. clarithromycin, ketoconazole, itraconazole, ritonavir, lopinavir-ritonavir, indinavir-ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, conivaptan, and telithromycin).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, endocrinologist, hepatologist, or nephrologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TOPICAL ANTINEOPLASTIC RETINOIDS

## Products Affected

- *bexarotene*
- PANRETIN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, oncologist or specialist for submitted diagnosis
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# TOPICAL TESTOSTERONE

## Products Affected

- testosterone transdermal gel 1.62 %, 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)
- testosterone transdermal solution

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patient has history of prostate cancer or breast cancer.
<b>Required Medical Information</b>	New starts of topical testosterone therapy for hypogonadism must have both of the following characteristics of hypogonadism: 1) symptoms associated with hypogonadism (e.g. unexplained mild anemia, low libido, decreased energy, etc.) 2) Two separate instances of low serum total or free testosterone taken in the morning, as defined by the lab reference range.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TRANSDERMAL LIDOCAINE

## Products Affected

- *lidocaine external patch 5 %*
- ZTLIDO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of a medically-accepted indication.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the request is for the product ZTLido, must provide medical reason for not being able to use generic lidocaine 5% patch
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# TREMFYA

## Products Affected

- TREMFYA CROHNS INDUCTION
- TREMFYA ONE-PRESS
- TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 200 MG/2ML
- TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 200 MG/2ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For UC: Approve. Crohn's Disease (CD) - Initial: Trial of, contraindication to, or medical reason (i.e. patient has a diagnosis of severe Crohn's disease) for not using (i.e. severe Crohns disease), or contraindication to 1 of the following: mercaptopurine, azathioprine, methotrexate, sulfasalazine, or corticosteroid (e.g., prednisone, methylprednisolone). Continuation of therapy: patient has been receiving Tremfya for a minimum of 4 months and has a positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# TRIENTINE

## Products Affected

- CUVRIOR
- trientine hcl oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the request is for Cuvrior for new starts, member must have trial of, contraindication to, or medical reason for not using trientine hydrochloride.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# TRIKAFTA

## Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Orkambi, or Symdeko.
Required Medical Information	Documentation of CFTR gene that is responsive to elexacaftor-tezacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No



# TYMLOS

## Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation showing patient falls into one of the following categories: a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or patient has had an osteoporotic fracture or patient has T-scores from -1.5 to -2.5 at the femoral neck or spine, and a 10-year probability of hip fracture greater than or equal to 3% or a 10-year probability of any major osteoporosis-related fracture greater than or equal to 20% based on the United States-adapted FRAX model.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	The following criteria is also applicable: 1) trial of, contraindication to, or medical reason for not using an oral bisphosphonate and Prolia, and 2) therapy does not exceed 2 years.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# TYVASO

## Products Affected

- TYVASO DPI MAINTENANCE KIT  
INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG
- TYVASO DPI TITRATION KIT  
INHALATION POWDER 16 & 32 & 48 MCG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For the treatment of pulmonary arterial hypertension (PAH): 1) documentation of PAH WHO Group I classification and PAH Functional Class and 2) trial of, contraindication to, or medical reason for not using a generic phosphodiesterase inhibitor and a generic endothelin receptor antagonist. For the treatment of pulmonary hypertension associated with interstitial lung disease (PH-ILD, WHO Group 3): documentation of PH-ILD and PAH Functional Class.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# UPTRAVI

## Products Affected

- UPTRAVI ORAL
- UPTRAVI TITRATION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using a generic phosphodiesterase inhibitor and a generic endothelin receptor antagonist.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# USTEKINUMAB

## Products Affected

- IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- SELARSDI INTRAVENOUS
- SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- STELARA INTRAVENOUS
- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- STEQEYMA INTRAVENOUS
- STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- *ustekinumab subcutaneous solution*
- *ustekinumab subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml*
- *ustekinumab-aekn subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml*
- YESINTEK INTRAVENOUS
- YESINTEK SUBCUTANEOUS SOLUTION
- YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For Crohns Disease: Either 1) Trial of, medical reason for not using (i.e. severe Crohns disease), or contraindication to 1 of the following: mercaptopurine, azathioprine, methotrexate, sulfasalazine, or corticosteroid (e.g., prednisone, methylprednisolone) or 2) If utilized within the past 120 days, approve for continuation of therapy. For psoriasis: Approve. For PsA: Approve. For UC: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine),

<b>PA Criteria</b>	<b>Criteria Details</b>
	azathioprine or a corticosteroid (i.e. prednisone, methylprednisolone) or 2) If utilized within the past 120 days, approve for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# UZEDY

## Products Affected

- UZEDY SUBCUTANEOUS  
SUSPENSION PREFILLED SYRINGE  
100 MG/0.28ML, 125 MG/0.35ML, 150  
MG/0.42ML, 200 MG/0.56ML, 250  
MG/0.7ML, 50 MG/0.14ML, 75  
MG/0.21ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure of, contraindication, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using at least two of the following: Abilify Maintena, Abilify Asimtufii, Invega Sustenna, Invega Trinza, Invega Hafyera, or Risperidone Microspheres ER.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# VALCHLOR

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## Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not being able to use one of the following: a topical corticosteroids or a topical retinoids.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# VEMLIDY

## Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: attestation that member has been tested for HIV infection. If member is HIV-positive, Vemlidy is not used alone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No



# VEOZAH

## Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Initial: (1) Documented diagnosis of moderate to severe vasomotor symptoms due to menopause AND (2) Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using a hormonal therapy (e.g., estradiol, oral Premarin, Prempro). Reauthorization: (1) Documentation of positive clinical response to therapy (e.g., decrease in frequency or severity of vasomotor symptoms from baseline)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# VIGABATRIN

## Products Affected

- *vigabatrin*
- VIGAFYDE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For infantile spasms or West syndrome, the request will be approved. For diagnosis of refractory complex partial seizures: 1) documentation of diagnosis, and 2) attestation the member is currently receiving another antiepileptic drug, and 3) attestation the member has experienced treatment failure from two alternative antiepileptic agents.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# VIJOICE

## Products Affected

- VIJOICE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts, all of the following must be included: 1) Documentation of genetic testing confirming diagnosis AND 2) Member has at least one target lesion identified on imaging AND 3) Prescriber attests the patient's condition is severe or life-threatening and necessitates systemic treatment. For continuation of therapy or reauthorization, attestation of a positive clinical response (i.e. reduction in the sum of measurable target lesion volume, absence of progression of non-target lesions, absence of any new lesions, etc.).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, dermatologist, vascular surgeon, hematologist/oncologist, or other specialist in the treatment of PIK3CA-Related Overgrowth Spectrum(PROs).
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# VMAT-2 INHIBITORS

## Products Affected

- AUSTEDO
- AUSTEDO XR
- AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG
- INGREZZA ORAL CAPSULE
- INGREZZA ORAL CAPSULE SPRINKLE
- INGREZZA ORAL CAPSULE THERAPY PACK
- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist, clinical geneticist, or psychiatrist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the request is for tetrabenazine, Ingrezza or Ingrezza Sprinkle, request will be approved. If the request is for Austedo or Austedo XR, the member must have trial of or medical reason for not using tetrabenazine. Reauthorization: Confirmation of improvement in tardive dyskinesia symptoms or chorea associated with Huntington disease symptoms.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# VORICONAZOLE

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## Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	Non-Part D indications.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# VOSEVI

## Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Detectable HCV RNA viral load prior to treatment within 6 months of request. In addition, documentation of treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 12 weeks as per AASLD-IDSA guidance.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# VOWST

## Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of Clostridioides difficile infection (CDI)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all the criteria are met, the request will be approved for 1 month
Other Criteria	Diagnosis of at least 1 recurrent episode of CDI
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# WEGOVY

## Products Affected

- WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML, 0.5 MG/0.5ML, 1

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	The member has an indication of only weight reduction or maintenance for overweight or obesity. The member has concurrent use of any GLP-1 receptor agonist. The member has a personal history of Type 1 or Type 2 diabetes. The member has a personal history of medullary thyroid carcinoma. The member has Multiple Endocrine Neoplasia syndrome type 2.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For new starts: The member has an indication for reducing the risk of adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease. Documentation demonstrates patient has established cardiovascular disease (i.e., prior myocardial infarction, prior stroke, symptomatic peripheral arterial disease). Documentation is provided that the patient is overweight or obese (defined as a BMI of greater than or equal to 27 kg/m <sup>2</sup> ). Documentation is provided that the patient's Hb A1c is less than or equal to 6.4%. For continuation of therapy or reauthorization: Documentation is provided that the patient's Hb A1c is less than or equal to 6.4%. Patient continues to not have Type 1 or Type 2 diabetes.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

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PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	No

# WHITE BLOOD CELL STIMULATORS

## Products Affected

- FULPHILA
- FYLNETRA
- LEUKINE INJECTION SOLUTION RECONSTITUTED
- NEULASTA ONPRO
- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for Neulasta and Fylnetra: documentation of trial of, contraindication to, or medical reason for not using Fulphila. Continuation of therapy or re-authorization criteria: diagnosis of chronic neutropenia or a medical reason for continued need for GCSF.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# WINREVAIR

## Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1)- Initial: [Note: documentation required] (1) PAH was confirmed by right heart catheterization AND (2) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg AND (3) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND (4) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. Continuation of therapy: patient has positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documented trial and failure of, or contraindication to combination therapy including one PDE-5 inhibitor AND one endothelin receptor antagonist. Documentation of platelet count of greater than 50,000/mm <sup>3</sup> .
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# XDEMVY

## Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# XELJANZ

## Products Affected

- XELJANZ ORAL SOLUTION
- XELJANZ ORAL TABLET
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen and 1 of the following: an adalimumab product, Enbrel or Cosentyx. For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide and 1 of the following: an adalimumab product, Enbrel. For PsA: Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel, an adalimumab product or Cosentyx. For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine) and 1 of the following: Enbrel or an adalimumab product. For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine), azathioprine or a corticosteroid (i.e. prednisone, methylprednisolone) and an adalimumab product. Continuation of therapy: patient has been receiving Xeljanz for a minimum of 4 months and has a positive clinical response.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# XERMELO

## Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: 1) Attestation that diarrhea is inadequately controlled by stable dose of SSA therapy for at least three months. For continuation of therapy or reauthorization: 1) documentation of positive clinical response to xermelo and 2) Attestation to continue to be used in combination with SSA.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# XIFAXAN

## Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For HE: gastroenterologist or hepatologist. For IBS-D: gastroenterologist.
Coverage Duration	For HE: contract year. For IBSD: 14 days (cannot exceed 3 courses of 14 days each). For TD: 3 days.
Other Criteria	For diagnosis of hepatic encephalopathy (HE): trial of, contraindication to, or medical reason for not using lactulose. For diagnosis of irritable bowel syndrome with diarrhea (IBSD): No more than 3 courses of 14 days each. For travelers diarrhea (TD) caused by noninvasive strains of E. Coli (with no bloody stools or fever): patient must be intolerant to or must have had a trial of at least 3 days of one of the following agents: ciprofloxacin, ofloxacin, levofloxacin or azithromycin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# XOLAIR

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist, allergist, immunologist, dermatologist, or otolaryngologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for moderate to severe persistent allergic asthma: 1) Evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen, AND 2) Pretreatment serum IgE levels greater than 30 IU/mL, AND 3) Symptoms are not adequately controlled with high-dose inhaled corticosteroid (ICS) plus additional controller medication (ie. long-acting B2 agonist) for at least 3 months, or there is a medical reason for not using these drugs. Continuation of therapy or reauthorization criteria for moderate to severe persistent allergic asthma: 1) Reduction in asthma exacerbation resulting in systemic steroid use and/or hospitalization, OR 2) Reduction of rescue inhaler use, OR 3) Documentation of improvement in pulmonary function tests since baseline (prior to initiation of Xolair). New starts for chronic idiopathic urticaria: 1) inadequate symptomatic relief despite trial of two weeks of two different oral antihistamine therapies (unless contraindicated), AND 2) disease must be severe enough to warrant short term systemic corticosteroid therapy for management of urticaria. Continuation of therapy or reauthorization criteria for chronic idiopathic urticaria: 1) improvement from baseline of symptoms associated with urticaria within 6 months of Xolair use. New starts for nasal polyps: 1) currently using an intranasal corticosteroid, will be prescribed an intranasal corticosteroid with request, or has a medical reason for not using an intranasal corticosteroid.

PA Criteria	Criteria Details
	Continuation of therapy or reauthorization criteria for nasal polyps: 1) Documentation has been provided that demonstrates a clinical benefit (e.g. improvements in symptom severity, nasal polyp score [NPS], sino-nasal outcome test-22 [SNOT-22], nasal congestion score [NCS]) AND 2) continued use of intranasal corticosteroid, or has a medical reason for not using one. New starts for food allergy: 1) diagnosis of IgE-mediated food allergy 2) Xolair will be used in conjunction with food allergen avoidance. Continuation of therapy or reauthorization criteria for food allergy: 1) Documentation of clinical benefit
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# XOLREMDI

## Products Affected

- XOLREMDI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an immunologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: 1) A documented diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome confirmed by genotype variant of chemokine receptor 4 (CXCR4) and absolute neutrophil count (ANC) of less than or equal to 400 cells/microliter or white blood cells (WBC) less than or equal to 400 cells/microliter and 2) Documentation of baseline ANC and absolute lymphocyte count (ALC). For renewal 1) Documentation or provider attestation of positive clinical response (i.e. improvement from baseline in ANC, WBC and/or ALC or reduced frequency, duration, or severity of infections, fewer warts, or improved or stabilized clinical signs and/or symptoms of WHIM).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# XYWAV

## Products Affected

- XYWAV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a sleep specialist, pulmonologist or a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For treatment of somnolence associated with narcolepsy, patient must have documentation of either trial of or a medical reason for being unable to use a CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.). For the treatment of cataplexy associated with narcolepsy or idiopathic hypersomnia, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# YORVIPATH

## Products Affected

- YORVIPATH

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Diagnosis of acute post-surgical hypoparathyroidism.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	For new starts: 1) Documented diagnosis of chronic hypoparathyroidism AND 2) Provider attestation that patient is currently receiving or has medical reason for not receiving calcium supplementation and active vitamin D treatment AND 3) An albumin-corrected serum calcium level of 7.8 mg/dL or greater. For reauthorization: Documentation of improvement in albumin-corrected serum calcium from baseline.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# YUTREPIA

## Products Affected

- YUTREPIA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For the treatment of pulmonary arterial hypertension (PAH): 1) documentation of PAH WHO Group I classification and PAH Functional Class and 2) trial of, contraindication to, or medical reason for not using a generic phosphodiesterase inhibitor and a generic endothelin receptor antagonist. For the treatment of pulmonary hypertension associated with interstitial lung disease (PH-ILD, WHO Group 3): documentation of PHILD and PAH Functional Class.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ZEPBOUND

## Products Affected

- ZEPBOUND SUBCUTANEOUS  
SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	The member has an indication of only weight reduction or maintenance for overweight or obesity. The member has concurrent use of any GLP-1 receptor agonist. The member has a personal history of medullary thyroid carcinoma. The member has Multiple Endocrine Neoplasia syndrome type 2.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a sleep disorder specialist, pulmonologist, ENT, or other provider specializing in obstructive sleep apnea.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For new starts: The member has an indication for moderate to severe obstructive sleep apnea (OSA) in adults with obesity. Documentation of diagnosis of OSA through polysomnography (sleep study) with an apnea-hypopnea index of 15 or more events per hour, or five or more events per hour in the presence of symptoms (e.g., cognitive impairment, fatigue, insomnia, loud snoring) or cardiovascular comorbidities (e.g., hypertension, ischemic heart disease, previous stroke). Documentation is provided that the patient is obese (defined as a BMI of greater than or equal to 30 kg/m <sup>2</sup> ). For continuation of therapy: Documentation of positive response to treatment. Documentation member has achieved and/or maintained a decrease in weight since baseline.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	No



# ZEPOSIA

## Products Affected

- ZEPOSIA
- ZEPOSIA 7-DAY STARTER PACK
- ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG & 0.46MG 0.92MG(21)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For multiple sclerosis: Trial of, contraindication to, or medical reason for not using two of the following: dalfampridine ER, dimethyl fumarate, fingolimod, glatiramer, glatopa, or teriflunomide. For ulcerative colitis: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: an ustekinumab product or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ZILBRYSQ

## Products Affected

- ZILBRYSQ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist, rheumatologist, or other appropriate specialist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient has tried and failed, a medical reason for not using, or has a contraindication to two (2) or more conventional therapies (i.e. pyridostigmine, corticosteroids, or non-steroidal immunosuppressive therapies)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ZTALMY

## Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

# ZURZUVAE

## Products Affected

- ZURZUVAE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented diagnosis of postpartum depression
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist or obstetrician/gynecologist
Coverage Duration	Request will be authorized until the end of the contract year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

## PART B VERSUS PART D

### Products Affected

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml*
- *amphotericin b intravenous solution reconstituted 50 mg*
- *amphotericin b liposome intravenous suspension reconstituted 50 mg*
- *aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg*
- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- *azathioprine oral tablet 50 mg*
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
- *calcium acetate (phos binder) oral capsule 667 mg*
- *clinisol sf intravenous solution 15 %*
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclophosphamide oral tablet 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML
- ENGERIX-B INJECTION SUSPENSION 20 MCG/ML
- ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML
- ENVARUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- *everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg*
- *formoterol fumarate inhalation nebulization solution 20 mcg/2ml*
- GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML
- GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM
- GAMMAKED INJECTION SOLUTION 1 GM/10ML
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- *gengraf oral capsule 100 mg, 25 mg*
- *granisetron hcl oral tablet 1 mg*
- HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML
- IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- *lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg*

- *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*
- NUTRILIPID INTRAVENOUS EMULSION 20 %
- *ondansetron hcl oral solution 4 mg/5ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet dispersible 4 mg, 8 mg*
- *pentamidine isethionate inhalation solution reconstituted 300 mg*
- *plenamine intravenous solution 15 %*
- PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML
- PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML
- PROGRAF INTRAVENOUS SOLUTION 5 MG/ML
- PROGRAF ORAL PACKET 0.2 MG, 1 MG
- PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML
- RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED
- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML
- RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML
- *sevelamer carbonate oral packet 0.8 gm, 2.4 gm*
- *sevelamer carbonate oral tablet 800 mg*
- *sirolimus oral solution 1 mg/ml*
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION)
- *tobramycin inhalation nebulization solution 300 mg/4ml, 300 mg/5ml*

## Details

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

## Index

### A

ABELCET INTRAVENOUS	
SUSPENSION 5 MG/ML.....	234
abiraterone acetate .....	11, 12, 13
ABIRTEGA .....	11, 12, 13
acetylcysteine inhalation solution 10 %, 20 % .....	234
acitretin .....	1
ACTEMRA ACTPEN .....	4
ACTEMRA SUBCUTANEOUS .....	4
acyclovir sodium intravenous solution 50 mg/ml .....	234
adalimumab-fkjp (2 pen).....	5, 6
adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml .....	5, 6
ADEMPAS .....	7
AIMOVIG.....	30, 31
AKEEGA .....	11, 12, 13
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml .....	234
ALECENSA.....	11, 12, 13
ALUNBRIG.....	11, 12, 13
ALYFTREK ORAL TABLET 10-50-125 MG, 4-20-50 MG .....	9
ambrisentan .....	10
amitriptyline hcl oral.....	78
amoxapine .....	78
amphotericin b intravenous solution reconstituted 50 mg .....	234
amphotericin b liposome intravenous suspension reconstituted 50 mg .....	234
apomorphine hcl subcutaneous .....	14
aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg .....	234
AQNEURSA.....	15
ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG.....	8
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML .....	58
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE .....	58
ARCALYST .....	16
ARIKAYCE.....	17
ARISTADA INITIO .....	18
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML .....	18
armodafinil.....	116
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG .....	234
AUGTYRO .....	11, 12, 13
AUSTEDO.....	209
AUSTEDO XR .....	209
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG .....	209
AUVELITY .....	19
AVMAPKI FAKZYNJA CO-PACK. 11, 12, 13	
AYVAKIT .....	11, 12, 13
azathioprine oral tablet 50 mg.....	234
<b>B</b>	
bac (butalbital-acetamin-caff).....	79
BAFIERTAM .....	110, 111
BALVERSA .....	11, 12, 13
BENLYSTA SUBCUTANEOUS.....	21, 22
benztropine mesylate oral .....	76, 77
BESREMI .....	23
BETASERON SUBCUTANEOUS KIT 110, 111	
bexarotene .....	11, 12, 13, 192
BONSITY .....	187
bosentan oral tablet .....	24
BOSULIF.....	11, 12, 13
BRAFTOVI ORAL CAPSULE 75 MG .. 11, 12, 13	

BRUKINSA ..... 11, 12, 13  
budesonide inhalation suspension 0.25  
mg/2ml, 0.5 mg/2ml, 1 mg/2ml ..... 234  
butalbital-acetaminophen oral tablet 50-325  
mg ..... 79  
butalbital-apap-caff-cod oral capsule 50-  
325-40-30 mg ..... 79  
butalbital-apap-caffeine oral capsule 50-  
325-40 mg ..... 79  
butalbital-apap-caffeine oral solution ..... 79  
butalbital-apap-caffeine oral tablet 50-325-  
40 mg ..... 79  
butalbital-asa-caff-codeine ..... 79  
butalbital-aspirin-caffeine oral capsule ..... 79  
**C**  
CABOMETYX ..... 11, 12, 13  
calcium acetate (phos binder) oral capsule  
667 mg ..... 234  
CALQUENCE ORAL TABLET .. 11, 12, 13  
CAMZYOS ..... 25, 26  
CAPLYTA ..... 125, 126  
CAPRELSA ..... 11, 12, 13  
carglumic acid oral tablet soluble ..... 27  
carisoprodol oral ..... 81  
caspofungin acetate ..... 28  
CAYSTON ..... 20  
CERDELGA ..... 29  
chlorzoxazone oral tablet 500 mg ..... 81  
CHOLBAM ..... 32  
CIBINQO ..... 33  
CIMZIA (2 SYRINGE) ..... 34, 35  
CIMZIA SUBCUTANEOUS KIT 2 X 200  
MG ..... 34, 35  
CIMZIA-STARTER ..... 34, 35  
CINRYZE ..... 75  
clinisol sf intravenous solution 15 % ..... 234  
clomipramine hcl oral ..... 78  
COBENFY ..... 125, 126  
COBENFY STARTER PACK ..... 125, 126  
COMETRIQ (100 MG DAILY DOSE)  
ORAL KIT 80 & 20 MG ..... 11, 12, 13  
COMETRIQ (140 MG DAILY DOSE)  
ORAL KIT 3 X 20 MG & 80 MG . 11, 12,  
13  
COMETRIQ (60 MG DAILY DOSE)11, 12,  
13

COPIKTRA ..... 11, 12, 13  
CORLANOR ORAL SOLUTION ..... 36  
CORTROPHIN ..... 37  
CORTROPHIN GEL ..... 37  
COSENTYX (300 MG DOSE) ..... 38  
COSENTYX INTRAVENOUS ..... 38  
COSENTYX SENSOREADY (300 MG). 38  
COSENTYX SENSOREADY PEN ..... 38  
COSENTYX SUBCUTANEOUS  
SOLUTION PREFILLED SYRINGE 150  
MG/ML, 75 MG/0.5ML ..... 38  
COSENTYX UNOREADY ..... 38  
COTELIC ..... 11, 12, 13  
CRESEMBA ORAL ..... 39  
cromolyn sodium inhalation nebulization  
solution 20 mg/2ml ..... 234  
CUVRIOR ..... 196  
cyclobenzaprine hcl oral tablet 10 mg, 5 mg  
..... 81  
cyclophosphamide oral capsule 25 mg, 50  
mg ..... 234  
cyclophosphamide oral tablet 25 mg, 50 mg  
..... 234  
cyclosporine modified oral capsule 100 mg,  
25 mg, 50 mg ..... 234  
cyclosporine modified oral solution 100  
mg/ml ..... 234  
cyclosporine oral capsule 100 mg, 25 mg234  
cyproheptadine hcl oral ..... 76, 77  
CYSTAGON ..... 40  
CYSTARAN ..... 41  
**D**  
dalfampridine er ..... 42  
DANZITEN ..... 11, 12, 13  
dasatinib ..... 11, 12, 13  
DAURISMO ..... 11, 12, 13  
deferasirox ..... 43  
deferasirox granules ..... 43  
deferiprone ..... 44  
DIACOMIT ..... 45  
dihydroergotamine mesylate nasal ..... 46  
dimethyl fumarate oral capsule delayed  
release 120 mg, 240 mg ..... 110, 111  
dimethyl fumarate starter pack oral capsule  
delayed release therapy pack ..... 110, 111  
diphenoxylate-atropine oral liquid ..... 76, 77



diphenoxylate-atropine oral tablet 2.5-0.025 mg ..... 76, 77  
dipyridamole oral ..... 76, 77  
DOPTELET ..... 47  
doxepin hcl external ..... 48  
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg ..... 234  
DUPIXENT SUBCUTANEOUS  
SOLUTION AUTO-INJECTOR .... 49, 50  
DUPIXENT SUBCUTANEOUS  
SOLUTION PREFILLED SYRINGE 200  
MG/1.14ML, 300 MG/2ML ..... 49, 50  
**E**  
EGRIFTA SV ..... 51  
EGRIFTA WR ..... 51  
ELIGARD ..... 72  
eltrombopag olamine oral packet 12.5 mg,  
25 mg ..... 146  
eltrombopag olamine oral tablet 12.5 mg, 25  
mg, 50 mg, 75 mg ..... 146  
EMEND ORAL SUSPENSION  
RECONSTITUTED 125 MG/5ML .... 234  
EMGALITY ..... 30, 31  
EMGALITY (300 MG DOSE) ..... 30, 31  
EMSAM ..... 52  
ENBREL MINI ..... 53  
ENBREL SUBCUTANEOUS SOLUTION  
25 MG/0.5ML ..... 53  
ENBREL SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE ..... 53  
ENBREL SURECLICK SUBCUTANEOUS  
SOLUTION AUTO-INJECTOR ..... 53  
ENGERIX-B INJECTION SUSPENSION  
20 MCG/ML ..... 234  
ENGERIX-B INJECTION SUSPENSION  
PREFILLED SYRINGE 10 MCG/0.5ML,  
20 MCG/ML ..... 234  
ENSACOVE ..... 11, 12, 13  
ENTYVIO PEN ..... 55  
ENVARUSUS XR ORAL TABLET  
EXTENDED RELEASE 24 HOUR 0.75  
MG, 1 MG, 4 MG ..... 234  
EPIDIOLEX ..... 56  
EPOGEN INJECTION SOLUTION 10000  
UNIT/ML, 2000 UNIT/ML, 20000

UNIT/ML, 3000 UNIT/ML, 4000  
UNIT/ML ..... 58  
EPRONTIA ..... 57  
ergotamine-caffeine ..... 76, 77  
ERIVEDGE ..... 11, 12, 13  
ERLEADA ..... 11, 12, 13  
erlotinib hcl ..... 11, 12, 13  
ERZOFRI INTRAMUSCULAR  
SUSPENSION PREFILLED SYRINGE  
117 MG/0.75ML, 156 MG/ML, 234  
MG/1.5ML, 351 MG/2.25ML, 39  
MG/0.25ML, 78 MG/0.5ML ..... 59  
eszopiclone ..... 82  
EUCRISA ..... 60  
EULEXIN ..... 11, 12, 13  
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75  
mg, 1 mg ..... 234  
everolimus oral tablet 10 mg, 2.5 mg, 5 mg,  
7.5 mg ..... 11, 12, 13  
everolimus oral tablet soluble ..... 11, 12, 13  
EVRYSDI ..... 61  
**F**  
FABHALTA ..... 62  
FANAPT ..... 125, 126  
FANAPT TITRATION PACK A ... 125, 126  
FANAPT TITRATION PACK B ORAL  
TABLET ..... 125, 126  
FANAPT TITRATION PACK C ORAL  
TABLET ..... 125, 126  
FASENRA ..... 63, 64  
FASENRA PEN ..... 63, 64  
FILSPARI ..... 65  
fingolimod hcl ..... 110, 111  
FINTEPLA ..... 66  
FIRDAPSE ..... 67  
FIRMAGON (240 MG DOSE) ..... 72  
FIRMAGON SUBCUTANEOUS  
SOLUTION RECONSTITUTED 80 MG  
..... 72  
flucytosine oral ..... 68  
formoterol fumarate inhalation nebulization  
solution 20 mcg/2ml ..... 234  
FOTIVDA ..... 11, 12, 13  
FRUZAQLA ..... 11, 12, 13  
FULPHILA ..... 215  
FYLNETRA ..... 215

**G**

GALAFOLD .....	69
GAMMAGARD INJECTION SOLUTION	
1 GM/10ML, 10 GM/100ML, 2.5	
GM/25ML, 20 GM/200ML, 30	
GM/300ML, 5 GM/50ML .....	234
GAMMAGARD S/D LESS IGA	
INTRAVENOUS SOLUTION	
RECONSTITUTED 10 GM, 5 GM....	234
GAMMAKED INJECTION SOLUTION 1	
GM/10ML .....	234
GAMMAPLEX INTRAVENOUS	
SOLUTION 10 GM/100ML, 10	
GM/200ML, 20 GM/200ML, 5	
GM/50ML .....	234
GAMUNEX-C INJECTION SOLUTION 1	
GM/10ML .....	234
GATTEX.....	70
GAVRETO .....	11, 12, 13
gefitinib .....	11, 12, 13
gengraf oral capsule 100 mg, 25 mg .....	234
GENOTROPIN MINIQUICK	
SUBCUTANEOUS PREFILLED	
SYRINGE .....	74
GENOTROPIN SUBCUTANEOUS	
CARTRIDGE.....	74
GILOTRIF .....	11, 12, 13
GLASSIA.....	8
glatiramer acetate subcutaneous solution	
prefilled syringe 20 mg/ml, 40 mg/ml 110,	
111	
glatopa subcutaneous solution prefilled	
syringe 20 mg/ml, 40 mg/ml .....	110, 111
glyburide micronized oral tablet 1.5 mg, 3	
mg, 6 mg .....	76, 77
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	
.....	76, 77
glyburide-metformin oral tablet 1.25-250	
mg, 2.5-500 mg .....	76, 77
glyburide-metformin oral tablet 5-500 mg	
.....	76, 77
GOCOVRI .....	73
GOMEKLI .....	11, 12, 13
granisetron hcl oral tablet 1 mg .....	234

guanfacine hcl er oral tablet extended	
release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	
.....	76, 77
guanfacine hcl oral .....	76, 77
<b>H</b>	
HAEGARDA .....	75
HEPLISAV-B INTRAMUSCULAR	
SOLUTION PREFILLED SYRINGE 20	
MCG/0.5ML .....	234
HETLIOZ LQ .....	183
hydroxyzine hcl oral syrup.....	76, 77
hydroxyzine hcl oral tablet.....	76, 77
hydroxyzine pamoate oral.....	76, 77
HYFTOR.....	83
<b>I</b>	
IBRANCE .....	11, 12, 13
IBTROZI.....	11, 12, 13
icatibant acetate subcutaneous solution	
prefilled syringe .....	84
ICLUSIG .....	11, 12, 13
IDHIFA .....	11, 12, 13
ILARIS SUBCUTANEOUS SOLUTION	85
ILUMYA.....	86
imatinib mesylate oral.....	11, 12, 13
IMBRUVICA ORAL CAPSULE.....	87
IMBRUVICA ORAL SUSPENSION.....	87
IMBRUVICA ORAL TABLET 140 MG,	
280 MG, 420 MG.....	87
IMKELDI.....	11, 12, 13
IMOVAX RABIES INTRAMUSCULAR	
SUSPENSION RECONSTITUTED 2.5	
UNIT/ML.....	234
IMPAVIDO.....	88
IMULDOSA SUBCUTANEOUS	
SOLUTION PREFILLED SYRINGE 45	
MG/0.5ML, 90 MG/ML .....	201, 202
INCRELEX.....	89
indomethacin oral capsule 25 mg, 50 mg	76,
77	
INGREZZA ORAL CAPSULE.....	209
INGREZZA ORAL CAPSULE SPRINKLE	
.....	209
INGREZZA ORAL CAPSULE THERAPY	
PACK.....	209
INLYTA.....	11, 12, 13
INQOVI .....	11, 12, 13

INREBIC..... 11, 12, 13  
 INTRALIPID INTRAVENOUS  
   EMULSION 20 %, 30 % ..... 234  
 ipratropium bromide inhalation solution  
   0.02 % ..... 234  
 ipratropium-albuterol inhalation solution  
   0.5-2.5 (3) mg/3ml ..... 234  
 ITOVEBI..... 11, 12, 13  
 ivabradine hcl..... 36  
 IWILFIN ..... 11, 12, 13

## J

JAKAFI..... 90  
 JAYPIRCA ..... 11, 12, 13  
 JYLAMVO ..... 105

## K

KALYDECO..... 91  
 KERENDIA ..... 92, 93  
 KESIMPTA..... 110, 111  
 ketorolac tromethamine oral ..... 76, 77  
 KEVZARA ..... 94  
 KINERET SUBCUTANEOUS SOLUTION  
   REFILLED SYRINGE ..... 95  
 KISQALI (200 MG DOSE)..... 11, 12, 13  
 KISQALI (400 MG DOSE)..... 11, 12, 13  
 KISQALI (600 MG DOSE)..... 11, 12, 13  
 KISQALI FEMARA (400 MG DOSE) ... 11,  
   12, 13  
 KISQALI FEMARA (600 MG DOSE) ... 11,  
   12, 13  
 KOSELUGO ..... 11, 12, 13  
 KRAZATI..... 11, 12, 13

## L

lanthanum carbonate oral tablet chewable  
   1000 mg, 500 mg, 750 mg ..... 234  
 lapatinib ditosylate..... 11, 12, 13  
 LAZCLUZE..... 11, 12, 13  
 lenalidomide..... 11, 12, 13  
 LENVIMA (10 MG DAILY DOSE) . 11, 12,  
   13  
 LENVIMA (12 MG DAILY DOSE) . 11, 12,  
   13  
 LENVIMA (14 MG DAILY DOSE) . 11, 12,  
   13  
 LENVIMA (18 MG DAILY DOSE) . 11, 12,  
   13

LENVIMA (20 MG DAILY DOSE) . 11, 12,  
   13  
 LENVIMA (24 MG DAILY DOSE) . 11, 12,  
   13  
 LENVIMA (4 MG DAILY DOSE) ... 11, 12,  
   13  
 LENVIMA (8 MG DAILY DOSE) ... 11, 12,  
   13  
 LEQSELVI ..... 96  
 LEUKERAN ..... 11, 12, 13  
 LEUKINE INJECTION SOLUTION  
   RECONSTITUTED ..... 215  
 leuprolide acetate (3 month) ..... 72  
 leuprolide acetate injection ..... 72  
 levalbuterol hcl inhalation nebulization  
   solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25  
   mg/3ml ..... 235  
 l-glutamine oral packet ..... 54  
 lidocaine external patch 5 % ..... 194  
 liraglutide ..... 71  
 LITFULO..... 97  
 LIVMARLI..... 98  
 LIVTENCITY ..... 99  
 LODOCO ..... 100  
 lofexidine hcl ..... 101  
 LONSURF ..... 11, 12, 13  
 LORBRENA..... 11, 12, 13  
 LUMAKRAS ..... 11, 12, 13  
 LUPKYNIS..... 102  
 LUPRON DEPOT (1-MONTH) ..... 72  
 LUPRON DEPOT (3-MONTH) ..... 72  
 LUPRON DEPOT (4-MONTH) ..... 72  
 LUPRON DEPOT (6-MONTH) ..... 72  
 LUTRATE DEPOT ..... 72  
 LYBALVI..... 103  
 LYNPARZA ORAL TABLET .... 11, 12, 13  
 LYTGobi (12 MG DAILY DOSE) .. 11, 12,  
   13  
 LYTGobi (16 MG DAILY DOSE) .. 11, 12,  
   13  
 LYTGobi (20 MG DAILY DOSE) .. 11, 12,  
   13

## M

MAVENCLAD (10 TABS) ..... 110, 111  
 MAVENCLAD (4 TABS) ..... 110, 111  
 MAVENCLAD (5 TABS) ..... 110, 111

MAVENCLAD (6 TABS) .....	110, 111	nitisinone .....	115
MAVENCLAD (7 TABS) .....	110, 111	nortriptyline hcl oral .....	78
MAVENCLAD (8 TABS) .....	110, 111	NUBEQA .....	12, 13
MAVENCLAD (9 TABS) .....	110, 111	NUCALA .....	117, 118
MAVYRET .....	104	NUEDEXTA .....	119
MAYZENT .....	110, 111	NUPLAZID ORAL CAPSULE .....	120
MAYZENT STARTER PACK .....	110, 111	NUPLAZID ORAL TABLET 10 MG ....	120
megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 625 mg/5ml .....	80	NURTEC .....	30, 31
megestrol acetate oral tablet .....	80	NUTRILIPID INTRAVENOUS EMULSION 20 % .....	235
MEKINIST .....	11, 12, 13	<b>O</b>	
MEKTOVI .....	11, 12, 13	OCALIVA .....	121
mercaptopurine oral suspension ....	11, 12, 13	octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml .....	122
metaxalone oral tablet 800 mg .....	81	octreotide acetate intramuscular .....	122
methocarbamol oral tablet 500 mg, 750 mg .....	81	ODOMZO .....	12, 13
methyltestosterone oral .....	106	OFEV .....	123
metyrosine .....	107	OGSIVEO .....	12, 13
mifepristone oral tablet 300 mg .....	108	OJEMDA .....	12, 13
miglustat .....	109	OJJAARA .....	12, 13
modafinil oral .....	116	OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE .....	74
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR .....	71	OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED .....	74
mycophenolate mofetil oral capsule 250 mg .....	235	ondansetron hcl oral solution 4 mg/5ml..	235
mycophenolate mofetil oral suspension reconstituted 200 mg/ml .....	235	ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg .....	235
mycophenolate mofetil oral tablet 500 mg .....	235	ondansetron oral tablet dispersible 4 mg, 8 mg .....	235
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg .....	235	ONUREG .....	12, 13
MYFEMBREE .....	112, 113	OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG .....	125, 126
<b>N</b>		OPSUMIT .....	124
NAYZILAM .....	114	ORENCIA CLICKJECT .....	127, 128
NERLYNX .....	11, 12, 13	ORENCIA INTRAVENOUS .....	127, 128
NEULASTA ONPRO .....	215	ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML .....	127, 128
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	215	ORFADIN ORAL SUSPENSION .....	115
NEXLETOL .....	2, 3	ORGOVYX .....	12, 13
NEXLIZET .....	2, 3	ORIAHNN .....	129
NGENLA .....	74	ORILISSA .....	130
nifedipine oral .....	76, 77	ORKAMBI .....	131
nilotinib d-tartrate .....	11, 12, 13	ORLADEYO .....	75
nilotinib hcl .....	11, 12, 13	orphenadrine citrate er .....	81
nilutamide .....	12, 13		
NINLARO .....	12, 13		

ORSERDU ..... 12, 13  
 OTEZLA ..... 132  
 OXERVATE ..... 133  
 OXYCONTIN ORAL TABLET ER 12  
 HOUR ABUSE-DETERRENT 10 MG,  
 15 MG, 20 MG, 30 MG, 40 MG, 60 MG,  
 80 MG ..... 134, 135  
 OZEMPIC (0.25 OR 0.5 MG/DOSE)  
 SUBCUTANEOUS SOLUTION PEN-  
 INJECTOR 2 MG/3ML ..... 71  
 OZEMPIC (1 MG/DOSE)  
 SUBCUTANEOUS SOLUTION PEN-  
 INJECTOR 4 MG/3ML ..... 71  
 OZEMPIC (2 MG/DOSE) ..... 71  
**P**  
 PANRETIN ..... 192  
 pazopanib hcl ..... 12, 13  
 PEGASYS SUBCUTANEOUS SOLUTION  
 180 MCG/ML ..... 138  
 PEGASYS SUBCUTANEOUS SOLUTION  
 PREFILLED SYRINGE ..... 138  
 PEMAZYRE ..... 12, 13  
 penicillamine oral tablet ..... 139  
 pentamidine isethionate inhalation solution  
 reconstituted 300 mg ..... 235  
 perphenazine-amitriptyline ..... 78  
 PERSERIS ..... 140  
 phenobarbital oral elixir 20 mg/5ml ..... 78  
 phenobarbital oral tablet ..... 78  
 phenoxybenzamine hcl oral ..... 141  
 PIQRAY (200 MG DAILY DOSE).... 12, 13  
 PIQRAY (250 MG DAILY DOSE).... 12, 13  
 PIQRAY (300 MG DAILY DOSE).... 12, 13  
 pirfenidone ..... 142  
 plenamine intravenous solution 15 % ..... 235  
 POMALYST ..... 12, 13  
 PONVORY ..... 110, 111  
 PONVORY STARTER PACK..... 110, 111  
 posaconazole oral ..... 143  
 PREHEVBRIO INTRAMUSCULAR  
 SUSPENSION 10 MCG/ML ..... 235  
 pretomanid ..... 144  
 PREVYMIS ORAL ..... 145  
 PRIVIGEN INTRAVENOUS SOLUTION  
 10 GM/100ML, 20 GM/200ML, 40  
 GM/400ML, 5 GM/50ML ..... 235

PROCRT ..... 58  
 PROGRAF INTRAVENOUS SOLUTION 5  
 MG/ML ..... 235  
 PROGRAF ORAL PACKET 0.2 MG, 1 MG  
 ..... 235  
 PROLASTIN-C INTRAVENOUS  
 SOLUTION ..... 8  
 promethazine hcl oral solution 6.25 mg/5ml  
 ..... 76, 77  
 promethazine hcl oral syrup ..... 76, 77  
 promethazine hcl oral tablet ..... 76, 77  
 promethazine hcl rectal suppository 12.5  
 mg, 25 mg ..... 76, 77  
 promethazine-phenylephrine ..... 76, 77  
 promethegan rectal suppository 50 mg 76, 77  
 PULMOZYME INHALATION  
 SOLUTION 2.5 MG/2.5ML ..... 235  
 PYRUKYND ..... 147  
 PYRUKYND TAPER PACK ..... 147  
**Q**  
 QINLOCK ..... 12, 13  
 QULIPTA ..... 30, 31  
**R**  
 RABAVERT INTRAMUSCULAR  
 SUSPENSION RECONSTITUTED... 235  
 RADICAVA ORS ..... 148  
 RADICAVA ORS STARTER KIT ..... 148  
 RAVICTI ..... 149  
 REBIF REBIDOSE SUBCUTANEOUS  
 SOLUTION AUTO-INJECTOR 110, 111  
 REBIF REBIDOSE TITRATION PACK  
 SUBCUTANEOUS SOLUTION AUTO-  
 INJECTOR ..... 110, 111  
 REBIF SUBCUTANEOUS SOLUTION  
 PREFILLED SYRINGE ..... 110, 111  
 REBIF TITRATION PACK  
 SUBCUTANEOUS SOLUTION  
 PREFILLED SYRINGE ..... 110, 111  
 RECOMBIVAX HB INJECTION  
 SUSPENSION 10 MCG/ML, 40  
 MCG/ML, 5 MCG/0.5ML ..... 235  
 RECOMBIVAX HB INJECTION  
 SUSPENSION PREFILLED SYRINGE  
 10 MCG/ML, 5 MCG/0.5ML ..... 235  
 RECORLEV ..... 150  
 REGRANEX ..... 151

RELISTOR ORAL.....	152	sildenafil citrate oral suspension	
RELISTOR SUBCUTANEOUS		reconstituted.....	165
SOLUTION.....	152	sildenafil citrate oral tablet 20 mg .....	165
REPATHA .....	136, 137	SILIQ .....	166
REPATHA PUSHTRONEX SYSTEM. 136,		SIMLANDI (1 PEN) SUBCUTANEOUS	
137		AUTO-INJECTOR KIT 40 MG/0.4ML,	
REPATHA SURECLICK.....	136, 137	80 MG/0.8ML .....	5, 6
RETACRIT INJECTION SOLUTION		SIMLANDI (1 SYRINGE).....	5, 6
10000 UNIT/ML, 10000		SIMLANDI (2 PEN).....	5, 6
UNIT/ML(1ML), 2000 UNIT/ML, 20000		SIMLANDI (2 SYRINGE)	
UNIT/ML, 3000 UNIT/ML, 4000		SUBCUTANEOUS PREFILLED	
UNIT/ML, 40000 UNIT/ML .....	58	SYRINGE KIT 20 MG/0.2ML, 40	
RETEVMO ORAL TABLET .....	12, 13	MG/0.4ML .....	5, 6
REVCovi.....	153	SIMPONI SUBCUTANEOUS SOLUTION	
REVLIMID .....	12, 13	AUTO-INJECTOR .....	167, 168
REVUFORJ .....	12, 13	SIMPONI SUBCUTANEOUS SOLUTION	
REXULTI .....	154	PREFILLED SYRINGE .....	167, 168
REZDIFFRA.....	155, 156	sirolimus oral solution 1 mg/ml .....	235
REZLIDHIA .....	12, 13	sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	235
REZUROCK.....	157	SIRTURO .....	169
ROMVIMZA .....	12, 13	SKYTROFA .....	74
ROZLYTREK.....	12, 13	sodium oxybate .....	170
RUBRACA .....	12, 13	sodium phenylbutyrate oral powder 3 gm/tsp	
rufinamide oral suspension .....	158	.....	171
rufinamide oral tablet.....	158	sodium phenylbutyrate oral tablet.....	171
RYBELSUS .....	71	SOFOSBUVIR-VELPATASVIR .....	172
RYDAPT.....	12, 13	SOLTAMOX .....	12, 13
RYKINDO .....	159	SOMAVERT.....	173
RYLAZE.....	160	sorafenib tosylate .....	12, 13
<b>S</b>		SOTYKTU .....	174
sapropterin dihydrochloride oral packet .	161	STELARA INTRAVENOUS .....	201, 202
sapropterin dihydrochloride oral tablet...	161	STELARA SUBCUTANEOUS	
SCEMBLIX .....	12, 13	SOLUTION 45 MG/0.5ML.....	201, 202
SECUADO.....	162	STELARA SUBCUTANEOUS	
SELARSDI INTRAVENOUS .....	201, 202	SOLUTION PREFILLED SYRINGE 45	
SELARSDI SUBCUTANEOUS		MG/0.5ML, 90 MG/ML .....	201, 202
SOLUTION PREFILLED SYRINGE 45		STEQUEYMA INTRAVENOUS .....	201, 202
MG/0.5ML, 90 MG/ML .....	201, 202	STEQUEYMA SUBCUTANEOUS	
SEROSTIM SUBCUTANEOUS		SOLUTION PREFILLED SYRINGE 45	
SOLUTION RECONSTITUTED 4 MG,		MG/0.5ML, 90 MG/ML .....	201, 202
5 MG, 6 MG.....	163	STIVARGA .....	12, 13
sevelamer carbonate oral packet 0.8 gm, 2.4		SUCRAID .....	175
gm .....	235	sunitinib malate.....	12, 13
sevelamer carbonate oral tablet 800 mg..	235	SYMDEKO.....	176
SIGNIFOR .....	164	SYNAREL .....	177

## T

TABLOID .....	12, 13
TABRECTA .....	12, 13
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg .....	235
tadalafil (pah) .....	178
tadalafil oral tablet 5 mg .....	179
TADLIQ.....	178
TAFINLAR.....	12, 13
TAGRISSO .....	12, 13
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR .....	180, 181
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML, 40 MG/0.5ML, 80 MG/ML .....	180, 181
TALZENNA .....	12, 13
TARPEYO .....	182
TASCENSO ODT.....	110, 111
tasimelteon .....	183
TAVNEOS .....	184, 185
TAZVERIK.....	12, 13
temazepam .....	82
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION) .....	235
TEPEZZA .....	186
TEPMETKO .....	12, 13
teriflunomide.....	110, 111
teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml .....	187
testosterone transdermal gel 1.62 %, 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%) .....	193
testosterone transdermal solution.....	193
tetrabenazine .....	209
THALOMID ORAL CAPSULE 100 MG, 50 MG .....	12, 13
TIBSOVO .....	12, 13
tigecycline .....	189
tiopronin oral.....	188
TOBI PODHALER.....	190
tobramycin inhalation nebulization solution 300 mg/4ml, 300 mg/5ml.....	235
tolvaptan.....	191

topiramate oral solution .....	57
toremifene citrate .....	12, 13
TRELSTAR MIXJECT .....	72
TREMFYA CROHNS INDUCTION.....	195
TREMFYA ONE-PRESS.....	195
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 200 MG/2ML .....	195
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 200 MG/2ML .....	195
tretinoin oral.....	12, 13
trientine hcl oral capsule 250 mg.....	196
TRIKAFTA.....	197
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR .....	71
TRUQAP.....	12, 13
TUKYSA .....	12, 13
TURALIO ORAL CAPSULE 125 MG... 12, 13 .....	13
TYMLOS .....	198
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG .....	199
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG .....	199
<b>U</b>	
UBRELVY.....	30, 31
UPTRAVI ORAL .....	200
UPTRAVI TITRATION.....	200
ustekinumab subcutaneous solution 201, 202 .....	201, 202
ustekinumab subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml..	201, 202
ustekinumab-aekn subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml .....	201, 202
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML, 125 MG/0.35ML, 150 MG/0.42ML, 200 MG/0.56ML, 250 MG/0.7ML, 50 MG/0.14ML, 75 MG/0.21ML .....	203
<b>V</b>	
VALCHLOR.....	204
VALTOCO 10 MG DOSE.....	114

VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML .....	114
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML .....	114
VALTOCO 5 MG DOSE.....	114
VANFLYTA .....	12, 13
VEMLIDY .....	205
VENCLEXTA.....	12, 13
VENCLEXTA STARTING PACK ....	12, 13
VEOZAH .....	206
VERZENIO.....	12, 13
vigabatrin .....	207
VIGAFYDE .....	207
VIJOICE .....	208
VITRAKVI .....	12, 13
VIZIMPRO .....	12, 13
VONJO .....	12, 13
VORANIGO .....	12, 13
voriconazole intravenous .....	210
VOSEVI.....	211
VOWST .....	212
VRAYLAR ORAL CAPSULE.....	125, 126
<b>W</b>	
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML ...	213, 214
WELIREG.....	12, 13
WINREVAIR.....	216
<b>X</b>	
XALKORI.....	12, 13
XATMEP .....	105
XDEMVEY.....	217
XELJANZ ORAL SOLUTION .....	218, 219
XELJANZ ORAL TABLET.....	218, 219
XELJANZ XR .....	218, 219
XERMELO .....	220
XIFAXAN.....	221
XOLAIR .....	222, 223
XOLREMDI .....	224
XOSPATA .....	12, 13
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG .....	12, 13

XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 40 MG .....	12, 13
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG .....	12, 13
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG... 12, 13	
XPOVIO (60 MG TWICE WEEKLY)12, 13	
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG... 12, 13	
XPOVIO (80 MG TWICE WEEKLY)12, 13	
XTANDI .....	12, 13
XYWAV .....	225
<b>Y</b>	
YESINTEK INTRAVENOUS.....	201, 202
YESINTEK SUBCUTANEOUS SOLUTION.....	201, 202
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML .....	201, 202
YONSA.....	12, 13
YORVIPATH .....	226
YUTREPIA.....	227
<b>Z</b>	
zaleplon oral capsule 10 mg, 5 mg.....	82
ZARXIO .....	215
ZAVZPRET .....	30, 31
ZEJULA ORAL TABLET.....	12, 13
ZELBORAF.....	12, 13
ZEMAIRA .....	8
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR	228, 229
ZEPOSIA .....	230
ZEPOSIA 7-DAY STARTER PACK....	230
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21).....	230
ZILBRYSQ.....	231
ZOLINZA .....	12, 13
zolpidem tartrate er .....	82
zolpidem tartrate oral tablet .....	82
ZTALMY .....	232
ZTLIDO .....	194



ZURZUVAE ..... 233  
ZYDELIG ..... 12, 13

ZYKADIA ORAL TABLET ..... 12, 13

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