

ABALOPARATIDE

Products Affected

- TYMLOS

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

ABATACEPT IV

Products Affected

- ORENCIA (WITH MALTOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	RA, PJIA, PSA: INITIAL: 6 MOS, RENEWAL: 12 MOS. ACUTE GRAFT VERSUS HOST DISEASE (AGVHD): 1 MO.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. RENEWAL: RA, PJIA, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

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

ABATACEPT SQ

Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PJIA, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ABEMACICLIB

Products Affected

- VERZENIO

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

ABIRATERONE

Products Affected

- *abiraterone*
- *abirtega*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC HIGH-RISK CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC), METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ACALABRUTINIB

Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

ADAGRASIB

Products Affected

- KRAZATI

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

ADALIMUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST.
Coverage Duration	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: DOES NOT HAVE ISOLATED ANTERIOR UVEITIS. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA, AS, PSO, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ADALIMUMAB-AATY

Products Affected

- YUFLYMA(CF)
- YUFLYMA(CF) AI CROHN'S-UC-HS
- YUFLYMA(CF) AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST.
Coverage Duration	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: DOES NOT HAVE ISOLATED ANTERIOR UVEITIS. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA, AS, PSO, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ADALIMUMAB-ADBIM

Products Affected

- CYLTEZO(CF)
- CYLTEZO(CF) PEN
- CYLTEZO(CF) PEN CROHN'S-UC-HS
- CYLTEZO(CF) PEN PSORIASIS-UV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST.
Coverage Duration	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: DOES NOT HAVE ISOLATED ANTERIOR UVEITIS. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA, AS, PSO, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AFATINIB

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ALECTINIB

Products Affected

- ALECENSA

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

ALPELISIB-PIQRAY

Products Affected

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

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

AMIKACIN LIPOSOMAL INH

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MYCOBACTERIUM AVIUM COMPLEX (MAC) LUNG DISEASE: RENEWAL: 1) NO POSITIVE MAC SPUTUM CULTURE AFTER CONSECUTIVE NEGATIVE CULTURES, AND 2) IMPROVEMENT IN SYMPTOMS. ADDITIONALLY, FOR FIRST RENEWAL, APPROVAL REQUIRES AT LEAST ONE NEGATIVE SPUTUM CULTURE FOR MAC BY SIX MONTHS OF ARIKAYCE TREATMENT. FOR SECOND AND SUBSEQUENT RENEWALS, APPROVAL REQUIRES AT LEAST THREE NEGATIVE SPUTUM CULTURES FOR MAC BY 12 MONTHS OF ARIKAYCE TREATMENT.
Age Restrictions	
Prescriber Restrictions	MAC LUNG DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: 6 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AMIVANTAMAB-VMJW

Products Affected

- RYBREVANT

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

ANAKINRA

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS.
Required Medical Information	INITIAL: CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR, SERUM AMYLOID A PROTEIN (SAA) OR S100 PROTEINS), AND 2) TWO OF THE FOLLOWING: URTICARIAL-LIKE RASH (NEUTROPHILIC DERMATITIS), COLD-TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS, CHRONIC ASEPTIC MENINGITIS, SKELETAL ABNORMALITIES. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) ONE OF THE FOLLOWING: PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, ONYCHOMADESIS.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. CAPS, DIRA: LIFETIME.

PA Criteria	Criteria Details
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: RA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

APALUTAMIDE

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC, METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: NMCRPC, MCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

APOMORPHINE - ONAPGO

Products Affected

- ONAPGO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

APOMORPHINE - SL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	PD: RENEWAL: IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MILD PLAQUE PSORIASIS (PSO): 1) PSORIASIS COVERING 2 PERCENT OF BODY SURFACE AREA (BSA), 2) STATIC PHYSICIAN GLOBAL ASSESSMENT (SPGA) SCORE OF 2, OR 3) PSORIASIS AREA AND SEVERITY INDEX (PASI) SCORE OF 2 TO 9. MODERATE TO SEVERE PSO: PSORIASIS COVERING 3 PERCENT OR MORE OF BSA, OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL SYSTEMIC THERAPY (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE) OR ONE CONVENTIONAL TOPICAL THERAPY (E.G., TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. BEHCETS DISEASE: 1) HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID, ORAL CORTICOSTEROID). INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ARIMOCLOMOL

Products Affected

- MIPLYFFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NIEMANN-PICK DISEASE TYPE C (NPC): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH NEUROLOGIST OR GENETICIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	NPC: RENEWAL: IMPROVEMENT OR SLOWING OF DISEASE PROGRESSION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ASCIMINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED OR T315I MUTATION PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND SCEMBLIX IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ASFOTASE ALFA

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOPHOSPHATASIA (HPP): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, GENETICIST, OR METABOLIC SPECIALIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

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

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

ATOGEPANT

Products Affected

- QULIPTA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AVACOPAN

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ANTI-NEUTROPHIL CYTOPLASMIC AUTOANTIBODY (ANCA)-ASSOCIATED VASCULITIS: INITIAL: ANCA SEROPOSITIVE (ANTI-PR3 OR ANTI-MPO).
Age Restrictions	
Prescriber Restrictions	ANCA-ASSOCIATED VASCULITIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 6 MONTHS.
Other Criteria	ANCA-ASSOCIATED VASCULITIS: RENEWAL: CONTINUES TO BENEFIT FROM THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AVAPRITINIB

Products Affected

- AYVAKIT

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

AVUTOMETINIB-DEFACTINIB

Products Affected

- AVMAPKI
- AVMAPKI-FAKZYNJA
- FAKZYNJA

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

AXATILIMAB-CSFR

Products Affected

- NIKTIMVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CHRONIC GRAFT VS HOST DISEASE (CGVHD): 1) FAILURE OF AT LEAST TWO LINES OF SYSTEMIC THERAPY, ONE OF WHICH MUST BE A TRIAL OF OR CONTRAINDICATION TO JAKAFI, AND 2) NO CONCURRENT USE WITH JAKAFI, REZUROCK, OR IMBRUVICA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

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

AZACITIDINE

Products Affected

- ONUREG

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

AZTREONAM INHALED

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	7 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BEDAQUILINE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

BELIMUMAB

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. LUPUS NEPHRITIS (LN): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: SLE: CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: PATIENT HAD CLINICAL IMPROVEMENT. LN: IMPROVEMENT IN RENAL RESPONSE FROM BASELINE LABORATORY VALUES (I.E., EGFR OR PROTEINURIA) AND/OR CLINICAL PARAMETERS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BELUMOSUDIL

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CHRONIC GRAFT VS HOST DISEASE (CGVHD): 1) FAILURE OF AT LEAST TWO LINES OF SYSTEMIC THERAPY, ONE OF WHICH MUST BE A TRIAL OF OR CONTRAINDICATION TO JAKAFI, AND 2) NO CONCURRENT USE WITH JAKAFI, NIKTIMVO, OR IMBRUVICA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BELZUTIFAN

Products Affected

- WELIREG

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

BENDAMUSTINE

Products Affected

- *bendamustine intravenous recon soln*
- BENDAMUSTINE INTRAVENOUS SOLUTION
- BENDEKA
- VIVIMUSTA

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

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS, OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ASTHMA: 1) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 2) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): REDUCTION IN EGPA SYMPTOMS COMPARED TO BASELINE OR ABILITY TO REDUCE/ELIMINATE CORTICOSTEROID USE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BETAINE

Products Affected

- *betaine*

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

BEVACIZUMAB-BVZR

Products Affected

- ZIRABEV

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

BEXAROTENE

Products Affected

- *bexarotene*

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

BINIMETINIB

Products Affected

- MEKTOVI

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

BORTEZOMIB

Products Affected

- *bortezomib injection*
- BORUZU

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

BOSENTAN

Products Affected

- *bosentan oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL: 1) DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASE IN BILIRUBIN BY 2 OR MORE TIMES ULN, AND 2) NO CONCURRENT USE WITH CYCLOSPORINE A OR GLYBURIDE. RENEWAL: NO CONCURRENT USE WITH CYCLOSPORINE A OR GLYBURIDE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BOSUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

BRIGATINIB

Products Affected

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

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

C1 ESTERASE INHIBITOR-HAEGARDA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, ALLERGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CABOZANTINIB CAPSULE

Products Affected

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

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

CABOZANTINIB TABLET

Products Affected

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

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

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

CAPIVASERTIB

Products Affected

- TRUQAP

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

CAPMATINIB

Products Affected

- TABRECTA

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

CARGLUMIC ACID

Products Affected

- *carglumic acid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ACUTE OR CHRONIC HYPERAMMONEMIA (HA) DUE TO N ACETYLGLUTAMATE SYNTHASE (NAGS) DEFICIENCY: NAGS GENE MUTATION IS CONFIRMED BY BIOCHEMICAL OR GENETIC TESTING. ACUTE HA DUE TO PROPIONIC ACIDEMIA (PA): 1) CONFIRMED BY ELEVATED METHYLCITRIC ACID AND NORMAL METHYLMALONIC ACID, OR 2) GENETIC TESTING CONFIRMS MUTATION IN THE PCCA OR PCCB GENE. ACUTE HA DUE TO METHYLMALONIC ACIDEMIA (MMA): 1) CONFIRMED BY ELEVATED METHYLMALONIC ACID, METHYLCITRIC ACID, OR 2) GENETIC TESTING CONFIRMS MUTATION IN THE MMUT, MMA, MMAB OR MMADHC GENES.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE HA DUE TO NAGS/PA/MMA: 7 DAYS. CHRONIC HA DUE TO NAGS: INITIAL: 6 MOS, RENEWAL: 12 MOS.
Other Criteria	RENEWAL: CHRONIC HA DUE TO NAGS: PATIENT HAS SHOWN CLINICAL IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CERITINIB

Products Affected

- ZYKADIA

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

CERTOLIZUMAB PEGOL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA, SELARSDI/YESINTEK, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ. CD: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK, HUMIRA/CYLTEZO/YUFLYMA, RINVOQ, SKYRIZI, TREMFYA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA, SELARSDI/YESINTEK, SKYRIZI, TREMFYA, OTEZLA. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, ORENCIA, RINVOQ. INITIAL FOR RA, PSA, PSO, AS, CD, PJIA: TRIAL OF OR CONTRAINDICATION TO THE STEP AGENTS IS NOT REQUIRED IF THE PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL FOR RA, PSA, AS, PSO, NR-AXSPA, PJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

CETUXIMAB

Products Affected

- ERBITUX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CLADRIBINE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 WEEKS.
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): HAS NOT RECEIVED A TOTAL OF TWO YEARS OF MAVENCLAD TREATMENT (I.E., TWO YEARLY TREATMENT COURSES OF TWO CYCLES IN EACH).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	LENNOX-GASTAUT SYNDROME (LGS): THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	LGS: 1) UNABLE TO TAKE TABLETS OR SUSPENSIONS, AND 2) TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF CLOBAZAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

COBIMETINIB

Products Affected

- COTELLIC

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

CORTICOTROPIN

Products Affected

- CORTROPHIN GEL INJECTION

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: NOT APPROVED FOR DIAGNOSTIC PURPOSES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.
Coverage Duration	INFANTILE SPASMS AND MS: 28 DAYS. ALL OTHER FDA APPROVED INDICATIONS: INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO INTRAVENOUS (IV) CORTICOSTEROIDS. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MS: DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS. PART B BEFORE PART D STEP THERAPY, APPLIES ONLY TO BENEFICIARIES IN AN MA-PD PLAN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	Yes

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

CRIZOTINIB CAPSULE

Products Affected

- XALKORI ORAL CAPSULE

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

CRIZOTINIB PELLETS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	NON-SMALL CELL LUNG CANCER (NSCLC), ANAPLASTIC LARGE CELL LYMPHOMA (ALCL), INFLAMMATORY MYOFIBROBLASTIC TUMOR (IMT): UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DABRAFENIB CAPSULES

Products Affected

- TAFINLAR ORAL CAPSULE

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

DABRAFENIB SUSPENSION

Products Affected

- TAFINLAR ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNABLE TO SWALLOW TAFINLAR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DACOMITINIB

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

DAROLUTAMIDE

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC, METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (MHSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: NMCRPC, MHSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

DASATINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND DASATINIB IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DATOPOTAMAB DERUXTECAN-DLNK

Products Affected

- DATROWAY

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

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

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

DEFERASIROX

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DENOSUMAB-BMWO - OSENVELT

Products Affected

- OSENVELT

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

DENOSUMAB-XGEVA

Products Affected

- XGEVA

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

DEUTETRABENAZINE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTON DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	TARDIVE DYSKINESIA: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DICLOFENAC TOPICAL SOLUTION

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	OSTEOARTHRITIS OF THE KNEE: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DICLOFENAC SODIUM 1% TOPICAL GEL AND A FORMULARY VERSION OF DICLOFENAC SODIUM 1.5% TOPICAL DROPS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DICLOFENAC-FLECTOR

Products Affected

- *diclofenac epolamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DIMETHYL FUMARATE

Products Affected

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

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

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

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

DORDAVIPRONE

Products Affected

- MODEYSO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

DOSTARLIMAB-GXLY

Products Affected

- JEMPERLI

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

DRONABINOL CAPSULE

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY: TRIAL OF OR CONTRAINDICATION TO ONE ANTIEMETIC THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DROXIDOPA

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH): INITIAL: 1) BASELINE BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE POSITION. 2) A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION.
Age Restrictions	
Prescriber Restrictions	NOH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
Other Criteria	NOH: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DUPILUMAB

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DUVELISIB

Products Affected

- COPIKTRA

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

EFLORNITHINE

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ELACESTRANT

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

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

ELAGOLIX

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 2) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND A PROGESTIN-CONTAINING PREPARATION. RENEWAL: 1) IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ELAPEGADEMASE-LVLR

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ADENOSINE DEAMINASE SEVERE COMBINED IMMUNE DEFICIENCY (ADA-SCID): INITIAL: ADA-SCID AS MANIFESTED BY: 1) CONFIRMATORY GENETIC TEST, OR 2) SUGGESTIVE LABORATORY FINDINGS (E.G., ELEVATED DEOXYADENOSINE NUCLEOTIDE [DAXP] LEVELS, LYMPHOPENIA) AND HALLMARK SIGNS/SYMPTOMS (E.G., RECURRENT INFECTIONS, FAILURE TO THRIVE, PERSISTENT DIARRHEA).
Age Restrictions	
Prescriber Restrictions	ADA-SCID: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH IMMUNOLOGIST, HEMATOLOGIST/ONCOLOGIST, OR PHYSICIAN SPECIALIZING IN INHERITED METABOLIC DISORDERS.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ADA-SCID: RENEWAL: 1) IMPROVEMENT OR MAINTENANCE OF IMMUNE FUNCTION FROM BASELINE, AND 2) HAS NOT RECEIVED SUCCESSFUL HCT OR GENE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ELEXACFTOR-TEZACFTOR-IVACFTOR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
Other Criteria	CF: INITIAL: NO CONCURRENT USE WITH ANOTHER CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) MODULATOR. RENEWAL: 1) IMPROVEMENT IN CLINICAL STATUS, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ELRANATAMAB-BCMM

Products Affected

- ELREXFIO 44 MG/1.1 ML VIAL INNER, SUV, P/F
- ELREXFIO SUBCUTANEOUS SOLUTION 40 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RELAPSED OR REFRACTORY MULTIPLE MYELOMA: RENEWAL: 1) HAS RECEIVED AT LEAST 24 WEEKS OF TREATMENT WITH ELREXFIO, AND 2) HAS RESPONDED TO TREATMENT (PARTIAL RESPONSE OR BETTER), AND HAS MAINTAINED THIS RESPONSE FOR AT LEAST 2 MONTHS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ELTROMBOPAG - ALVAIZ

Products Affected

- ALVAIZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: 1) PLATELET COUNT IS LESS THAN $30 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LABS IN THE LAST 3 MONTHS, OR 2) PLATELET COUNT IS LESS THAN $50 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LABS IN THE LAST 3 MONTHS AND HAD A PRIOR BLEEDING EVENT.
Age Restrictions	
Prescriber Restrictions	INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	ITP: INITIAL: 6 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	INITIAL: ITP: 1) TRIAL OF OR CONTRAINDICATION TO ONE CORTICOSTEROID OR IMMUNOGLOBULIN, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY, AND 2) NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS) OR SPLEEN TYROSINE KINASE (SYK) INHIBITOR. RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNT FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS OR SYK INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ELTROMBOPAG - PROMACTA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ENASIDENIB

Products Affected

- IDHIFA

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

ENCORAFENIB

Products Affected

- BRAFTOVI

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

ENTRECTINIB CAPSULES

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

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

ENTRECTINIB PELLETS

Products Affected

- ROZLYTREK ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC), SOLID TUMORS: 1) TRIAL OF OR CONTRAINDICATION TO ROZLYTREK CAPSULES MADE INTO AN ORAL SUSPENSION, AND 2) DIFFICULTY OR UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ENZALUTAMIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: ALL INDICATIONS: 12 MONTHS. RENEWAL: MCRPC, NMCRPC, MCSPC: 12 MONTHS.
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (NMCSPC): HIGH RISK FOR METASTASIS (I.E. PSA DOUBLING TIME OF 9 MONTHS OR LESS). METASTATIC CRPC (MCRPC), NMCRPC, METASTATIC CSPC (MCSPC), NMCSPC : 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: MCRPC, NMCRPC, MCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

EPCORITAMAB-BYSP

Products Affected

- EPKINLY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

EPOETIN ALFA-EPBX

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

ERDAFITINIB

Products Affected

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

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

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ERLOTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ESKETAMINE

Products Affected

- SPRAVATO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: TREATMENT-RESISTANT DEPRESSION (TRD), MAJOR DEPRESSIVE DISORDER (MDD): PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
Coverage Duration	INITIAL: TRD: 3 MONTHS. MDD: 4 WEEKS. RENEWAL: TRD, MDD: 12 MONTHS.
Other Criteria	INITIAL: TRD, MDD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, AND 2) NO ACTIVE SUBSTANCE ABUSE. RENEWAL: TRD, MDD: DEMONSTRATED CLINICAL BENEFIT (IMPROVEMENT IN DEPRESSION) COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ETANERCEPT

Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

EVEROLIMUS-AFINITOR

Products Affected

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

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

EVEROLIMUS-AFINITOR DISPERZ

Products Affected

- *everolimus (antineoplastic) oral tablet for suspension*

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

FECAL MICROBIOTA CAPSULE

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	CLOSTRIDIoidES DIFFICILE INFECTION (CDI): 1) HAS NOT PREVIOUSLY RECEIVED VOWST: COMPLETION OF ANTIBIOTIC TREATMENT FOR RECURRENT CDI (AT LEAST 3 CDI EPISODES), OR 2) PREVIOUSLY RECEIVED VOWST: (A) TREATMENT FAILURE (DEFINED AS THE PRESENCE OF CDI DIARRHEA WITHIN 8 WEEKS OF FIRST DOSE OF VOWST AND A POSITIVE STOOL TEST FOR C. DIFFICILE), AND (B) HAS NOT RECEIVED MORE THAN ONE TREATMENT COURSE OF VOWST WHICH WAS AT LEAST 12 DAYS AND NOT MORE THAN 8 WEEKS PRIOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	MYELOFIBROSIS: INITIAL: TRIAL OF OR CONTRAINDICATION TO JAKAFI (RUXOLITINIB). RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FENFLURAMINE

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: DRAVET SYNDROME, LENNOX-GASTAUT SYNDROME (LGS): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	DRAVET SYNDROME: INITIAL/RENEWAL: 12 MONTHS. LGS: 12 MONTHS.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM. RENEWAL: DRAVET SYNDROME: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER RELATED PAIN: 1) CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR PATIENT HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FEZOLINETANT

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FILGRASTIM-AAFI

Products Affected

- NIVESTYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

FINERENONE

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

FINGOLIMOD

Products Affected

- *fingolimod*

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

FOSCARBIDOPA-FOSLEVODOPA

Products Affected

- VYALEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	PD: INITIAL: 1) RESPONSIVE TO LEVODOPA, 2) CURRENT REGIMEN INCLUDES AT LEAST 400 MG/DAY OF LEVODOPA, 3) MOTOR SYMPTOMS ARE CURRENTLY UNCONTROLLED (DEFINED AS AN AVERAGE OFF TIME OF AT LEAST 2.5 HOURS/DAY OVER 3 CONSECUTIVE DAYS, WITH A MINIMUM OF 2 HOURS EACH DAY), AND 4) ONE OF THE FOLLOWING: (A) UNABLE TO SWALLOW EXTENDED-RELEASE (ER) TABLETS OR ADMINISTER ER CAPSULES VIA A FEEDING TUBE, OR (B) FAILURE TO ADHERE OR TOLERATE VIA A FEEDING TUBE AN ORAL CARBIDOPA/LEVODOPA REGIMEN. RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

FRUQUINTINIB

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

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

FUTIBATINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INTRAHEPATIC CHOLANGIOCARCINOMA (ICCA): COMPLETE A COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY PEN
- EMGALITY SYRINGE SUBCUTANEOUS
SYRINGE 120 MG/ML, 300 MG/3 ML (100
MG/ML X 3)

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

GANAXOLONE

Products Affected

- ZTALMY

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

GEFITINIB

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GILTERITINIB

Products Affected

- XOSPATA

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

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

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

GLATIRAMER

Products Affected

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

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

GLP1-DULAGLUTIDE

Products Affected

- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC
- RYBELSUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GLP1-TIRZEPATIDE

Products Affected

- MOUNJARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GOSERELIN

Products Affected

- ZOLADEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	
Prescriber Restrictions	ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	STAGE B2-C PROSTATIC CARCINOMA: 4 MOS. ENDOMETRIOSIS: 6 MOS PER LIFETIME. ALL OTHERS: 12 MONTHS.
Other Criteria	ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

GUSELKUMAB

Products Affected

- TREMFYA INJECTOR 200 MG/2 ML
- TREMFYA 100 MG/ML ONE-PRESS
- TREMFYA PEN INDUCTION PK-CROHN
- TREMFYA PEN SUBCUTANEOUS PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

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

HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

Products Affected

- *morphine concentrate oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

IBRUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CHRONIC GRAFT VS HOST DISEASE (CGVHD): NO CONCURRENT USE WITH JAKAFI, NIKTIMVO, OR REZUROCK.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ICATIBANT

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	HAE: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR THE TREATMENT OF ACUTE HAE ATTACKS. RENEWAL: REDUCTION IN SEVERITY OR DURATION OF ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IDEALALISIB

Products Affected

- ZYDELIG

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

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IMATINIB SOLUTION

Products Affected

- IMKELDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR. ALL INDICATIONS: UNABLE TO SWALLOW GENERIC IMATINIB TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IMETELSTAT

Products Affected

- RYTELO

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

INAVOLISIB

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

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

INFLIXIMAB

Products Affected

- *infliximab*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

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

INSULIN SUPPLIES PAYMENT DETERMINATION

Products Affected

- 1ST TIER UNIFINE PENTP 5MM 31G
- 1ST TIER UNIFINE PNTIP 4MM 32G
- 1ST TIER UNIFINE PNTIP 6MM 31G
- 1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT
- 1ST TIER UNIFINE PNTP 29GX1/2"
- 1ST TIER UNIFINE PNTP 31GX3/16
- 1ST TIER UNIFINE PNTP 32GX5/32
- ABOUTTIME PEN NEEDLE
- ADVOCATE INS 0.3 ML 30GX5/16"
- ADVOCATE INS 0.3 ML 31GX5/16"
- ADVOCATE INS 0.5 ML 30GX5/16"
- ADVOCATE INS 0.5 ML 31GX5/16"
- ADVOCATE INS 1 ML 31GX5/16"
- ADVOCATE INS SYR 0.3 ML 29GX1/2
- ADVOCATE INS SYR 0.5 ML 29GX1/2
- ADVOCATE INS SYR 1 ML 29GX1/2"
- ADVOCATE INS SYR 1 ML 30GX5/16
- ADVOCATE PEN NDL 12.7MM 29G
- ADVOCATE PEN NEEDLE 32G 4MM
- ADVOCATE PEN NEEDLE 4MM 33G
- ADVOCATE PEN NEEDLES 5MM 31G
- ADVOCATE PEN NEEDLES 8MM 31G
- ALCOHOL 70% SWABS
- ALCOHOL PADS
- ALCOHOL WIPES
- AQINJECT PEN NEEDLE 31G 5MM
- AQINJECT PEN NEEDLE 32G 4MM
- ASSURE ID DUO PRO NDL 31G 5MM
- ASSURE ID DUO-SHIELD 30GX3/16"
- ASSURE ID DUO-SHIELD 30GX5/16"
- ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- ASSURE ID PEN NEEDLE 30GX3/16"
- ASSURE ID PEN NEEDLE 30GX5/16"
- ASSURE ID PEN NEEDLE 31GX3/16"
- ASSURE ID PRO PEN NDL 30G 5MM
- ASSURE ID SYR 0.5 ML 31GX15/64"
- ASSURE ID SYR 1 ML 31GX15/64"
- AUTOSHIELD DUO PEN NDL 30G 5MM
- BD AUTOSHIELD DUO NDL 5MMX30G
- BD ECLIPSE 30GX1/2" SYRINGE
- BD ECLIPSE NEEDLE 30GX1/2" (OTC)
- BD INS SYR 0.3 ML 8MMX31G(1/2)
- BD INS SYR UF 0.3 ML 12.7MMX30G
- BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE
- BD INSULIN SYR 1 ML 25GX1"
- BD INSULIN SYR 1 ML 25GX5/8"
- BD INSULIN SYR 1 ML 26GX1/2"
- BD INSULIN SYR 1 ML 27GX12.7MM
- BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE
- BD INSULIN SYRINGE SLIP TIP
- BD LO-DOSE ULTRA-FINE
- BD NANO 2 GEN PEN NDL 32G 4MM
- BD SAFETGLD INS 0.3 ML 29G 13MM
- BD SAFETGLD INS 0.5 ML 13MMX29G
- BD SAFETYGLD INS 0.3 ML 31G 8MM
- BD SAFETYGLD INS 0.5 ML 30G 8MM
- BD SAFETYGLD INS 1 ML 29G 13MM
- BD SAFETYGLID INS 1 ML 6MMX31G
- BD SAFETYGLIDE SYRINGE 27GX5/8
- BD SAFTYGLD INS 0.3 ML 6MMX31G
- BD SAFTYGLD INS 0.5 ML 29G 13MM
- BD SAFTYGLD INS 0.5 ML 6MMX31G
- BD UF MICRO PEN NEEDLE 6MMX32G
- BD UF MINI PEN NEEDLE 5MMX31G
- BD UF NANO PEN NEEDLE 4MMX32G
- BD UF ORIG PEN NDL 12.7MMX29G
- BD UF SHORT PEN NEEDLE 8MMX31G
- BD VEO INS 0.3 ML 6MMX31G (1/2)
- BD VEO INS SYRING 1 ML 6MMX31G
- BD VEO INS SYRN 0.3 ML 6MMX31G
- BD VEO INS SYRN 0.5 ML 6MMX31G
- BORDERED GAUZE 2"X2"
- CAREFINE PEN NEEDLE 12.7MM 29G
- CAREFINE PEN NEEDLE 4MM 32G
- CAREFINE PEN NEEDLE 5MM 32G
- CAREFINE PEN NEEDLE 6MM 31G
- CAREFINE PEN NEEDLE 8MM 30G
- CAREFINE PEN NEEDLES 6MM 32G

- CAREFINE PEN NEEDLES 8MM 31G
- CARETOUCH ALCOHOL 70% PREP PAD
- CARETOUCH PEN NEEDLE 29G 12MM
- CARETOUCH PEN NEEDLE 31GX1/4"
- CARETOUCH PEN NEEDLE 31GX3/16"
- CARETOUCH PEN NEEDLE 31GX5/16"
- CARETOUCH PEN NEEDLE 32GX3/16"
- CARETOUCH PEN NEEDLE 32GX5/32"
- CARETOUCH SYR 0.3 ML 31GX5/16"
- CARETOUCH SYR 0.5 ML 30GX5/16"
- CARETOUCH SYR 0.5 ML 31GX5/16"
- CARETOUCH SYR 1 ML 28GX5/16"
- CARETOUCH SYR 1 ML 29GX5/16"
- CARETOUCH SYR 1 ML 30GX5/16"
- CARETOUCH SYR 1 ML 31GX5/16"
- CLICKFINE PEN NEEDLE 32GX5/32"
32GX4MM, STERILE
- COMFORT EZ 0.3 ML 31G 15/64"
- COMFORT EZ 0.5 ML 31G 15/64"
- COMFORT EZ INS 0.3 ML 30GX1/2"
- COMFORT EZ INS 0.3 ML 30GX5/16"
- COMFORT EZ INS 1 ML 31G 15/64"
- COMFORT EZ INS 1 ML 31GX5/16"
- COMFORT EZ INSULIN SYR 0.3 ML
- COMFORT EZ INSULIN SYR 0.5 ML
- COMFORT EZ PEN NEEDLE 12MM 29G
- COMFORT EZ PEN NEEDLES 4MM 32G
SINGLE USE, MICRO
- COMFORT EZ PEN NEEDLES 4MM 33G
- COMFORT EZ PEN NEEDLES 5MM 31G
MINI
- COMFORT EZ PEN NEEDLES 5MM 32G
SINGLE USE,MINI,HRI
- COMFORT EZ PEN NEEDLES 5MM 33G
- COMFORT EZ PEN NEEDLES 6MM 31G
- COMFORT EZ PEN NEEDLES 6MM 32G
- COMFORT EZ PEN NEEDLES 6MM 33G
- COMFORT EZ PEN NEEDLES 8MM 31G
SHORT
- COMFORT EZ PEN NEEDLES 8MM 32G
- COMFORT EZ PEN NEEDLES 8MM 33G
- COMFORT EZ PRO PEN NDL 30G 8MM
- COMFORT EZ PRO PEN NDL 31G 4MM
- COMFORT EZ PRO PEN NDL 31G 5MM
- COMFORT EZ SYR 0.3 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 28GX1/2"
- COMFORT EZ SYR 0.5 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 28GX1/2"
- COMFORT EZ SYR 1 ML 29GX1/2"
- COMFORT EZ SYR 1 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 30GX5/16"
- COMFORT POINT PEN NDL 31GX1/3"
- COMFORT POINT PEN NDL 31GX1/6"
- COMFORT TOUCH PEN NDL 31G 4MM
- COMFORT TOUCH PEN NDL 31G 5MM
- COMFORT TOUCH PEN NDL 31G 6MM
- COMFORT TOUCH PEN NDL 31G 8MM
- COMFORT TOUCH PEN NDL 32G 4MM
- COMFORT TOUCH PEN NDL 32G 5MM
- COMFORT TOUCH PEN NDL 32G 6MM
- COMFORT TOUCH PEN NDL 32G 8MM
- COMFORT TOUCH PEN NDL 33G 4MM
- COMFORT TOUCH PEN NDL 33G 6MM
- COMFORT TOUCH PEN NDL 33GX5MM
- CURAD GAUZE PADS 2" X 2"
- CURITY GAUZE SPONGES (12 PLY)-
200/BAG
- CURITY GAUZE PADS 1'S(12 PLY)
- DERMACEA 2"X2" GAUZE 12 PLY, USP
TYPE VII
- DERMACEA GAUZE 2"X2" SPONGE 8
PLY
- DERMACEA NON-WOVEN 2"X2"
SPNGE
- DROPLET 0.3 ML 29G 12.7MM(1/2)
- DROPLET 0.3 ML 30G 12.7MM(1/2)
- DROPLET 0.5 ML 29GX12.5MM(1/2)
- DROPLET 0.5 ML 30GX12.5MM(1/2)
- DROPLET INS 0.3 ML 29GX12.5MM
- DROPLET INS 0.3 ML 30G 8MM(1/2)
- DROPLET INS 0.3 ML 30GX12.5MM
- DROPLET INS 0.3 ML 31G 6MM(1/2)
- DROPLET INS 0.3 ML 31G 8MM(1/2)
- DROPLET INS 0.5 ML 29G 12.7MM
- DROPLET INS 0.5 ML 30G 12.7MM
- DROPLET INS 0.5 ML 30GX6MM(1/2)
- DROPLET INS 0.5 ML 30GX8MM(1/2)
- DROPLET INS 0.5 ML 31GX6MM(1/2)
- DROPLET INS 0.5 ML 31GX8MM(1/2)
- DROPLET INS SYR 0.3 ML 30GX6MM
- DROPLET INS SYR 0.3 ML 30GX8MM
- DROPLET INS SYR 0.3 ML 31GX6MM
- DROPLET INS SYR 0.3 ML 31GX8MM

- DROPLET INS SYR 0.5 ML 30G 8MM
- DROPLET INS SYR 0.5 ML 31G 6MM
- DROPLET INS SYR 0.5 ML 31G 8MM
- DROPLET INS SYR 1 ML 29G 12.7MM
- DROPLET INS SYR 1 ML 30G 8MM
- DROPLET INS SYR 1 ML 30GX12.5MM
- DROPLET INS SYR 1 ML 30GX6MM
- DROPLET INS SYR 1 ML 31G 6MM
- DROPLET INS SYR 1 ML 31GX6MM
- DROPLET INS SYR 1 ML 31GX8MM
- DROPLET MICRON 34G X 9/64"
- DROPLET PEN NEEDLE 29G 10MM
- DROPLET PEN NEEDLE 29G 12MM
- DROPLET PEN NEEDLE 30G 8MM
- DROPLET PEN NEEDLE 31G 5MM
- DROPLET PEN NEEDLE 31G 6MM
- DROPLET PEN NEEDLE 31G 8MM
- DROPLET PEN NEEDLE 32G 4MM
- DROPLET PEN NEEDLE 32G 5MM
- DROPLET PEN NEEDLE 32G 6MM
- DROPLET PEN NEEDLE 32G 8MM
- DROPSAFE ALCOHOL 70% PREP PADS
- DROPSAFE INS SYR 0.3 ML 31G 6MM
- DROPSAFE INS SYR 0.3 ML 31G 8MM
- DROPSAFE INS SYR 0.5 ML 31G 6MM
- DROPSAFE INS SYR 0.5 ML 31G 8MM
- DROPSAFE INSUL SYR 1 ML 31G 6MM
- DROPSAFE INSUL SYR 1 ML 31G 8MM
- DROPSAFE INSULN 1 ML 29G 12.5MM
- DROPSAFE PEN NEEDLE 31GX1/4"
- DROPSAFE PEN NEEDLE 31GX3/16"
- DROPSAFE PEN NEEDLE 31GX5/16"
- DRUG MART ULTRA COMFORT SYR
- EASY CMFT SFTY PEN NDL 31G 5MM
- EASY CMFT SFTY PEN NDL 31G 6MM
- EASY CMFT SFTY PEN NDL 32G 4MM
- EASY COMFORT 0.3 ML 31G 1/2"
- EASY COMFORT 0.3 ML 31G 5/16"
- EASY COMFORT 0.3 ML SYRINGE
- EASY COMFORT 0.5 ML 30GX1/2"
- EASY COMFORT 0.5 ML 31GX5/16"
- EASY COMFORT 0.5 ML 32GX5/16"
- EASY COMFORT 0.5 ML SYRINGE
- EASY COMFORT 1 ML 31GX5/16"
- EASY COMFORT 1 ML 32GX5/16"
- EASY COMFORT ALCOHOL 70% PAD
- EASY COMFORT INSULIN 1 ML SYR
- EASY COMFORT PEN NDL 29G 4MM
- EASY COMFORT PEN NDL 29G 5MM
- EASY COMFORT PEN NDL 31GX1/4"
- EASY COMFORT PEN NDL 31GX3/16"
- EASY COMFORT PEN NDL 31GX5/16"
- EASY COMFORT PEN NDL 32GX5/32"
- EASY COMFORT PEN NDL 33G 4MM
- EASY COMFORT PEN NDL 33G 5MM
- EASY COMFORT PEN NDL 33G 6MM
- EASY COMFORT SYR 0.5 ML 29G 8MM
- EASY COMFORT SYR 1 ML 29G 8MM
- EASY COMFORT SYR 1 ML 30GX1/2"
- EASY GLIDE INS 0.3 ML 31GX6MM
- EASY GLIDE INS 0.5 ML 31GX6MM
- EASY GLIDE INS 1 ML 31GX6MM
- EASY GLIDE PEN NEEDLE 4MM 33G
- EASY TOUCH 0.3 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 27GX1/2"
- EASY TOUCH 0.5 ML SYR 29GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX5/16
- EASY TOUCH 1 ML SYR 27GX1/2"
- EASY TOUCH 1 ML SYR 29GX1/2"
- EASY TOUCH 1 ML SYR 30GX1/2"
- EASY TOUCH FLIPLOK 1 ML 27GX0.5
- EASY TOUCH INSULIN 1 ML 29GX1/2
- EASY TOUCH INSULIN 1 ML 30GX1/2
- EASY TOUCH INSULIN SYR 0.3 ML
- EASY TOUCH INSULIN SYR 0.5 ML
- EASY TOUCH INSULIN SYR 1 ML
- EASY TOUCH INSULIN SYR 1 ML RETRACTABLE
- EASY TOUCH INSULN 1 ML 29GX1/2"
- EASY TOUCH INSULN 1 ML 30GX1/2"
- EASY TOUCH INSULN 1 ML 30GX5/16
- EASY TOUCH INSULN 1 ML 31GX5/16
- EASY TOUCH LUER LOK INSUL 1 ML
- EASY TOUCH PEN NEEDLE 29GX1/2"
- EASY TOUCH PEN NEEDLE 30GX5/16
- EASY TOUCH PEN NEEDLE 31GX1/4"
- EASY TOUCH PEN NEEDLE 31GX3/16
- EASY TOUCH PEN NEEDLE 31GX5/16
- EASY TOUCH PEN NEEDLE 32GX1/4"
- EASY TOUCH PEN NEEDLE 32GX3/16
- EASY TOUCH PEN NEEDLE 32GX5/32
- EASY TOUCH SAF PEN NDL 29G 5MM
- EASY TOUCH SAF PEN NDL 29G 8MM

- EASY TOUCH SAF PEN NDL 30G 5MM
- EASY TOUCH SAF PEN NDL 30G 8MM
- EASY TOUCH SYR 0.5 ML 28G 12.7MM
- EASY TOUCH SYR 0.5 ML 29G 12.7MM
- EASY TOUCH SYR 1 ML 27G 16MM
- EASY TOUCH SYR 1 ML 28G 12.7MM
- EASY TOUCH SYR 1 ML 29G 12.7MM
- EASY TOUCH UNI-SLIP SYR 1 ML
- EASYTOUCH SAF PEN NDL 30G 6MM
- EMBRACE PEN NEEDLE 29G 12MM
- EMBRACE PEN NEEDLE 30G 5MM
- EMBRACE PEN NEEDLE 30G 8MM
- EMBRACE PEN NEEDLE 31G 5MM
- EMBRACE PEN NEEDLE 31G 6MM
- EMBRACE PEN NEEDLE 31G 8MM
- EMBRACE PEN NEEDLE 32G 4MM
- EQL INSULIN 0.5 ML SYRINGE
- EQL INSULIN 0.5 ML SYRINGE SHORT NEEDLE
- FP INSULIN 1 ML SYRINGE
- FREESTYLE PREC 0.5 ML 30GX5/16
- FREESTYLE PREC 0.5 ML 31GX5/16
- FREESTYLE PREC 1 ML 30GX5/16"
- FREESTYLE PREC 1 ML 31GX5/16"
- GAUZE PAD TOPICAL BANDAGE 2 X 2 "
- GNP CLICKFINE 31G X 1/4" NDL 6MM, UNIVERSAL
- GNP CLICKFINE 31G X 5/16" NDL 8MM, UNIVERSAL
- GNP SIMPLI PEN NEEDLE 32G 4MM
- GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT
- GNP ULT CMFRT 0.5 ML 29GX1/2"
- GNP ULTRA COMFORT 0.5 ML SYR
- GNP ULTRA COMFORT 1 ML SYRINGE
- GNP ULTRA COMFORT 3/10 ML SYR
- GS PEN NEEDLE 31G X 5MM
- GS PEN NEEDLE 31G X 8MM
- HEALTHWISE INS 0.3 ML 30GX5/16"
- HEALTHWISE INS 0.3 ML 31GX5/16"
- HEALTHWISE INS 0.5 ML 30GX5/16"
- HEALTHWISE INS 0.5 ML 31GX5/16"
- HEALTHWISE INS 1 ML 30GX5/16"
- HEALTHWISE INS 1 ML 31GX5/16"
- HEALTHWISE PEN NEEDLE 31G 5MM
- HEALTHWISE PEN NEEDLE 31G 8MM
- HEALTHWISE PEN NEEDLE 32G 4MM
- HEALTHY ACCENTS PENTIP 4MM 32G
- HEALTHY ACCENTS PENTIP 5MM 31G
- HEALTHY ACCENTS PENTIP 6MM 31G
- HEALTHY ACCENTS PENTIP 8MM 31G
- HEALTHY ACCENTS PENTIP 12MM 29G
- HEB INCONTROL ALCOHOL 70% PADS
- INCONTROL PEN NEEDLE 12MM 29G
- INCONTROL PEN NEEDLE 4MM 32G
- INCONTROL PEN NEEDLE 5MM 31G
- INCONTROL PEN NEEDLE 6MM 31G
- INCONTROL PEN NEEDLE 8MM 31G
- INSULIN 1 ML SYRINGE
- INSULIN SYR 0.3 ML 31GX1/4(1/2)
- INSULIN SYR 0.5 ML 28G 12.7MM (OTC)
- INSULIN SYRIN 0.5 ML 30GX1/2" (RX)
- INSULIN SYRING 0.5 ML 27G 1/2" INNER
- INSULIN SYRINGE 0.3 ML
- INSULIN SYRINGE 0.3 ML 31GX1/4
- INSULIN SYRINGE 0.5 ML
- INSULIN SYRINGE 0.5 ML 31GX1/4
- INSULIN SYRINGE 1 ML
- INSULIN SYRINGE 1 ML 27G 1/2" INNER
- INSULIN SYRINGE 1 ML 27G 16MM
- INSULIN SYRINGE 1 ML 28G 12.7MM (OTC)
- INSULIN SYRINGE 1 ML 30GX1/2" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 31GX1/4"
- INSULIN SYRINGE NEEDLELESS
- INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE
- INSULIN U-500 SYRINGE-NEEDLE
- INSUPEN 30G ULTRAFIN NEEDLE
- INSUPEN 31G ULTRAFIN NEEDLE
- INSUPEN 32G 8MM PEN NEEDLE
- INSUPEN PEN NEEDLE 29GX12MM
- INSUPEN PEN NEEDLE 31G 8MM
- INSUPEN PEN NEEDLE 31GX3/16"
- INSUPEN PEN NEEDLE 32G 6MM (RX)
- INSUPEN PEN NEEDLE 32GX4MM
- INSUPEN PEN NEEDLE 33GX4MM
- IV ANTISEPTIC WIPES
- KENDALL ALCOHOL 70% PREP PAD

- LISCO SPONGES 100/BAG
- LITE TOUCH 31GX1/4" PEN NEEDLE
- LITE TOUCH INSULIN 0.5 ML SYR
- LITE TOUCH INSULIN 1 ML SYR
- LITE TOUCH INSULIN SYR 1 ML
- LITE TOUCH PEN NEEDLE 29G
- LITE TOUCH PEN NEEDLE 31G
- LITETOUCH INS 0.3 ML 29GX1/2"
- LITETOUCH INS 0.3 ML 30GX5/16"
- LITETOUCH INS 0.3 ML 31GX5/16"
- LITETOUCH INS 0.5 ML 31GX5/16"
- LITETOUCH SYR 0.5 ML 28GX1/2"
- LITETOUCH SYR 0.5 ML 29GX1/2"
- LITETOUCH SYR 0.5 ML 30GX5/16"
- LITETOUCH SYRIN 1 ML 28GX1/2"
- LITETOUCH SYRIN 1 ML 29GX1/2"
- LITETOUCH SYRIN 1 ML 30GX5/16"
- MAGELLAN INSUL SYRINGE 0.3 ML
- MAGELLAN INSUL SYRINGE 0.5 ML
- MAGELLAN INSULIN SYR 0.3 ML
- MAGELLAN INSULIN SYR 0.5 ML
- MAGELLAN INSULIN SYRINGE 1 ML
- MAXI-COMFORT INS 0.5 ML 28G
- MAXI-COMFORT INS 1 ML 28GX1/2"
- MAXICOMFORT II PEN NDL 31GX6MM
- MAXICOMFORT INS 0.5 ML 27GX1/2"
- MAXICOMFORT INS 1 ML 27GX1/2"
- MAXICOMFORT PEN NDL 29G X 5MM
- MAXICOMFORT PEN NDL 29G X 8MM
- MICRODOT PEN NEEDLE 31GX6MM
- MICRODOT PEN NEEDLE 32GX4MM
- MICRODOT PEN NEEDLE 33GX4MM
- MICRODOT READYGARD NDL 31G 5MM OUTER
- MINI PEN NEEDLE 32G 4MM
- MINI PEN NEEDLE 32G 5MM
- MINI PEN NEEDLE 32G 6MM
- MINI PEN NEEDLE 32G 8MM
- MINI PEN NEEDLE 33G 4MM
- MINI PEN NEEDLE 33G 5MM
- MINI PEN NEEDLE 33G 6MM
- MINI ULTRA-THIN II PEN NDL 31G STERILE
- MONOJECT 0.5 ML SYRN 28GX1/2"
- MONOJECT 1 ML SYRN 27X1/2"
- MONOJECT 1 ML SYRN 28GX1/2" (OTC)
- MONOJECT INSUL SYR U100 (OTC)
- MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)
- MONOJECT INSUL SYR U100 1 ML
- MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)
- MONOJECT INSULIN SYR 0.3 ML
- MONOJECT INSULIN SYR 0.3 ML (OTC)
- MONOJECT INSULIN SYR 0.5 ML
- MONOJECT INSULIN SYR 0.5 ML (OTC)
- MONOJECT INSULIN SYR 1 ML 3'S (OTC)
- MONOJECT INSULIN SYR U-100
- MONOJECT SYRINGE 0.3 ML
- MONOJECT SYRINGE 0.5 ML
- MONOJECT SYRINGE 1 ML
- MS INSULIN SYR 1 ML 31GX5/16" (OTC)
- MS INSULIN SYRINGE 0.3 ML
- NANO 2 GEN PEN NEEDLE 32G 4MM
- NANO PEN NEEDLE 32G 4MM
- NOVOFINE 30
- NOVOFINE 32G NEEDLES
- NOVOFINE PLUS PEN NDL 32GX1/6"
- NOVOTWIST
- PC UNIFINE PENTIPS 8MM NEEDLE SHORT
- PEN NEEDLE 30G 5MM OUTER
- PEN NEEDLE 30G 8MM INNER
- PEN NEEDLE 30G X 5/16"
- PEN NEEDLE 31G X 1/4" HRI
- PEN NEEDLE 6MM 31G 6MM
- PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLES 12MM 29G 29GX12MM,STRL
- PEN NEEDLES 4MM 32G
- PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC)
- PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC)
- PENTIPS PEN NEEDLE 29G 1/2"
- PENTIPS PEN NEEDLE 31G 1/4"
- PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM

- PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM
- PENTIPS PEN NEEDLE 32G 1/4"
- PENTIPS PEN NEEDLE 32GX5/32" 4MM
- PIP PEN NEEDLE 31G X 5MM
- PIP PEN NEEDLE 32G X 4MM
- PREFPLS INS SYR 1 ML 30GX5/16" (OTC)
- PREVENT PEN NEEDLE 31GX1/4"
- PREVENT PEN NEEDLE 31GX5/16"
- PRO COMFORT 0.5 ML 30GX1/2"
- PRO COMFORT 0.5 ML 30GX5/16"
- PRO COMFORT 0.5 ML 31GX5/16"
- PRO COMFORT 1 ML 30GX1/2"
- PRO COMFORT 1 ML 30GX5/16"
- PRO COMFORT 1 ML 31GX5/16"
- PRO COMFORT ALCOHOL 70% PADS
- PRO COMFORT PEN NDL 32G 8MM
- PRO COMFORT PEN NDL 32G X 1/4"
- PRO COMFORT PEN NDL 4MM 32G
- PRO COMFORT PEN NDL 5MM 32G
- PRODIGY INS SYR 1 ML 28GX1/2"
- PRODIGY SYRNG 0.5 ML 31GX5/16"
- PRODIGY SYRNG 0.3 ML 31GX5/16"
- PURE CMFT SFTY PEN NDL 31G 5MM
- PURE CMFT SFTY PEN NDL 31G 6MM
- PURE CMFT SFTY PEN NDL 32G 4MM
- PURE COMFORT ALCOHOL 70% PADS
- PURE COMFORT PEN NDL 32G 4MM
- PURE COMFORT PEN NDL 32G 5MM
- PURE COMFORT PEN NDL 32G 6MM
- PURE COMFORT PEN NDL 32G 8MM
- RAYA SURE PEN NEEDLE 29G 12MM
- RAYA SURE PEN NEEDLE 31G 4MM
- RAYA SURE PEN NEEDLE 31G 5MM
- RAYA SURE PEN NEEDLE 31G 6MM
- RELI-ON INSULIN 1 ML SYR
- RELION INS SYR 0.3 ML 31GX6MM
- RELION INS SYR 0.5 ML 31GX6MM
- RELION INS SYR 1 ML 31GX15/64"
- SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10
- SAFETY PEN NEEDLE 31G 4MM
- SAFETY PEN NEEDLE 5MM X 31G
- SAFETY SYRINGE 0.5 ML 30G 1/2"
- SECURESAFE PEN NDL 30GX5/16" OUTER
- SECURESAFE SYR 0.5 ML 29G 1/2" OUTER
- SECURESAFE SYRNG 1 ML 29G 1/2" OUTER
- SKY SAFETY PEN NEEDLE 30G 5MM
- SKY SAFETY PEN NEEDLE 30G 8MM
- SM ULT CFT 0.3 ML 31GX5/16(1/2)
- STERILE PADS 2" X 2"
- SURE CMFT SFTY PEN NDL 31G 6MM
- SURE CMFT SFTY PEN NDL 32G 4MM
- SURE COMFORT 0.5 ML SYRINGE
- SURE COMFORT 1 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE
- SURE COMFORT 30G PEN NEEDLE
- SURE COMFORT INS 0.3 ML 31GX1/4
- SURE COMFORT INS 0.5 ML 31GX1/4
- SURE COMFORT INS 1 ML 31GX1/4"
- SURE COMFORT PEN NDL 29GX1/2" 12.7MM
- SURE COMFORT PEN NDL 31G 5MM
- SURE COMFORT PEN NDL 31G 8MM
- SURE COMFORT PEN NDL 32G 4MM
- SURE COMFORT PEN NDL 32G 6MM
- SURE-FINE PEN NEEDLES 12.7MM
- SURE-FINE PEN NEEDLES 5MM
- SURE-FINE PEN NEEDLES 8MM
- SURE-JECT INSU SYR U100 0.3 ML
- SURE-JECT INSU SYR U100 0.5 ML
- SURE-JECT INSU SYR U100 1 ML
- SURE-JECT INSUL SYR U100 1 ML
- SURE-JECT INSULIN SYRINGE 1 ML
- SURE-PREP ALCOHOL PREP PADS
- TECHLITE 0.3 ML 29GX12MM (1/2)
- TECHLITE 0.3 ML 30GX8MM (1/2)
- TECHLITE 0.3 ML 31GX6MM (1/2)
- TECHLITE 0.3 ML 31GX8MM (1/2)
- TECHLITE 0.5 ML 30GX12MM (1/2)

- TECHLITE 0.5 ML 30GX8MM (1/2)
- TECHLITE 0.5 ML 31GX6MM (1/2)
- TECHLITE 0.5 ML 31GX8MM (1/2)
- TECHLITE INS SYR 1 ML 29GX12MM
- TECHLITE INS SYR 1 ML 30GX12MM
- TECHLITE INS SYR 1 ML 31GX6MM
- TECHLITE INS SYR 1 ML 31GX8MM
- TECHLITE PEN NEEDLE 29GX1/2"
- TECHLITE PEN NEEDLE 29GX3/8"
- TECHLITE PEN NEEDLE 31GX1/4"
- TECHLITE PEN NEEDLE 31GX3/16"
- TECHLITE PEN NEEDLE 31GX5/16"
- TECHLITE PEN NEEDLE 32GX1/4"
- TECHLITE PEN NEEDLE 32GX5/16"
- TECHLITE PEN NEEDLE 32GX5/32"
- TECHLITE PLUS PEN NDL 32G 4MM
- TERUMO INS SYRINGE U100-1 ML
- TERUMO INS SYRINGE U100-1/2 ML
- TERUMO INS SYRINGE U100-1/3 ML
- TERUMO INS SYRNG U100-1/2 ML
- THINPRO INS SYRIN U100-0.3 ML
- THINPRO INS SYRIN U100-0.5 ML
- THINPRO INS SYRIN U100-1 ML
- TOPCARE CLICKFINE 31G X 1/4"
- TOPCARE CLICKFINE 31G X 5/16"
- TOPCARE ULTRA COMFORT SYRINGE
- TRUE CMFRT PRO 0.5 ML 30G 5/16"
- TRUE CMFRT PRO 0.5 ML 31G 5/16"
- TRUE CMFRT PRO 0.5 ML 32G 5/16"
- TRUE CMFT SFTY PEN NDL 31G 5MM
- TRUE CMFT SFTY PEN NDL 31G 6MM
- TRUE CMFT SFTY PEN NDL 32G 4MM
- TRUE COMFORT 0.5 ML 30G 1/2"
- TRUE COMFORT 0.5 ML 30G 5/16"
- TRUE COMFORT 0.5 ML 31G 5/16"
- TRUE COMFORT 0.5 ML 31GX5/16"
- TRUE COMFORT 1 ML 31GX5/16"
- TRUE COMFORT ALCOHOL 70% PADS
- TRUE COMFORT PEN NDL 31G 8MM
- TRUE COMFORT PEN NDL 31GX5MM
- TRUE COMFORT PEN NDL 31GX6MM
- TRUE COMFORT PEN NDL 32G 5MM
- TRUE COMFORT PEN NDL 32G 6MM
- TRUE COMFORT PEN NDL 32GX4MM
- TRUE COMFORT PEN NDL 33G 4MM
- TRUE COMFORT PEN NDL 33G 5MM
- TRUE COMFORT PEN NDL 33G 6MM
- TRUE COMFORT PRO 1 ML 30G 1/2"
- TRUE COMFORT PRO 1 ML 30G 5/16"
- TRUE COMFORT PRO 1 ML 31G 5/16"
- TRUE COMFORT PRO 1 ML 32G 5/16"
- TRUE COMFORT PRO ALCOHOL PADS
- TRUE COMFORT SFTY 1 ML 30G 1/2"
- TRUE COMFRT PRO 0.5 ML 30G 1/2"
- TRUE COMFRT SFTY 1 ML 30G 5/16"
- TRUE COMFRT SFTY 1 ML 31G 5/16"
- TRUE COMFRT SFTY 1 ML 32G 5/16"
- TRUEPLUS PEN NEEDLE 29GX1/2"
- TRUEPLUS PEN NEEDLE 31G X 1/4"
- TRUEPLUS PEN NEEDLE 31GX3/16"
- TRUEPLUS PEN NEEDLE 31GX5/16"
- TRUEPLUS PEN NEEDLE 32GX5/32"
- TRUEPLUS SYR 0.3 ML 29GX1/2"
- TRUEPLUS SYR 0.3 ML 30GX5/16"
- TRUEPLUS SYR 0.3 ML 31GX5/16"
- TRUEPLUS SYR 0.5 ML 28GX1/2"
- TRUEPLUS SYR 0.5 ML 29GX1/2"
- TRUEPLUS SYR 0.5 ML 30GX5/16"
- TRUEPLUS SYR 0.5 ML 31GX5/16"
- TRUEPLUS SYR 1 ML 28GX1/2"
- TRUEPLUS SYR 1 ML 29GX1/2"
- TRUEPLUS SYR 1 ML 30GX5/16"
- TRUEPLUS SYR 1 ML 31GX5/16"
- ULTICAR INS 0.3 ML 31GX1/4(1/2)
- ULTICARE INS 1 ML 31GX1/4"
- ULTICARE INS SYR 0.3 ML 30G 8MM
- ULTICARE INS SYR 0.3 ML 31G 6MM
- ULTICARE INS SYR 0.3 ML 31G 8MM
- ULTICARE INS SYR 0.5 ML 30G 8MM (OTC)
- ULTICARE INS SYR 0.5 ML 31G 6MM
- ULTICARE INS SYR 0.5 ML 31G 8MM (OTC)
- ULTICARE INS SYR 1 ML 30GX1/2"
- ULTICARE PEN NEEDLE 31GX3/16"
- ULTICARE PEN NEEDLE 6MM 31G
- ULTICARE PEN NEEDLE 8MM 31G
- ULTICARE PEN NEEDLES 12MM 29G
- ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM
- ULTICARE PEN NEEDLES 6MM 32G
- ULTICARE SAFE PEN NDL 30G 8MM
- ULTICARE SAFE PEN NDL 5MM 30G
- ULTICARE SAFETY 0.5 ML 29GX1/2

- (RX)
- ULTICARE SYR 0.3 ML 29G 12.7MM
- ULTICARE SYR 0.3 ML 30GX1/2"
- ULTICARE SYR 0.3 ML 31GX5/16"
SHORT NDL
- ULTICARE SYR 0.5 ML 30GX1/2"
- ULTICARE SYR 0.5 ML 31GX5/16"
SHORT NDL
- ULTICARE SYR 1 ML 31GX5/16"
- ULTIGUARD SAFE 1 ML 30G 12.7MM
- ULTIGUARD SAFE0.3 ML 30G 12.7MM
- ULTIGUARD SAFE0.5 ML 30G 12.7MM
- ULTIGUARD SAFEPACK 1 ML 31G 8MM
- ULTIGUARD SAFEPACK 29G 12.7MM
- ULTIGUARD SAFEPACK 31G 5MM
- ULTIGUARD SAFEPACK 31G 6MM
- ULTIGUARD SAFEPACK 31G 8MM
- ULTIGUARD SAFEPACK 32G 4MM
- ULTIGUARD SAFEPACK 32G 6MM
- ULTIGUARD SAFEPK 0.3 ML 31G 8MM
- ULTIGUARD SAFEPK 0.5 ML 31G 8MM
- ULTILET ALCOHOL STERL SWAB
- ULTILET INSULIN SYRINGE 0.3 ML
- ULTILET INSULIN SYRINGE 0.5 ML
- ULTILET INSULIN SYRINGE 1 ML
- ULTILET PEN NEEDLE
- ULTILET PEN NEEDLE 4MM 32G
- ULTRA COMFORT 0.3 ML SYRINGE
- ULTRA COMFORT 0.5 ML 28GX1/2"
CONVERTS TO 29G
- ULTRA COMFORT 0.5 ML 29GX1/2"
- ULTRA COMFORT 0.5 ML SYRINGE
- ULTRA COMFORT 1 ML 31GX5/16"
- ULTRA COMFORT 1 ML SYRINGE
- ULTRA FLO 0.3 ML 30G 1/2" (1/2)
- ULTRA FLO 0.3 ML 30G 5/16"(1/2)
- ULTRA FLO 0.3 ML 31G 5/16"(1/2)
- ULTRA FLO PEN NEEDLE 31G 5MM
- ULTRA FLO PEN NEEDLE 31G 8MM
- ULTRA FLO PEN NEEDLE 32G 4MM
- ULTRA FLO PEN NEEDLE 33G 4MM
- ULTRA FLO PEN NEEDLES 12MM 29G
- ULTRA FLO SYR 0.3 ML 29GX1/2"
- ULTRA FLO SYR 0.3 ML 30G 5/16"
- ULTRA FLO SYR 0.3 ML 31G 5/16"
- ULTRA FLO SYR 0.5 ML 29G 1/2"
- ULTRA THIN PEN NDL 32G X 4MM
- ULTRA-FINE 0.3 ML 30G 12.7MM
- ULTRA-FINE 0.3 ML 31G 6MM (1/2)
- ULTRA-FINE 0.3 ML 31G 8MM (1/2)
- ULTRA-FINE 0.5 ML 30G 12.7MM
- ULTRA-FINE INS SYR 1 ML 31G 6MM
- ULTRA-FINE INS SYR 1 ML 31G 8MM
- ULTRA-FINE PEN NDL 29G 12.7MM
- ULTRA-FINE PEN NEEDLE 31G 5MM
- ULTRA-FINE PEN NEEDLE 31G 8MM
- ULTRA-FINE PEN NEEDLE 32G 6MM
- ULTRA-FINE SYR 0.3 ML 31G 8MM
- ULTRA-FINE SYR 0.5 ML 31G 6MM
- ULTRA-FINE SYR 0.5 ML 31G 8MM
- ULTRA-FINE SYR 1 ML 30G 12.7MM
- ULTRA-THIN II 1 ML 31GX5/16"
- ULTRA-THIN II INS 0.3 ML 30G
- ULTRA-THIN II INS 0.3 ML 31G
- ULTRA-THIN II INS 0.5 ML 29G
- ULTRA-THIN II INS 0.5 ML 30G
- ULTRA-THIN II INS 0.5 ML 31G
- ULTRA-THIN II INS SYR 1 ML 29G
- ULTRA-THIN II INS SYR 1 ML 30G
- ULTRA-THIN II PEN NDL 29GX1/2"
- ULTRA-THIN II PEN NDL 31GX5/16"
- ULTRACARE INS 0.3 ML 30GX5/16"
- ULTRACARE INS 0.3 ML 31GX5/16"
- ULTRACARE INS 0.5 ML 30GX1/2"
- ULTRACARE INS 0.5 ML 30GX5/16"
- ULTRACARE INS 0.5 ML 31GX5/16"
- ULTRACARE INS 1 ML 30G X 5/16"
- ULTRACARE INS 1 ML 30GX1/2"
- ULTRACARE INS 1 ML 31G X 5/16"
- ULTRACARE PEN NEEDLE 31GX1/4"
- ULTRACARE PEN NEEDLE 31GX3/16"
- ULTRACARE PEN NEEDLE 31GX5/16"
- ULTRACARE PEN NEEDLE 32GX1/4"
- ULTRACARE PEN NEEDLE 32GX3/16"
- ULTRACARE PEN NEEDLE 32GX5/32"
- ULTRACARE PEN NEEDLE 33GX5/32"
- UNIFINE OTC PEN NEEDLE 32G 4MM
- UNIFINE OTC PEN NEEDLE NEEDLE 31
GAUGE X 3/16"
- UNIFINE PEN NEEDLE 32G 4MM
- UNIFINE PENTIPS 12MM 29G
29GX12MM, STRL
- UNIFINE PENTIPS 31GX3/16"
31GX5MM,STRL,MINI

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

PA Criteria	Criteria Details
Exclusion Criteria	ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME
Other Criteria	

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

INTERFERON FOR MS-AVONEX

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

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

INTERFERON FOR MS-BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

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

INTERFERON FOR MS-PLEGRIDY

Products Affected

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

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

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CHRONIC GRANULOMATOUS DISEASE (CGD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, INFECTIOUS DISEASE SPECIALIST, OR IMMUNOLOGIST. SEVERE MALIGNANT OSTEOPETROSIS (SMO): PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR HEMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: CGD, SMO: 1) DEMONSTRATED CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) HAS NOT RECEIVED HEMATOPOIETIC CELL TRANSPLANTATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IPILIMUMAB

Products Affected

- YERVOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: UNRESECT/MET MEL: 4MO, RCC/CRC/HCC: 3MO, ALL OTHERS: 12MO. INITIAL/RENEWAL: CUTAN MEL: 6MO
Other Criteria	RENEWAL: ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ISAVUCONAZONIUM

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INVASIVE ASPERGILLOSIS, INVASIVE MUCORMYCOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	6 MONTHS
Other Criteria	INVASIVE ASPERGILLOSIS: TRIAL OF OR CONTRAINDICATION TO VORICONAZOLE. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

IVACAFTOR

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
Other Criteria	CF: INITIAL: 1) NOT HOMOZYGOUS FOR F508DEL MUTATION IN THE CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) GENE, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR. RENEWAL: 1) IMPROVEMENT IN CLINICAL STATUS, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IVOSIDENIB

Products Affected

- TIBSOVO

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

IXAZOMIB

Products Affected

- NINLARO

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

LANREOTIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	ACROMEGALY: INITIAL: 3 MOS, RENEWAL: 12 MOS.GEP-NETS, CARCINOID SYNDROME: 12 MOS.
Other Criteria	ACROMEGALY: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE GENERIC OCTREOTIDE INJECTION. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

LAPATINIB

Products Affected

- *lapatinib*

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

LAROTRECTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	VITRAKVI ORAL SOLUTION: 1) TRIAL OF VITRAKVI CAPSULES, OR 2) UNABLE TO TAKE CAPSULE FORMULATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

LAZERTINIB

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

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

LEDIPASVIR-SOFOSBUVIR

Products Affected

- HARVONI ORAL PELLETS IN PACKET
33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, AND 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, TIPRANAVIR/RITONAVIR, SOFOSBUVIR (AS A SINGLE AGENT), EPCLUSA, ZEPATIER, MAVYRET, OR VOSEVI. REQUESTS FOR HARVONI 45MG-200MG PELLETS: PATIENT IS UNABLE TO SWALLOW TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LENALIDOMIDE

Products Affected

- *lenalidomide*

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

LENVATINIB

Products Affected

- LENVIMA

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

LETERMOVIR

Products Affected

- PREVYMIS ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HSCT: NOT AT RISK FOR LATE CMV: 4 MOS, AT RISK FOR LATE CMV: 7 MOS. KIDNEY TRANSPLANT: 7 MOS.
Other Criteria	HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT): 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 100 DAYS POST TRANSPLANT IF NOT AT RISK FOR LATE CYTOMEGALOVIRUS (CMV) INFECTION AND DISEASE, OR BEYOND 200 DAYS POST TRANSPLANT IF AT RISK FOR LATE CMV INFECTION AND DISEASE. KIDNEY TRANSPLANT: 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 7 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 200 DAYS POST TRANSPLANT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LEUPROLIDE

Products Affected

- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PROSTATE CANCER: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LEUPROLIDE DEPOT

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LEUPROLIDE-ELIGARD

Products Affected

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

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

LEUPROLIDE-LUPRON DEPOT

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	PROSTATE CA: 12 MOS. UTERINE FIBROIDS: 3 MOS. ENDOMETRIOSIS: INITIAL/RENEWAL: 6 MOS.
Other Criteria	INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. RENEWAL: ENDOMETRIOSIS: 1) IMPROVEMENT OF PAIN RELATED TO ENDOMETRIOSIS WHILE ON THERAPY, 2) RECEIVING CONCOMITANT ADD-BACK THERAPY (I.E., COMBINATION ESTROGEN-PROGESTIN OR PROGESTIN-ONLY CONTRACEPTIVE PREPARATION), 3) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 4) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

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

LEUPROLIDE-LUPRON DEPOT-PED

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CENTRAL PRECOCIOUS PUBERTY (CPP): INITIAL: FEMALES: ELEVATED LEVELS OF FOLLICLE-STIMULATING HORMONE (FSH) GREATER THAN 4.0 MIU/ML AND LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVELS OF FSH GREATER THAN 5.0 MIU/ML AND LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	CPP: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	CPP: INITIAL: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR BREAST DEVELOPMENT AND PUBIC HAIR GROWTH. MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR GENITAL DEVELOPMENT AND PUBIC HAIR GROWTH. RENEWAL: 1) TANNER STAGING AT INITIAL DIAGNOSIS HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

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

L-GLUTAMINE

Products Affected

- *glutamine (sickle cell)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SICKLE CELL DISEASE(SCD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME.
Other Criteria	SCD: INITIAL: AGES 18 YEARS OR OLDER: 1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR, 2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR 3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME. AGES 5 TO 17 YEARS: APPROVED WITHOUT ADDITIONAL CRITERIA. RENEWAL: MAINTAINED OR EXPERIENCED A REDUCTION IN ACUTE COMPLICATIONS OF SCD.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LIDOCAINE OINTMENT

Products Affected

- *lidocaine topical ointment*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LIDOCAINE PATCH

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) PAIN ASSOCIATED WITH POST-HERPETIC NEURALGIA, 2) NEUROPATHY DUE TO DIABETES MELLITUS, 3) CHRONIC BACK PAIN, OR 4) OSTEOARTHRITIS OF THE KNEE OR HIP.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LINVOSELTAMAB-GCPT

Products Affected

- LYNZOZYFIC INTRAVENOUS
SOLUTION 2 MG/ML, 20 MG/ML

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

LONCASTUXIMAB TESIRINE-LPYL

Products Affected

- ZYNLONTA

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

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

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

LOTILANER

Products Affected

- XDEM VY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	DEMODEX BLEPHARITIS: 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	6 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LUMACAFITOR-IVACAFITOR

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
Other Criteria	CF: INITIAL: NO CONCURRENT USE WITH ANOTHER CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) MODULATOR. RENEWAL: 1) IMPROVEMENT IN CLINICAL STATUS, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MACITENTAN

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MARGETUXIMAB-CMKB

Products Affected

- MARGENZA

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

MARIBAVIR

Products Affected

- LIVTENCITY

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

MAVACAMTEN

Products Affected

- CAMZYOS

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

MECASERMIN

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	GROWTH FAILURE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	GROWTH FAILURE: INITIAL: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF WRIST AND HAND. INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER GROWTH HORMONE MEDICATION. RENEWAL: IMPROVEMENT WHILE ON THERAPY (INCREASE IN HEIGHT OR INCREASE IN HEIGHT VELOCITY).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MECHLORETHAMINE

Products Affected

- VALCHLOR

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

MEPOLIZUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL: CRSWNP: 6 MO. OTHERS: 12 MO. RENEWAL: CRSWNP, ASTHMA, EGPA: 12 MO.

PA Criteria	Criteria Details
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR SAME INDICATION. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 3) INADEQUATELY CONTROLLED DISEASE. RENEWAL: ASTHMA: 1) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, AND 3) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SAME INDICATION. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SAME INDICATION.
	EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): 1) REDUCTION IN EGPA SYMPTOMS COMPARED TO BASELINE OR ABILITY TO REDUCE/ELIMINATE CORTICOSTEROID USE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SAME INDICATION.
Indications	All FDA-approved Indications.

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

METYROSINE

Products Affected

- *metirosine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PHEOCHROMOCYTOMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, ENDOCRINE SURGEON, OR HEMATOLOGIST-ONCOLOGIST.
Coverage Duration	PREOPERATIVE PREPARATION FOR SURGERY: 30 DAYS. MALIGNANT PHEOCHROMOCYTOMA: INITIAL/RENEWAL:12 MOS.
Other Criteria	PHEOCHROMOCYTOMA: INITIAL: HAS NON-METASTATIC PHEOCHROMOCYTOMA. PREOPERATIVE PREPARATION FOR SURGERY: USE IN COMBINATION WITH AN ALPHA-ADRENERGIC RECEPTOR BLOCKER. RENEWAL: MALIGNANT PHEOCHROMOCYTOMA: STABLE OR CLINICAL IMPROVEMENT WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MIDOSTAURIN

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CUSHINGS SYNDROME (CS): INITIAL: DIAGNOSIS CONFIRMED BY: 1) 24-HR URINE FREE CORTISOL (AT LEAST 2 TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (AT LEAST 2 TESTS TO CONFIRM).
Age Restrictions	
Prescriber Restrictions	CS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	CS: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICOIDS. RENEWAL: 1) CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE), 2) CONTINUES TO HAVE TOLERABILITY TO THERAPY, AND 3) CONTINUES TO NOT BE A CANDIDATE FOR SURGICAL TREATMENT OR HAS FAILED SURGERY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MILTEFOSINE

Products Affected

- IMPAVIDO

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

MIRDAMETINIB

Products Affected

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

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

MIRVETUXIMAB SORAVTANSINE-GYNX

Products Affected

- ELAHERE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: AN OPHTHALMIC EXAM, INCLUDING VISUAL ACUITY AND SLIT LAMP EXAM, WILL BE COMPLETED PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MOMELOTINIB

Products Affected

- OJJAARA

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

MOSUNETUZUMAB-AXGB

Products Affected

- LUNSUMIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: INITIAL: 6 MONTHS. RENEWAL: 7 MONTHS.
Other Criteria	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: RENEWAL: 1) HAS ACHIEVED A PARTIAL RESPONSE TO TREATMENT, AND 2) HAS NOT PREVIOUSLY RECEIVED MORE THAN 17 CYCLES OF TREATMENT. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NARCOLEPSY AGENTS

Products Affected

- *armodafinil*
- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NAXITAMAB-GQGK

Products Affected

- DANYELZA

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

NERATINIB

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

NILOTINIB - TASIGNA

Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND MEDICATION IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NILOTINIB-DANZITEN

Products Affected

- DANZITEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): 1) PERFORMED MUTATIONAL ANALYSIS PRIOR TO INITIATION OF THERAPY, AND 2) THERAPY IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NINTEDANIB

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 40% OF PREDICTED VALUE. CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 45% OF PREDICTED VALUE.
Age Restrictions	
Prescriber Restrictions	INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: SSC-ILD: 6 MOS. IPF, PF-ILD: 12 MOS. RENEWAL (ALL INDICATIONS): 12 MOS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: IPF: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ESBRIET (PIRFENIDONE). SSC-ILD: DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG TOXICITY, RECURRENT ASPIRATION). PF-ILD: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENERD/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). RENEWAL: IPF, SSC-ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NIRAPARIB

Products Affected

- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

NIRAPARIB-ABIRATERONE

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NIROGACESTAT

Products Affected

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

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

NITISINONE

Products Affected

- *nitisinone*
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY TYROSINEMIA TYPE 1 (HT-1): INITIAL: DIAGNOSIS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE. RENEWAL: URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.
Age Restrictions	
Prescriber Restrictions	HT-1: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	HT-1: INITIAL: ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED NITISINONE TABLETS OR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NIVOLUMAB

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NIVOLUMAB-HYALURONIDASE-NVHY

Products Affected

- OPDIVO QVANTIG

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

NIVOLUMAB-RELATLIMAB-RMBW

Products Affected

- OPDUALAG

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

NOGAPENDEKIN ALFA

Products Affected

- ANKTIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	40 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

OFATUMUMAB SQ

Products Affected

- KESIMPTA PEN

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

OLAPARIB

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER: MEDICATION WILL BE USED AS MONOTHERAPY. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

OLUTASIDENIB

Products Affected

- REZLIDHIA

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

OMACETAXINE

Products Affected

- SYNRIBO

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

OMALIZUMAB

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

OSIMERTINIB

Products Affected

- TAGRISSO

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

OXANDROLONE

Products Affected

- *oxandrolone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	PROTEIN CATABOLISM, BONE PAIN: 1) MONITORED FOR PELIOSIS HEPATIS, LIVER CELL TUMORS, AND BLOOD LIPID CHANGES, 2) DOES NOT HAVE KNOWN OR SUSPECTED: CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, NEPHROSIS (THE NEPHROTIC PHASE OF NEPHRITIS), OR HYPERCALCEMIA, AND 3) DOES NOT HAVE SEVERE HEPATIC DYSFUNCTION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PACRITINIB

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	MYELOFIBROSIS: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PALBOCICLIB

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED OR METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE PREFERRED AGENTS, WHERE INDICATIONS ALIGN: KISQALI, VERZENIO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PARATHYROID HORMONE

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: 1) TRIAL OF OR CONTRAINDICATION TO CALCITRIOL, 2) HYPOPARATHYROIDISM IS NOT DUE TO A CALCIUM SENSING RECEPTOR (CSR) MUTATION, AND 3) HYPOPARATHYROIDISM IS NOT CONSIDERED ACUTE POST-SURGICAL HYPOPARATHYROIDISM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PASIREOTIDE DIASPARTATE

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

PAZOPANIB

Products Affected

- *pazopanib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED SOFT TISSUE SARCOMA (STS): NOT USED FOR ADIPOCYTIC STS OR GASTROINTESTINAL STROMAL TUMORS (GIST)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEGFILGRASTIM - APGF

Products Affected

- NYVEPRIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEGFILGRASTIM - CBQV

Products Affected

- UDENYCA ONBODY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	NON MYELOID MALIGNANCY: UDENYCA: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA. UDENYCA ONBODY: 1) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA, OR 2) BARRIER TO ACCESS (E.G., TRAVEL BARRIERS, UNABLE TO RETURN TO CLINIC FOR INJECTIONS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PEGINTERFERON ALFA-2A

Products Affected

- PEGASYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEPATITIS B: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, OR PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G., HEPATOLOGIST).
Coverage Duration	HEP B/HEP C: 48 WEEKS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEGVISOMANT

Products Affected

- SOMAVERT

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

PEMBROLIZUMAB

Products Affected

- KEYTRUDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEMIGATINIB

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CHOLANGIOCARCINOMA, MYELOID/LYMPHOID NEOPLASMS: COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), WILL BE COMPLETED PRIOR TO INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PENICILLAMINE TABLET

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CYSTINURIA: HAS NEPHROLITHIASIS AND ONE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTINE, 2) PRESENCE OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) FAMILY HISTORY OF CYSTINURIA AND POSITIVE CYANIDE-NITROPRUSSIDE SCREENING.
Age Restrictions	
Prescriber Restrictions	INITIAL: WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 12 MONTHS, RENEWAL: LIFETIME.
Other Criteria	INITIAL: WILSONS DISEASE: 1) LEIPZIG SCORE OF 4 OR GREATER. RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. RENEWAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) EXPERIENCED OR MAINTAINED IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT COMPARED TO BASELINE. WILSONS DISEASE, CYSTINURIA: CONTINUES TO BENEFIT FROM THE MEDICATION.

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

PEXIDARTINIB

Products Affected

- TURALIO

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

PIMAVANSERIN

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PSYCHOSIS IN PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OR OLDER
Prescriber Restrictions	PSYCHOSIS IN PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (E.G., PSYCHIATRIST).
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PSYCHOSIS IN PD: RENEWAL: IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PIRFENIDONE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	IDIOPATHIC PULMONARY FIBROSIS (IPF): INITIAL: 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50% AT BASELINE.
Age Restrictions	IPF: INITIAL: 18 YEARS OR OLDER.
Prescriber Restrictions	IPF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	IPF: INITIAL: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, OR CANCER). RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

PIRTOBRUTINIB

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

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

POMALIDOMIDE

Products Affected

- POMALYST

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

PONATINIB

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHRONIC MYELOID LEUKEMIA (CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND ICLUSIG IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

POSACONAZOLE TABLET

Products Affected

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

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

PRALSETINIB

Products Affected

- GAVRETO

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

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

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

QUININE

Products Affected

- *quinine sulfate*

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

QUIZARTINIB

Products Affected

- VANFLYTA

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

REGORAFENIB

Products Affected

- STIVARGA

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

RELUGOLIX

Products Affected

- ORGOVYX

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

REPOTRECTINIB

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

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

RESMETIROM

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

RETIFANLIMAB-DLWR

Products Affected

- ZYNYZ

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

REVUMENIB

Products Affected

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

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

RIBOCICLIB

Products Affected

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

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

RIBOCICLIB-LETROZOLE

Products Affected

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

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

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TRAVELERS DIARRHEA, HEPATIC ENCEPHALOPATHY (HE): 12 MOS. IBS-D: 8 WKS.
Other Criteria	HE: TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RILONACEPT

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR, SERUM AMYLOID A PROTEIN (SAA) OR S100 PROTEINS), AND 2) TWO OF THE FOLLOWING: URTICARIAL-LIKE RASH (NEUTROPHILIC DERMATITIS), COLD-TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS, CHRONIC ASEPTIC MENINGITIS, SKELETAL ABNORMALITIES. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) ONE OF THE FOLLOWING: PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, ONYCHOMADESIS. RECURRENT PERICARDITIS (RP): TWO OF THE FOLLOWING: CHEST PAIN CONSISTENT WITH PERICARDITIS, PERICARDIAL FRICTION RUB, ECG SHOWING DIFFUSE ST-SEGMENT ELEVATION OR PR-SEGMENT DEPRESSION, NEW OR WORSENING PERICARDIAL EFFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CAPS, DIRA: LIFETIME. RP: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	CAPS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR CAPS. DIRA: 1) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR DIRA, AND 2) TRIAL OF THE PREFERRED AGENT: KINERET. RP: 1) HAD AN EPISODE OF ACUTE PERICARDITIS, 2) SYMPTOM-FREE FOR 4 TO 6 WEEKS, AND 3) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR RP.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RIMEGEPANT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RIOCIGUAT

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS. PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) (WHO GROUP 4): WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	INITIAL: PAH, CTEPH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PAH: NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE (PDE) INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. CTEPH: 1) NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PDE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS, AND 2) NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH OR HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. RENEWAL: PAH, CTEPH: NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PDE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	

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

RIPRETINIB

Products Affected

- QINLOCK

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

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PLAQUE PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

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

RITUXIMAB AND HYALURONIDASE HUMAN-SQ

Products Affected

- RITUXAN HYCELA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOLLICULAR LYMPHOMA (FL), DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): 1) HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

RITUXIMAB-ABBS

Products Affected

- TRUXIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA, PV: 12 MO. CLL: 6 MO.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: RA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ROPEGINTERFERON ALFA-2B-NJFT

Products Affected

- BESREMI

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

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

RUXOLITINIB

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MYELOFIBROSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. POLYCYTHEMIA VERA, GVHD: 12 MONTHS
Other Criteria	INITIAL: CHRONIC GRAFT VS HOST DISEASE (CGVHD): NO CONCURRENT USE WITH REZUROCK, NIKTIMVO, OR IMBRUVICA. RENEWAL: MYELOFIBROSIS: CONTINUES TO BENEFIT FROM THE MEDICATION. CGVHD: NO CONCURRENT USE WITH REZUROCK, NIKTIMVO, OR IMBRUVICA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SAPROPTERIN

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 2 MONTHS, RENEWAL 12 MONTHS.
Other Criteria	HYPERPHENYLALANINEMIA (HPA): INITIAL: NO CONCURRENT USE WITH PALYNZIQ. RENEWAL: 1) CONTINUES TO BENEFIT FROM TREATMENT, AND 2) NO CONCURRENT USE WITH PALYNZIQ.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SECUKINUMAB SQ

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, ENTHESITIS-RELATED ARTHRITIS (ERA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: HS: 12 MONTHS, ALL OTHER INDICATIONS: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID. ERA: TRIAL OF OR CONTRAINDICATION TO ONE NSAID, SULFASALAZINE, OR METHOTREXATE. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SELEXIPAG

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	PAH: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIN RECEPTOR ANTAGONIST, 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, 3) FORMULARY VERSION OF AN ORAL CGMP STIMULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SELINEXOR

Products Affected

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

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

SELPERCATINIB

Products Affected

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

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

SELUMETINIB

Products Affected

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG

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

SILDENAFIL TABLET

Products Affected

- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: AGES 18 YEARS OR OLDER: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS. AGES 1 TO 17 YEARS: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PAP GREATER THAN 20 MMHG, 2) PCWP OF 15 MMHG OR LESS, AND 3) PVR OF 3 WOOD UNITS OR GREATER.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL/RENEWAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA) OR ANY ORGANIC NITRATES IN ANY FORM AND 2) NO CONCURRENT USE WITH GUANYLATE CYCLASE STIMULATORS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

SIPONIMOD

Products Affected

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

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

SIROLIMUS PROTEIN-BOUND

Products Affected

- FYARRO

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

SODIUM OXYBATE-XYREM

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SOFOSBUVIR/VELPATASVIR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR, TOPOTECAN, SOVALDI (AS A SINGLE AGENT), HARVONI, ZEPATIER, MAVYRET, OR VOSEVI, AND 3) PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR, TIPRANAVIR/RITONAVIR, SOVALDI (AS A SINGLE AGENT), EPCLUSA, HARVONI, ZEPATIER, OR MAVYRET, AND 3) DOES NOT HAVE MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

SOMATROPIN - NORDITROPIN

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
Required Medical Information	INITIAL: PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS BELOW THE MEAN HEIGHT FOR CHILDREN OF THE SAME AGE AND GENDER. TURNER SYNDROME (TS): CONFIRMED BY CHROMOSOMAL ANALYSIS (KARYOTYPING). PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS OF PWS. ADULT GHD: 1) HAS A CONGENITAL, GENETIC, OR ORGANIC DISEASE (E.G., CRANIOPHARYNGIOMA, PITUITARY HYPOPLASIA, ECTOPIC POSTERIOR PITUITARY, PREVIOUS CRANIAL IRRADIATION), OR 2) GHD CONFIRMED BY ONE OF THE FOLLOWING GROWTH HORMONE (GH) STIMULATION TESTS: (A) INSULIN TOLERANCE TEST (PEAK GH OF 5 NG/ML OR LESS), (B) GLUCAGON-STIMULATION TEST (ONE OF THE FOLLOWING: (I) PEAK RESPONSE OF 3 NG/ML OR LESS AND BMI LESS THAN 25 KG/M2, (II) PEAK RESPONSE OF 3 NG/ML OR LESS AND BMI IS BETWEEN 25 - 30 KG/M2 WITH A PRE-TEST PROBABILITY, (III) PEAK RESPONSE OF 1 NG/ML OR LESS AND BMI IS BETWEEN 25 - 30 KG/M2 WITH LOW TEST PROBABILITY, OR (IV) PEAK RESPONSE OF 1 NG/ML OR LESS AND BMI IS GREATER THAN 30 KG/M2), OR (C) MACIMORELIN TEST (PEAK GH OF 2.8 NG/ML OR LESS).
Age Restrictions	SGA: 2 YEARS OF AGE OR OLDER.
Prescriber Restrictions	INITIAL/RENEWAL: ALL INDICATIONS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. INITIAL/RENEWAL: ADULT GHD, PEDIATRIC GHD, SGA, TS, PWS, NOONAN SYNDROME: NO CONCURRENT USE WITH INCRELEX. RENEWAL: ISS: 1) IMPROVEMENT WHILE ON THERAPY (INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. PEDIATRIC GHD, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND OR HAS NOT COMPLETED PREPUBERTAL GROWTH. PWS: IMPROVEMENT IN BODY COMPOSITION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SOMATROPIN - SEROSTIM

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SONIDEGIB

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	LOCALLY ADVANCED BASAL CELL CARCINOMA (BCC): BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SORAFENIB

Products Affected

- *sorafenib*

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

SOTATERCEPT-CSRK

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

SOTORASIB

Products Affected

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

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

STIRIPENTOL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SUNITINIB

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO IMATINIB.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TADALAFIL - ADCIRCA, ALYQ

Products Affected

- *alyq*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL/RENEWAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA) OR ANY ORGANIC NITRATES IN ANY FORM, AND 2) NO CONCURRENT USE WITH GUANYLATE CYCLASE STIMULATORS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TADALAFIL-CIALIS

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA (BPH).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	BPH: 1) TRIAL OF ONE ALPHA BLOCKER (E.G., DOXAZOSIN, TERAZOSIN, TAMSULOSIN, ALFUZOSIN), AND 2) TRIAL OF ONE 5-ALPHA-REDUCTASE INHIBITOR (E.G., FINASTERIDE, DUTASTERIDE). APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TALAZOPARIB

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED OR METASTATIC BREAST CANCER: 1) HAS BEEN TREATED WITH CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING, AND 2) IF HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER, RECEIVED PRIOR TREATMENT WITH ENDOCRINE THERAPY OR IS CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TALETRECTINIB

Products Affected

- IBTROZI

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

TALQUETAMAB-TGVS

Products Affected

- TALVEY

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

TARLATAMAB-DLLE

Products Affected

- IMDELLTRA

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

TAZEMETOSTAT

Products Affected

- TAZVERIK

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

TEBENTAFUSP-TEBN

Products Affected

- KIMMTRAK

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

TECLISTAMAB-CQYV

Products Affected

- TECVAYLI

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

TELISOTUZUMAB VEDOTIN-TLLV

Products Affected

- EMRELIS

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

TELOTRISTAT

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CARCINOID SYNDROME DIARRHEA: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST OR GASTROENTEROLOGIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TEPOTINIB

Products Affected

- TEPMETKO

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

TERIPARATIDE

Products Affected

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

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

TESTOSTERONE

Products Affected

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

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

TESTOSTERONE CYPIONATE - DEPO

Products Affected

- *testosterone cypionate*

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

TESTOSTERONE ENANTHATE

Products Affected

- *testosterone enanthate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: MALE DELAYED PUBERTY: 6MO, MALE HYPOGONADISM: 12 MO. OTHER INDICATIONS: 12 MO.
Other Criteria	INITIAL: MALE HYPOGONADISM: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: MALE HYPOGONADISM: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT. MALE DELAYED PUBERTY: HAS NOT RECEIVED MORE THAN TWO 6-MONTH COURSES OF TESTOSTERONE REPLACEMENT THERAPY
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

THALIDOMIDE

Products Affected

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

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

TISLELIZUMAB-JSGR

Products Affected

- TEVIMBRA

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

TISOTUMAB VEDOTIN-TFTV

Products Affected

- TIVDAK

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

TIVOZANIB

Products Affected

- FOTIVDA

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

TOCILIZUMAB-AAZG IV

Products Affected

- TYENNE

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: RA, PJIA, SJIA, GCA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: RA, PJIA, SJIA, GCA: 12 MONTHS.

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

TOCILIZUMAB-AAZG SQ

Products Affected

- TYENNE
- TYENNE AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOID, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, ORENCIA, RINVOQ. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

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

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PSA, AS, PCJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

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

TOLVAPTAN

Products Affected

- JYNARQUE ORAL TABLET
- *tolvaptan (polycys kidney dis) oral tablets, sequential*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

TOPICAL TRETINOIN

Products Affected

- ALTRENO
- *tretinoin topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ACNE VULGARIS: BRAND TOPICAL TRETINOIN REQUIRES TRIAL OF OR CONTRAINDICATION TO A GENERIC TOPICAL TRETINOIN PRODUCT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TORIPALIMAB-TPZI

Products Affected

- LOQTORZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	NASOPHARYNGEAL CARCINOMA (NPC): FIRST LINE TREATMENT: 24 MOS, PREVIOUSLY TREATED: LIFETIME.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TOVORAFENIB

Products Affected

- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION
- OJEMDA ORAL TABLET

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

TRAMETINIB SOLUTION

Products Affected

- MEKINIST ORAL RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA, MELANOMA, METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC), LOCALLY ADVANCED OR METASTATIC ANAPLASTIC THYROID CANCER (ATC), UNRESECTABLE OR METASTATIC SOLID TUMOR, LOW-GRADE GLIOMA (LGG): UNABLE TO SWALLOW MEKINIST TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TRAMETINIB TABLET

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

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

TRASTUZUMAB-DKST

Products Affected

- OGIVRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TRASTUZUMAB-HYALURONIDASE-OYSK

Products Affected

- HERCEPTIN HYLECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADJUVANT BREAST CANCER, METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: HERZUMA, OGIVRI, ONTRUZANT, TRAZIMERA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TRAZODONE

Products Affected

- RALDESY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MAJOR DEPRESSIVE DISORDER (MDD); CONTRAINDICATION TO OR UNABLE TO SWALLOW TRAZODONE TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TREMELIMUMAB-ACTL

Products Affected

- IMJUDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	UHCC: 30 DAYS. METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): 5 MONTHS.
Other Criteria	UNRESECTABLE HEPATOCELLULAR CARCINOMA (UHCC): HAS NOT RECEIVED PRIOR TREATMENT WITH IMJUDO. NSCLC: HAS NOT RECEIVED A TOTAL OF 5 DOSES OF IMJUDO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TRIENTINE CAPSULE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WILSONS DISEASE: INITIAL: LEIPZIG SCORE OF 4 OR GREATER.
Age Restrictions	
Prescriber Restrictions	WILSONS DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 12 MONTHS, RENEWAL: LIFETIME.
Other Criteria	WILSONS DISEASE: INITIAL: TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF PENICILLAMINE TABLET. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TRIFLURIDINE/TIPIRACIL

Products Affected

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

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

TRIPTORELIN-TRELSTAR

Products Affected

- TRELSTAR INTRAMUSCULAR
SUSPENSION FOR RECONSTITUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

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

UBROGEPANT

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ACUTE MIGRAINE TREATMENT: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. RENEWAL: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT, AND 2) ONE OF THE FOLLOWING: (A) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR (B) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

UPADACITINIB

Products Affected

- RINVOQ
- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). ATOPIC DERMATITIS (AD): ATOPIC DERMATITIS COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. AD: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 2) TRIAL OF OR CONTRAINDICATION TO A TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR, AND 3) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR ATOPIC DERMATITIS OR OTHER JAK INHIBITORS FOR ANY INDICATION. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. GIANT CELL ARTERITIS (GCA): HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOID. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. AD: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR ATOPIC DERMATITIS OR OTHER JAK INHIBITOR FOR ANY INDICATION. PSA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE

PA Criteria	Criteria Details
	WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. PJIA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

USTEKINUMAB IV

Products Affected

- STELARA
- *ustekinumab*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL/RENEWAL: ALL INDICATIONS: 1) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: SELARSDI, YESINTEK. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

USTEKINUMAB SQ

Products Affected

- STELARA
- *ustekinumab*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL/RENEWAL: ALL INDICATIONS: 1) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: SELARSDI, YESINTEK. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

USTEKINUMAB-AEKN IV

Products Affected

- SELARSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

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

USTEKINUMAB-AEKN SQ

Products Affected

- SELARSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

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

USTEKINUMAB-KFCE IV

Products Affected

- YESINTEK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

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

USTEKINUMAB-KFCE SQ

Products Affected

- YESINTEK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

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

VALBENAZINE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TARDIVE DYSKINESIA (TD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST. CHOREA ASSOCIATED WITH HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	TD: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CURRENTLY STABLE ON CAPRELSA REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VANZACAFTOR-TEZACAFTOR- DEUTIVACAFTOR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
Other Criteria	CF: INITIAL: NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR. RENEWAL: 1) IMPROVEMENT IN CLINICAL STATUS, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MELANOMA: ZELBORAF WILL BE USED ALONE OR IN COMBINATION WITH COTELLIC
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VENETOCLAX

Products Affected

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

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

VERICIGUAT

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VIGABATRIN

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	CPS: TRIAL OF OR CONTRAINDICATION TO TWO ANTIEPILEPTIC AGENTS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VIMSELTINIB

Products Affected

- ROMVIMZA

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

VISMODEGIB

Products Affected

- ERIVEDGE

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

VONOPRAZAN

Products Affected

- VOQUEZNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: EROSION ESOPHAGITIS (EE): DIAGNOSIS CONFIRMED BY ENDOSCOPY (E.G., LOS ANGELES CLASSIFICATION OF REFLUX ESOPHAGITIS GRADE A-D). NON-EROSIVE GASTROESOPHAGEAL REFLUX DISEASE (NERD): DIAGNOSIS CONFIRMED BY ENDOSCOPY AND DOES NOT HAVE PRESENCE OF VISIBLE EROSION (E.G., DOES NOT HAVE LOS ANGELES CLASSIFICATION OF REFLUX ESOPHAGITIS GRADE A-D).
Age Restrictions	
Prescriber Restrictions	INITIAL: EE, NERD: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: H PYLORI: 30 DAYS. EE: 8 WEEKS. NERD: 4 WEEKS. RENEWAL: EE: 24 WEEKS.
Other Criteria	INITIAL: EE: TRIAL OF OR CONTRAINDICATION TO TWO PROTON PUMP INHIBITORS AT MAXIMUM DOSE FOR 8 WEEKS EACH. NERD: 1) NO PREVIOUS TREATMENT FAILURE WITH VOQUEZNA IN THE LAST 12 MONTHS, AND 2) TRIAL OF OR CONTRAINDICATION TO TWO PROTON PUMP INHIBITORS AT MAXIMUM DOSE FOR 8 WEEKS EACH. RENEWAL: EE: MAINTAINED A CLINICAL RESPONSE ON VOQUEZNA
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VORASIDENIB

Products Affected

- VORANIGO

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

VORICONAZOLE SUSPENSION

Products Affected

- *voriconazole oral suspension for reconstitution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CANDIDA INFECTIONS: 3 MOS. CONTINUATION OF THERAPY, ALL OTHER INDICATIONS: 6 MOS.
Other Criteria	CANDIDA INFECTIONS: CONTRAINDICATION TO OR UNABLE TO SWALLOW FLUCONAZOLE TABLETS. ALL INDICATIONS EXCEPT ESOPHAGEAL CANDIDIASIS: UNABLE TO SWALLOW TABLETS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ZANIDATAMAB-HR11

Products Affected

- ZIIHERA

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

ZANUBRUTINIB

Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZENOCUTUZUMAB-ZBCO

Products Affected

- BIZENGRI

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

ZOLBETUXIMAB-CLZB

Products Affected

- VYLOY

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

ZONGERTINIB

Products Affected

- HERNEXEOS

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZURANOLONE

Products Affected

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

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

INDEX

1ST TIER UNIFINE PENTP 5MM 31G...	158	ARCALYST.....	274
1ST TIER UNIFINE PNTIP 4MM 32G.....	158	ARIKAYCE.....	20
1ST TIER UNIFINE PNTIP 6MM 31G.....	158	<i>armodafinil</i>	218
1ST TIER UNIFINE PNTIP 8MM 31G		ASSURE ID DUO PRO NDL 31G 5MM..	158
STRL,SINGLE-USE,SHRT.....	158	ASSURE ID DUO-SHIELD 30GX3/16"...	158
1ST TIER UNIFINE PNTIP 29GX1/2".....	158	ASSURE ID DUO-SHIELD 30GX5/16"...	158
1ST TIER UNIFINE PNTIP 31GX3/16.....	158	ASSURE ID INSULIN SAFETY	
1ST TIER UNIFINE PNTIP 32GX5/32.....	158	SYRINGE 1 ML 29 GAUGE X 1/2".....	158
<i>abiraterone</i>	7	ASSURE ID PEN NEEDLE 30GX3/16"...	158
<i>abirtega</i>	7	ASSURE ID PEN NEEDLE 30GX5/16"...	158
ABOUTTIME PEN NEEDLE.....	158	ASSURE ID PEN NEEDLE 31GX3/16"...	158
ACTIMMUNE.....	171	ASSURE ID PRO PEN NDL 30G 5MM...	158
ADEMPAS.....	277	ASSURE ID SYR 0.5 ML 31GX15/64"....	158
ADVOCATE INS 0.3 ML 30GX5/16".....	158	ASSURE ID SYR 1 ML 31GX15/64".....	158
ADVOCATE INS 0.3 ML 31GX5/16".....	158	AUGTYRO ORAL CAPSULE 160 MG,	
ADVOCATE INS 0.5 ML 30GX5/16".....	158	40 MG.....	267
ADVOCATE INS 0.5 ML 31GX5/16".....	158	AUSTEDO ORAL TABLET 12 MG, 6	
ADVOCATE INS 1 ML 31GX5/16".....	158	MG, 9 MG.....	88
ADVOCATE INS SYR 0.3 ML 29GX1/2..	158	AUSTEDO XR ORAL TABLET	
ADVOCATE INS SYR 0.5 ML 29GX1/2..	158	EXTENDED RELEASE 24 HR 12 MG, 18	
ADVOCATE INS SYR 1 ML 29GX1/2"..	158	MG, 24 MG, 30 MG, 36 MG, 42 MG, 48	
ADVOCATE INS SYR 1 ML 30GX5/16..	158	MG, 6 MG.....	88
ADVOCATE PEN NDL 12.7MM 29G.....	158	AUSTEDO XR TITRATION KT(WK1-4)..	88
ADVOCATE PEN NEEDLE 32G 4MM...	158	AUTOSHIELD DUO PEN NDL 30G	
ADVOCATE PEN NEEDLE 4MM 33G...	158	5MM.....	158
ADVOCATE PEN NEEDLES 5MM 31G..	158	AVMAPKI.....	38
ADVOCATE PEN NEEDLES 8MM 31G..	158	AVMAPKI-FAKZYNJA.....	38
AIMOVIG AUTOINJECTOR.....	118	AVONEX INTRAMUSCULAR PEN	
AKEEGA.....	226	INJECTOR KIT.....	168
ALCOHOL 70% SWABS.....	158	AVONEX INTRAMUSCULAR	
ALCOHOL PADS.....	158	SYRINGE KIT.....	168
ALCOHOL WIPES.....	158	AYVAKIT.....	37
ALECENSA.....	18	BALVERSA ORAL TABLET 3 MG, 4	
ALTRENO.....	340	MG, 5 MG.....	117
ALUNBRIG ORAL TABLET 180 MG, 30		BD AUTOSHIELD DUO NDL	
MG, 90 MG.....	57	5MMX30G.....	158
ALUNBRIG ORAL TABLETS,DOSE		BD ECLIPSE 30GX1/2" SYRINGE.....	158
PACK.....	57	BD ECLIPSE NEEDLE 30GX1/2" (OTC)	158
ALVAIZ.....	106	BD INS SYR 0.3 ML 8MMX31G(1/2).....	158
ALYFTREK ORAL TABLET 10-50-125		BD INS SYR UF 0.3 ML 12.7MMX30G..	158
MG, 4-20-50 MG.....	371	BD INS SYR UF 0.5 ML 12.7MMX30G	
<i>alyq</i>	312	NOT FOR RETAIL SALE.....	158
ANKTIVA.....	232	BD INSULIN SYR 1 ML 25GX1".....	158
AQINJECT PEN NEEDLE 31G 5MM.....	158	BD INSULIN SYR 1 ML 25GX5/8".....	158
AQINJECT PEN NEEDLE 32G 4MM.....	158	BD INSULIN SYR 1 ML 26GX1/2".....	158

BD INSULIN SYR 1 ML 27GX12.7MM..	158	BRAFTOVI.....	110
BD INSULIN SYR 1 ML 27GX5/8"		BRUKINSA ORAL CAPSULE.....	382
MICRO-FINE.....	158	BRUKINSA ORAL TABLET.....	382
BD INSULIN SYRINGE SLIP TIP.....	158	CABOMETYX ORAL TABLET 20 MG,	
BD LO-DOSE ULTRA-FINE.....	158	40 MG, 60 MG.....	60
BD NANO 2 GEN PEN NDL 32G 4MM..	158	CALQUENCE.....	9
BD SAFETGLD INS 0.3 ML 29G 13MM.	158	CALQUENCE (ACALABRUTINIB	
BD SAFETGLD INS 0.5 ML 13MMX29G		MAL).....	9
.....	158	CAMZYOS.....	204
BD SAFETYGLD INS 0.3 ML 31G 8MM	158	CAPRELSA ORAL TABLET 100 MG,	
BD SAFETYGLD INS 0.5 ML 30G 8MM	158	300 MG.....	370
BD SAFETYGLD INS 1 ML 29G 13MM.	158	CAREFINE PEN NEEDLE 12.7MM 29G.	158
BD SAFETYGLID INS 1 ML 6MMX31G	158	CAREFINE PEN NEEDLE 4MM 32G.....	158
BD SAFETYGLIDE SYRINGE 27GX5/8	158	CAREFINE PEN NEEDLE 5MM 32G.....	158
BD SAFTYGLD INS 0.3 ML 6MMX31G	158	CAREFINE PEN NEEDLE 6MM 31G.....	158
BD SAFTYGLD INS 0.5 ML 29G 13MM	158	CAREFINE PEN NEEDLE 8MM 30G.....	158
BD SAFTYGLD INS 0.5 ML 6MMX31G	158	CAREFINE PEN NEEDLES 6MM 32G...	158
BD UF MICRO PEN NEEDLE		CAREFINE PEN NEEDLES 8MM 31G...	158
6MMX32G.....	158	CARETOUCH ALCOHOL 70% PREP	
BD UF MINI PEN NEEDLE 5MMX31G.	158	PAD.....	158
BD UF NANO PEN NEEDLE 4MMX32G		CARETOUCH PEN NEEDLE 29G 12MM	
.....	158	.....	158
BD UF ORIG PEN NDL 12.7MMX29G...	158	CARETOUCH PEN NEEDLE 31GX1/4" .	158
BD UF SHORT PEN NEEDLE		CARETOUCH PEN NEEDLE 31GX3/16"	
8MMX31G.....	158	.....	158
BD VEO INS 0.3 ML 6MMX31G (1/2)....	158	CARETOUCH PEN NEEDLE 31GX5/16"	
BD VEO INS SYRING 1 ML 6MMX31G	158	.....	158
BD VEO INS SYRN 0.3 ML 6MMX31G.	158	CARETOUCH PEN NEEDLE 32GX3/16"	
BD VEO INS SYRN 0.5 ML 6MMX31G.	158	.....	158
<i>bendamustine intravenous recon soln</i>	47	CARETOUCH PEN NEEDLE 32GX5/32"	
BENDAMUSTINE INTRAVENOUS		.....	158
SOLUTION.....	47	CARETOUCH SYR 0.3 ML 31GX5/16"..	158
BENDEKA.....	47	CARETOUCH SYR 0.5 ML 30GX5/16"..	158
BENLYSTA SUBCUTANEOUS.....	44	CARETOUCH SYR 0.5 ML 31GX5/16"..	158
BESREMI.....	285	CARETOUCH SYR 1 ML 28GX5/16".....	158
<i>betaine</i>	50	CARETOUCH SYR 1 ML 29GX5/16".....	158
BETASERON SUBCUTANEOUS KIT ...	169	CARETOUCH SYR 1 ML 30GX5/16".....	158
<i>bexarotene</i>	52	CARETOUCH SYR 1 ML 31GX5/16".....	158
BIZENGRI.....	383	<i>carglumic acid</i>	64
BORDERED GAUZE 2"X2".....	158	CAYSTON.....	42
<i>bortezomib injection</i>	54	CIMZIA POWDER FOR RECONST.....	66
BORUZU.....	54	CIMZIA SUBCUTANEOUS SYRINGE	
<i>bosentan oral tablet</i>	55	KIT 400 MG/2 ML (200 MG/ML X 2).....	66
BOSULIF ORAL CAPSULE 100 MG, 50		CLICKFINE PEN NEEDLE 32GX5/32"	
MG.....	56	32GX4MM, STERILE.....	158
BOSULIF ORAL TABLET 100 MG, 400			
MG, 500 MG.....	56		

COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY).....	59
COMFORT EZ 0.3 ML 31G 15/64"	158
COMFORT EZ 0.5 ML 31G 15/64"	158
COMFORT EZ INS 0.3 ML 30GX1/2"	158
COMFORT EZ INS 0.3 ML 30GX5/16"... ..	158
COMFORT EZ INS 1 ML 31G 15/64"	158
COMFORT EZ INS 1 ML 31GX5/16"	158
COMFORT EZ INSULIN SYR 0.3 ML	158
COMFORT EZ INSULIN SYR 0.5 ML	158
COMFORT EZ PEN NEEDLE 12MM 29G.....	158
COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO	158
COMFORT EZ PEN NEEDLES 4MM 33G.....	158
COMFORT EZ PEN NEEDLES 5MM 31G MINI.....	158
COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI.....	158
COMFORT EZ PEN NEEDLES 5MM 33G.....	158
COMFORT EZ PEN NEEDLES 6MM 31G.....	158
COMFORT EZ PEN NEEDLES 6MM 32G.....	158
COMFORT EZ PEN NEEDLES 6MM 33G.....	158
COMFORT EZ PEN NEEDLES 8MM 31G SHORT.....	158
COMFORT EZ PEN NEEDLES 8MM 32G.....	158
COMFORT EZ PEN NEEDLES 8MM 33G.....	158
COMFORT EZ PRO PEN NDL 30G 8MM	158
COMFORT EZ PRO PEN NDL 31G 4MM	158
COMFORT EZ PRO PEN NDL 31G 5MM	158
COMFORT EZ SYR 0.3 ML 29GX1/2"	158
COMFORT EZ SYR 0.5 ML 28GX1/2"	158
COMFORT EZ SYR 0.5 ML 29GX1/2"	158
COMFORT EZ SYR 0.5 ML 30GX1/2"	158
COMFORT EZ SYR 1 ML 28GX1/2"	158
COMFORT EZ SYR 1 ML 29GX1/2"	158
COMFORT EZ SYR 1 ML 30GX1/2"	158
COMFORT EZ SYR 1 ML 30GX5/16"	158
COMFORT POINT PEN NDL 31GX1/3".	158
COMFORT POINT PEN NDL 31GX1/6".	158
COMFORT TOUCH PEN NDL 31G 4MM	158
COMFORT TOUCH PEN NDL 31G 5MM	158
COMFORT TOUCH PEN NDL 31G 6MM	158
COMFORT TOUCH PEN NDL 31G 8MM	158
COMFORT TOUCH PEN NDL 32G 4MM	158
COMFORT TOUCH PEN NDL 32G 5MM	158
COMFORT TOUCH PEN NDL 32G 6MM	158
COMFORT TOUCH PEN NDL 32G 8MM	158
COMFORT TOUCH PEN NDL 33G 4MM	158
COMFORT TOUCH PEN NDL 33G 6MM	158
COMFORT TOUCH PEN NDL 33GX5MM.....	158
COPIKTRA	98
CORTROPHIN GEL INJECTION	72
COSENTYX (2 SYRINGES).....	289
COSENTYX PEN (2 PENS).....	289
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML.....	289
COSENTYX UNOREADY PEN	289
COTELLIC	71
CRESEMBA ORAL	173
CURAD GAUZE PADS 2" X 2"	158
CURITY GAUZE SPONGES (12 PLY)- 200/BAG	158
CURITY GUAZE PADS 1'S(12 PLY).....	158
CYLTEZO(CF).....	15
CYLTEZO(CF) PEN	15
CYLTEZO(CF) PEN CROHN'S-UC-HS.....	15
CYLTEZO(CF) PEN PSORIASIS-UV	15
<i>dalfampridine</i>	79
DANYELZA	219
DANZITEN	222

<i>dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg</i>	82	DROPLET INS SYR 1 ML 29G 12.7MM.	158
DATROWAY	83	DROPLET INS SYR 1 ML 30G 8MM.....	158
DAURISMO ORAL TABLET 100 MG, 25 MG.....	140	DROPLET INS SYR 1 ML 30GX12.5MM	158
<i>deferasirox oral granules in packet</i>	85	DROPLET INS SYR 1 ML 30GX6MM....	158
<i>deferasirox oral tablet</i>	85	DROPLET INS SYR 1 ML 31G 6MM.....	158
DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII.....	158	DROPLET INS SYR 1 ML 31GX6MM....	158
DERMACEA GAUZE 2"X2" SPONGE 8 PLY	158	DROPLET INS SYR 1 ML 31GX8MM....	158
DERMACEA NON-WOVEN 2"X2" SPNGE.....	158	DROPLET MICRON 34G X 9/64"	158
<i>dermacinrx lidocan 5% patch outer</i>	194	DROPLET PEN NEEDLE 29G 10MM.....	158
DIACOMIT ORAL CAPSULE 250 MG, 500 MG.....	310	DROPLET PEN NEEDLE 29G 12MM.....	158
DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG.....	310	DROPLET PEN NEEDLE 30G 8MM.....	158
<i>diclofenac epolamine</i>	90	DROPLET PEN NEEDLE 31G 5MM.....	158
<i>diclofenac sodium topical solution in metered-dose pump</i>	89	DROPLET PEN NEEDLE 31G 6MM.....	158
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg</i>	91	DROPLET PEN NEEDLE 31G 8MM.....	158
<i>dronabinol</i>	95	DROPLET PEN NEEDLE 32G 4MM.....	158
DROPLET 0.3 ML 29G 12.7MM(1/2).....	158	DROPLET PEN NEEDLE 32G 5MM.....	158
DROPLET 0.3 ML 30G 12.7MM(1/2).....	158	DROPLET PEN NEEDLE 32G 6MM.....	158
DROPLET 0.5 ML 29GX12.5MM(1/2).....	158	DROPLET PEN NEEDLE 32G 8MM.....	158
DROPLET 0.5 ML 30GX12.5MM(1/2).....	158	DROPSAFE ALCOHOL 70% PREP PADS.....	158
DROPLET INS 0.3 ML 29GX12.5MM.....	158	DROPSAFE INS SYR 0.3 ML 31G 6MM	158
DROPLET INS 0.3 ML 30G 8MM(1/2)....	158	DROPSAFE INS SYR 0.3 ML 31G 8MM	158
DROPLET INS 0.3 ML 30GX12.5MM.....	158	DROPSAFE INS SYR 0.5 ML 31G 6MM	158
DROPLET INS 0.3 ML 31G 6MM(1/2)....	158	DROPSAFE INS SYR 0.5 ML 31G 8MM	158
DROPLET INS 0.3 ML 31G 8MM(1/2)....	158	DROPSAFE INSUL SYR 1 ML 31G 6MM.....	158
DROPLET INS 0.5 ML 29G 12.7MM.....	158	DROPSAFE INSUL SYR 1 ML 31G 8MM.....	158
DROPLET INS 0.5 ML 30G 12.7MM.....	158	DROPSAFE INSULN 1 ML 29G 12.5MM	158
DROPLET INS 0.5 ML 30GX6MM(1/2)..	158	DROPSAFE PEN NEEDLE 31GX1/4".....	158
DROPLET INS 0.5 ML 30GX8MM(1/2)..	158	DROPSAFE PEN NEEDLE 31GX3/16" ...	158
DROPLET INS 0.5 ML 31GX6MM(1/2)..	158	DROPSAFE PEN NEEDLE 31GX5/16" ...	158
DROPLET INS 0.5 ML 31GX8MM(1/2)..	158	<i>droxidopa</i>	96
DROPLET INS SYR 0.3 ML 30GX6MM.	158	DRUG MART ULTRA COMFORT SYR.	158
DROPLET INS SYR 0.3 ML 30GX8MM.	158	DUPIXENT PEN	97
DROPLET INS SYR 0.3 ML 31GX6MM.	158	DUPIXENT SYRINGE.....	97
DROPLET INS SYR 0.3 ML 31GX8MM.	158	EASY CMFT SFTY PEN NDL 31G 5MM	158
DROPLET INS SYR 0.5 ML 30G 8MM...	158	EASY CMFT SFTY PEN NDL 31G 6MM	158
DROPLET INS SYR 0.5 ML 31G 6MM...	158	EASY CMFT SFTY PEN NDL 32G 4MM	158
DROPLET INS SYR 0.5 ML 31G 8MM...	158	EASY COMFORT 0.3 ML 31G 1/2"	158
		EASY COMFORT 0.3 ML 31G 5/16"	158
		EASY COMFORT 0.3 ML SYRINGE.....	158
		EASY COMFORT 0.5 ML 30GX1/2"	158
		EASY COMFORT 0.5 ML 31GX5/16"	158
		EASY COMFORT 0.5 ML 32GX5/16"	158

EASY COMFORT 0.5 ML SYRINGE.....	158	EASY TOUCH PEN NEEDLE 31GX5/16	158
EASY COMFORT 1 ML 31GX5/16"	158	EASY TOUCH PEN NEEDLE 32GX1/4"	158
EASY COMFORT 1 ML 32GX5/16"	158	EASY TOUCH PEN NEEDLE 32GX3/16	158
EASY COMFORT ALCOHOL 70% PAD	158	EASY TOUCH PEN NEEDLE 32GX5/32	158
EASY COMFORT INSULIN 1 ML SYR..	158	EASY TOUCH SAF PEN NDL 29G 5MM	
EASY COMFORT PEN NDL 29G 4MM..	158	.....	158
EASY COMFORT PEN NDL 29G 5MM..	158	EASY TOUCH SAF PEN NDL 29G 8MM	
EASY COMFORT PEN NDL 31GX1/4"..	158	.....	158
EASY COMFORT PEN NDL 31GX3/16"	158	EASY TOUCH SAF PEN NDL 30G 5MM	
EASY COMFORT PEN NDL 31GX5/16"	158	.....	158
EASY COMFORT PEN NDL 32GX5/32"	158	EASY TOUCH SAF PEN NDL 30G 8MM	
EASY COMFORT PEN NDL 33G 4MM..	158	.....	158
EASY COMFORT PEN NDL 33G 5MM..	158	EASY TOUCH SYR 0.5 ML 28G	
EASY COMFORT PEN NDL 33G 6MM..	158	12.7MM.....	158
EASY COMFORT SYR 0.5 ML 29G		EASY TOUCH SYR 0.5 ML 29G	
8MM.....	158	12.7MM.....	158
EASY COMFORT SYR 1 ML 29G 8MM.	158	EASY TOUCH SYR 1 ML 27G 16MM....	158
EASY COMFORT SYR 1 ML 30GX1/2".	158	EASY TOUCH SYR 1 ML 28G 12.7MM.	158
EASY GLIDE INS 0.3 ML 31GX6MM....	158	EASY TOUCH SYR 1 ML 29G 12.7MM.	158
EASY GLIDE INS 0.5 ML 31GX6MM....	158	EASY TOUCH UNI-SLIP SYR 1 ML	158
EASY GLIDE INS 1 ML 31GX6MM.....	158	EASYTOUCH SAF PEN NDL 30G 6MM	158
EASY GLIDE PEN NEEDLE 4MM 33G..	158	ELAHERE.....	215
EASY TOUCH 0.3 ML SYR 30GX1/2"	158	ELIGARD.....	187
EASY TOUCH 0.5 ML SYR 27GX1/2"	158	ELIGARD (3 MONTH).....	187
EASY TOUCH 0.5 ML SYR 29GX1/2"	158	ELIGARD (4 MONTH).....	187
EASY TOUCH 0.5 ML SYR 30GX1/2"	158	ELIGARD (6 MONTH).....	187
EASY TOUCH 0.5 ML SYR 30GX5/16...	158	ELREXFIO 44 MG/1.1 ML VIAL INNER,	
EASY TOUCH 1 ML SYR 27GX1/2"	158	SUV, P/F	105
EASY TOUCH 1 ML SYR 29GX1/2"	158	ELREXFIO SUBCUTANEOUS	
EASY TOUCH 1 ML SYR 30GX1/2"	158	SOLUTION 40 MG/ML	105
EASY TOUCH FLIPLOK 1 ML 27GX0.5	158	<i>eltrombopag olamine oral powder in</i>	
EASY TOUCH INSULIN 1 ML 29GX1/2	158	<i>packet 12.5 mg, 25 mg.....</i>	108
EASY TOUCH INSULIN 1 ML 30GX1/2	158	<i>eltrombopag olamine oral tablet 12.5 mg,</i>	
EASY TOUCH INSULIN SYR 0.3 ML....	158	<i>25 mg, 50 mg, 75 mg.....</i>	108
EASY TOUCH INSULIN SYR 0.5 ML....	158	EMBRACE PEN NEEDLE 29G 12MM....	158
EASY TOUCH INSULIN SYR 1 ML.....	158	EMBRACE PEN NEEDLE 30G 5MM.....	158
EASY TOUCH INSULIN SYR 1 ML		EMBRACE PEN NEEDLE 30G 8MM.....	158
RETRACTABLE.....	158	EMBRACE PEN NEEDLE 31G 5MM.....	158
EASY TOUCH INSULN 1 ML 29GX1/2"	158	EMBRACE PEN NEEDLE 31G 6MM.....	158
EASY TOUCH INSULN 1 ML 30GX1/2"	158	EMBRACE PEN NEEDLE 31G 8MM.....	158
EASY TOUCH INSULN 1 ML 30GX5/16	158	EMBRACE PEN NEEDLE 32G 4MM.....	158
EASY TOUCH INSULN 1 ML 31GX5/16	158	EMGALITY PEN.....	136
EASY TOUCH LUER LOK INSUL 1 ML	158	EMGALITY SYRINGE	
EASY TOUCH PEN NEEDLE 29GX1/2"	158	SUBCUTANEOUS SYRINGE 120	
EASY TOUCH PEN NEEDLE 30GX5/16	158	MG/ML, 300 MG/3 ML (100 MG/ML X	
EASY TOUCH PEN NEEDLE 31GX1/4"	158	3).....	136
EASY TOUCH PEN NEEDLE 31GX3/16	158	EMRELIS.....	321

ENBREL.....	121	GNP CLICKFINE 31G X 1/4" NDL 6MM, UNIVERSAL.....	158
ENBREL MINI.....	121	GNP CLICKFINE 31G X 5/16" NDL 8MM, UNIVERSAL.....	158
ENBREL SURECLICK.....	121	GNP SIMPLI PEN NEEDLE 32G 4MM...	158
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG.....	300	GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT.....	158
EPCLUSA ORAL TABLET.....	300	GNP ULT CMFRT 0.5 ML 29GX1/2".....	158
EPIDIOLEX.....	61	GNP ULTRA COMFORT 0.5 ML SYR....	158
EPKINLY.....	115	GNP ULTRA COMFORT 1 ML SYRINGE.....	158
EQL INSULIN 0.5 ML SYRINGE.....	158	GNP ULTRA COMFORT 3/10 ML SYR..	158
EQL INSULIN 0.5 ML SYRINGE SHORT NEEDLE.....	158	GOMEKLI ORAL CAPSULE 1 MG, 2 MG.....	214
ERBITUX.....	68	GOMEKLI ORAL TABLET FOR SUSPENSION.....	214
ERIVEDGE.....	377	GS PEN NEEDLE 31G X 5MM.....	158
ERLEADA ORAL TABLET 240 MG, 60 MG.....	24	GS PEN NEEDLE 31G X 8MM.....	158
<i>erlotinib oral tablet 100 mg, 150 mg, 25 mg.....</i>	119	HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT.....	58
<i>everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg.....</i>	123	HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG.....	181
<i>everolimus (antineoplastic) oral tablet for suspension.....</i>	124	HARVONI ORAL TABLET.....	181
FAKZYNJA.....	38	HEALTHWISE INS 0.3 ML 30GX5/16"..	158
FASENRA.....	48	HEALTHWISE INS 0.3 ML 31GX5/16"..	158
FASENRA PEN.....	48	HEALTHWISE INS 0.5 ML 30GX5/16"..	158
<i>fentanyl citrate buccal lozenge on a handle</i>	128	HEALTHWISE INS 0.5 ML 31GX5/16"..	158
<i>fingolimod.....</i>	132	HEALTHWISE INS 1 ML 30GX5/16".....	158
FINTEPLA.....	127	HEALTHWISE INS 1 ML 31GX5/16".....	158
FOTIVDA.....	332	HEALTHWISE PEN NEEDLE 31G 5MM	158
FP INSULIN 1 ML SYRINGE.....	158	HEALTHWISE PEN NEEDLE 31G 8MM	158
FREESTYLE PREC 0.5 ML 30GX5/16....	158	HEALTHWISE PEN NEEDLE 32G 4MM	158
FREESTYLE PREC 0.5 ML 31GX5/16....	158	HEALTHY ACCENTS PENTIP 4MM 32G.....	158
FREESTYLE PREC 1 ML 30GX5/16".....	158	HEALTHY ACCENTS PENTIP 5MM 31G.....	158
FREESTYLE PREC 1 ML 31GX5/16".....	158	HEALTHY ACCENTS PENTIP 6MM 31G.....	158
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG.....	134	HEALTHY ACCENTS PENTIP 8MM 31G.....	158
FYARRO.....	298	HEALTHY ACCENTS PENTIP 12MM 29G.....	158
GAUZE PAD TOPICAL BANDAGE 2 X 2 ".....	158	HEB INCONTROL ALCOHOL 70% PADS.....	158
GAVRETO.....	261	HERCEPTIN HYLECTA.....	346
<i>gefitinib.....</i>	138	HERNEXEOS.....	385
GILOTRIF.....	17	HUMIRA PEN.....	11
<i>glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml.....</i>	141		
<i>glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml.....</i>	141		
<i>glutamine (sickle cell).....</i>	192		

HUMIRA PEN CROHNS-UC-HS START .	11	INSULIN SYRINGE 0.5 ML 31GX1/4.....	158
HUMIRA PEN PSOR-UEVITS-ADOL HS	11	INSULIN SYRINGE 1 ML.....	158
HUMIRA SUBCUTANEOUS SYRINGE		INSULIN SYRINGE 1 ML 27G 1/2"	
KIT 40 MG/0.8 ML	11	INNER.....	158
HUMIRA(CF).....	11	INSULIN SYRINGE 1 ML 27G 16MM....	158
HUMIRA(CF) PEDI CROHNS STARTER	11	INSULIN SYRINGE 1 ML 28G 12.7MM	
HUMIRA(CF) PEN	11	(OTC).....	158
HUMIRA(CF) PEN CROHNS-UC-HS.....	11	INSULIN SYRINGE 1 ML 30GX1/2"	
HUMIRA(CF) PEN PEDIATRIC UC.....	11	SHORT NEEDLE (OTC).....	158
HUMIRA(CF) PEN PSOR-UV-ADOL HS.	11	INSULIN SYRINGE 1 ML 31GX1/4"	158
IBRANCE	241	INSULIN SYRINGE NEEDLELESS	158
IBTROZI.....	315	INSULIN SYRINGE-NEEDLE U-100	
<i>icatibant</i>	150	SYRINGE 0.3 ML 29 GAUGE, 1 ML 29	
ICLUSIG	259	GAUGE X 1/2", 1/2 ML 28 GAUGE.....	158
IDHIFA	109	INSULIN U-500 SYRINGE-NEEDLE	158
<i>imatinib oral tablet 100 mg, 400 mg</i>	152	INSUPEN 30G ULTRAFIN NEEDLE	158
IMBRUVICA ORAL CAPSULE 140 MG,		INSUPEN 31G ULTRAFIN NEEDLE	158
70 MG	149	INSUPEN 32G 8MM PEN NEEDLE.....	158
IMBRUVICA ORAL SUSPENSION	149	INSUPEN PEN NEEDLE 29GX12MM....	158
IMBRUVICA ORAL TABLET	149	INSUPEN PEN NEEDLE 31G 8MM.....	158
IMDELLTRA	317	INSUPEN PEN NEEDLE 31GX3/16"	158
IMJUDO	348	INSUPEN PEN NEEDLE 32G 6MM (RX)	
IMKELDI.....	153	.....	158
IMPAVIDO	213	INSUPEN PEN NEEDLE 32GX4MM.....	158
INCONTROL PEN NEEDLE 12MM 29G	158	INSUPEN PEN NEEDLE 33GX4MM.....	158
INCONTROL PEN NEEDLE 4MM 32G ..	158	ITOVEBI ORAL TABLET 3 MG, 9 MG..	155
INCONTROL PEN NEEDLE 5MM 31G ..	158	IV ANTISEPTIC WIPES	158
INCONTROL PEN NEEDLE 6MM 31G ..	158	IWILFIN	99
INCONTROL PEN NEEDLE 8MM 31G ..	158	JAKAFI.....	287
INCRELEX	205	<i>javygtor oral tablet,soluble</i>	288
<i>infliximab</i>	156	JAYPIRCA ORAL TABLET 100 MG, 50	
INGREZZA	369	MG	257
INGREZZA INITIATION PK(TARDIV) ..	369	JEMPERLI.....	94
INGREZZA SPRINKLE	369	JYNARQUE ORAL TABLET	339
INLYTA ORAL TABLET 1 MG, 5 MG....	40	KALYDECO.....	174
INQOVI.....	84	KENDALL ALCOHOL 70% PREP PAD .	158
INREBIC	126	KERENDIA	131
INSULIN 1 ML SYRINGE.....	158	KESIMPTA PEN	233
INSULIN SYR 0.3 ML 31GX1/4(1/2).....	158	KEYTRUDA	249
INSULIN SYR 0.5 ML 28G 12.7MM		KIMMTRAK	319
(OTC).....	158	KINERET	22
INSULIN SYRIN 0.5 ML 30GX1/2" (RX)	158	KISQALI FEMARA CO-PACK ORAL	
INSULIN SYRING 0.5 ML 27G 1/2"		TABLET 200 MG/DAY(200 MG X 1)-2.5	
INNER.....	158	MG, 400 MG/DAY(200 MG X 2)-2.5 MG,	
INSULIN SYRINGE 0.3 ML	158	600 MG/DAY(200 MG X 3)-2.5 MG.....	272
INSULIN SYRINGE 0.3 ML 31GX1/4.....	158		
INSULIN SYRINGE 0.5 ML	158		

KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3).....	271	LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG.....	309
KOSELUGO ORAL CAPSULE 10 MG, 25 MG.....	294	LUNSUMIO.....	217
KRAZATI.....	10	LUPRON DEPOT.....	188
KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG.....	27	LUPRON DEPOT (3 MONTH).....	188
<i>lanreotide subcutaneous syringe 120 mg/0.5 ml</i>	177	LUPRON DEPOT (4 MONTH).....	188
<i>lapatinib</i>	178	LUPRON DEPOT (6 MONTH).....	188
LAZCLUZE ORAL TABLET 240 MG, 80 MG.....	180	LUPRON DEPOT-PED (3 MONTH).....	190
<i>lenalidomide</i>	182	LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT.....	190
LENVIMA.....	183	LUTRATE DEPOT (3 MONTH).....	186
<i>leuprolide acetate (3 month)</i>	186	LYNOZYFIC INTRAVENOUS SOLUTION 2 MG/ML, 20 MG/ML.....	196
<i>leuprolide subcutaneous kit</i>	185	LYNPARZA.....	234
<i>lidocaine topical adhesive patch, medicated 5 %</i>	194	LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5).....	135
<i>lidocaine topical ointment</i>	193	MAGELLAN INSUL SYRINGE 0.3 ML..	158
<i>lidocaine-prilocaine topical cream</i>	195	MAGELLAN INSUL SYRINGE 0.5 ML..	158
<i>lidocan iii</i>	194	MAGELLAN INSULIN SYR 0.3 ML.....	158
LISCO SPONGES 100/BAG.....	158	MAGELLAN INSULIN SYR 0.5 ML.....	158
LITE TOUCH 31GX1/4" PEN NEEDLE..	158	MAGELLAN INSULIN SYRINGE 1 ML	158
LITE TOUCH INSULIN 0.5 ML SYR.....	158	MARGENZA.....	202
LITE TOUCH INSULIN 1 ML SYR.....	158	MAVENCLAD (10 TABLET PACK).....	69
LITE TOUCH INSULIN SYR 1 ML.....	158	MAVENCLAD (4 TABLET PACK).....	69
LITE TOUCH PEN NEEDLE 29G.....	158	MAVENCLAD (5 TABLET PACK).....	69
LITE TOUCH PEN NEEDLE 31G.....	158	MAVENCLAD (6 TABLET PACK).....	69
LITETOUCH INS 0.3 ML 29GX1/2".....	158	MAVENCLAD (7 TABLET PACK).....	69
LITETOUCH INS 0.3 ML 30GX5/16".....	158	MAVENCLAD (8 TABLET PACK).....	69
LITETOUCH INS 0.3 ML 31GX5/16".....	158	MAVENCLAD (9 TABLET PACK).....	69
LITETOUCH INS 0.5 ML 31GX5/16".....	158	MAXICOMFORT II PEN NDL 31GX6MM.....	158
LITETOUCH SYR 0.5 ML 28GX1/2".....	158	MAXICOMFORT INS 0.5 ML 27GX1/2".....	158
LITETOUCH SYR 0.5 ML 29GX1/2".....	158	MAXI-COMFORT INS 0.5 ML 28G.....	158
LITETOUCH SYR 0.5 ML 30GX5/16"....	158	MAXICOMFORT INS 1 ML 27GX1/2"...	158
LITETOUCH SYRIN 1 ML 28GX1/2".....	158	MAXI-COMFORT INS 1 ML 28GX1/2"..	158
LITETOUCH SYRIN 1 ML 29GX1/2".....	158	MAXICOMFORT PEN NDL 29G X 5MM.....	158
LITETOUCH SYRIN 1 ML 30GX5/16"...	158	MAXICOMFORT PEN NDL 29G X 8MM.....	158
LIVTENCITY.....	203	MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG.....	297
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG.....	350	MAYZENT STARTER(FOR 1MG MAINT).....	297
LOQTORZI.....	341	MAYZENT STARTER(FOR 2MG MAINT).....	297
LORBRENA ORAL TABLET 100 MG, 25 MG.....	198	MEKINIST ORAL RECON SOLN.....	343

MEKINIST ORAL TABLET 0.5 MG, 2 MG.....	344	MONOJECT SYRINGE 1 ML.....	158
MEKTOVI.....	53	<i>morphine concentrate oral solution</i>	148
<i>metirosine</i>	210	MOUNJARO.....	144
MICRODOT PEN NEEDLE 31GX6MM..	158	MS INSULIN SYR 1 ML 31GX5/16" (OTC).....	158
MICRODOT PEN NEEDLE 32GX4MM..	158	MS INSULIN SYRINGE 0.3 ML.....	158
MICRODOT PEN NEEDLE 33GX4MM..	158	NANO 2 GEN PEN NEEDLE 32G 4MM..	158
MICRODOT READYGARD NDL 31G 5MM OUTER.....	158	NANO PEN NEEDLE 32G 4MM.....	158
<i>mifepristone oral tablet 300 mg</i>	212	NATPARA.....	242
MINI PEN NEEDLE 32G 4MM.....	158	NERLYNX.....	220
MINI PEN NEEDLE 32G 5MM.....	158	NIKTIMVO.....	39
MINI PEN NEEDLE 32G 6MM.....	158	NINLARO.....	176
MINI PEN NEEDLE 32G 8MM.....	158	<i>nitisinone</i>	228
MINI PEN NEEDLE 33G 4MM.....	158	NIVESTYM.....	130
MINI PEN NEEDLE 33G 5MM.....	158	NORDITROPIN FLEXPPO.....	303
MINI PEN NEEDLE 33G 6MM.....	158	NOVOFINE 30.....	158
MINI ULTRA-THIN II PEN NDL 31G STERILE.....	158	NOVOFINE 32G NEEDLES.....	158
MIPLYFFA.....	30	NOVOFINE PLUS PEN NDL 32GX1/6" ..	158
<i>modafinil oral tablet 100 mg, 200 mg</i>	218	NOVOTWIST.....	158
MODEYSO.....	93	NUBEQA.....	80
MONOJECT 0.5 ML SYRN 28GX1/2".....	158	NUCALA SUBCUTANEOUS AUTO-INJECTOR.....	207
MONOJECT 1 ML SYRN 27X1/2".....	158	NUCALA SUBCUTANEOUS RECON SOLN.....	207
MONOJECT 1 ML SYRN 28GX1/2" (OTC).....	158	NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML.....	207
MONOJECT INSUL SYR U100 (OTC).....	158	NUPLAZID.....	254
MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC).....	158	NURTEC ODT.....	276
MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC).....	158	NYVEPRIA.....	245
MONOJECT INSUL SYR U100 1 ML.....	158	ODOMZO.....	306
MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC).....	158	OFEV.....	223
MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC).....	158	OGIVRI.....	345
MONOJECT INSULIN SYR 0.3 ML.....	158	OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG.....	227
MONOJECT INSULIN SYR 0.3 ML (OTC).....	158	OJEMDA ORAL SUSPENSION FOR RECONSTITUTION.....	342
MONOJECT INSULIN SYR 0.5 ML.....	158	OJEMDA ORAL TABLET.....	342
MONOJECT INSULIN SYR 0.5 ML (OTC).....	158	OJJAARA.....	216
MONOJECT INSULIN SYR 1 ML 3'S (OTC).....	158	ONAPGO.....	26
MONOJECT INSULIN SYR U-100.....	158	ONUREG.....	41
MONOJECT SYRINGE 0.3 ML.....	158	OPDIVO.....	229
MONOJECT SYRINGE 0.5 ML.....	158	OPDIVO QVANTIG.....	230
		OPDUALAG.....	231
		OPSUMIT.....	201
		ORENCIA.....	4
		ORENCIA (WITH MALTOSE).....	2
		ORENCIA CLICKJECT.....	4

ORFADIN ORAL SUSPENSION.....	228	<i>pirfenidone oral capsule</i>	255
ORGOVYX.....	266	<i>pirfenidone oral tablet 267 mg, 534 mg, 801 mg</i>	255
ORLISSA ORAL TABLET 150 MG, 200 MG.....	101	PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML.....	170
ORKAMBI ORAL TABLET.....	200	PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML.....	170
ORSERDU ORAL TABLET 345 MG, 86 MG.....	100	POMALYST.....	258
OSENVELT.....	86	<i>posaconazole oral tablet, delayed release (dr/ec)</i>	260
OTEZLA.....	28	PREFPLS INS SYR 1 ML 30GX5/16" (OTC).....	158
OTEZLA STARTER.....	28	PREVENT PEN NEEDLE 31GX1/4".....	158
<i>oxandrolone</i>	239	PREVENT PEN NEEDLE 31GX5/16".....	158
OZEMPIC.....	143	PREVYMIS ORAL TABLET.....	184
<i>pazopanib</i>	244	PRO COMFORT 0.5 ML 30GX1/2".....	158
PC UNIFINE PENTIPS 8MM NEEDLE SHORT.....	158	PRO COMFORT 0.5 ML 30GX5/16".....	158
PEGASYS.....	247	PRO COMFORT 0.5 ML 31GX5/16".....	158
PEMAZYRE.....	250	PRO COMFORT 1 ML 30GX1/2".....	158
PEN NEEDLE 30G 5MM OUTER.....	158	PRO COMFORT 1 ML 30GX5/16".....	158
PEN NEEDLE 30G 8MM INNER.....	158	PRO COMFORT 1 ML 31GX5/16".....	158
PEN NEEDLE 30G X 5/16".....	158	PRO COMFORT ALCOHOL 70% PADS.....	158
PEN NEEDLE 31G X 1/4" HRI.....	158	PRO COMFORT PEN NDL 32G 8MM....	158
PEN NEEDLE 6MM 31G 6MM.....	158	PRO COMFORT PEN NDL 32G X 1/4"....	158
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2".....	158	PRO COMFORT PEN NDL 4MM 32G....	158
PEN NEEDLES 12MM 29G 29GX12MM,STRL.....	158	PRO COMFORT PEN NDL 5MM 32G....	158
PEN NEEDLES 4MM 32G.....	158	PRODIGY INS SYR 1 ML 28GX1/2".....	158
PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC).....	158	PRODIGY SYRNG 0.5 ML 31GX5/16"....	158
PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC).....	158	PRODIGY SYRNGE 0.3 ML 31GX5/16".....	158
<i>penicillamine oral tablet</i>	251	PURE CMFT SFTY PEN NDL 31G 5MM.....	158
PENTIPS PEN NEEDLE 29G 1/2".....	158	PURE CMFT SFTY PEN NDL 31G 6MM.....	158
PENTIPS PEN NEEDLE 31G 1/4".....	158	PURE CMFT SFTY PEN NDL 32G 4MM.....	158
PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM.....	158	PURE COMFORT ALCOHOL 70% PADS.....	158
PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM.....	158	PURE COMFORT PEN NDL 32G 4MM..	158
PENTIPS PEN NEEDLE 32G 1/4".....	158	PURE COMFORT PEN NDL 32G 5MM..	158
PENTIPS PEN NEEDLE 32GX5/32" 4MM.....	158	PURE COMFORT PEN NDL 32G 6MM..	158
PIP PEN NEEDLE 31G X 5MM.....	158	PURE COMFORT PEN NDL 32G 8MM..	158
PIP PEN NEEDLE 32G X 4MM.....	158	<i>pyrimethamine</i>	262
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2).....	19	QINLOCK.....	279
		<i>quinine sulfate</i>	263
		QULIPTA.....	35
		RALDESY.....	347
		RAYA SURE PEN NEEDLE 29G 12MM.....	158
		RAYA SURE PEN NEEDLE 31G 4MM....	158

RAYA SURE PEN NEEDLE 31G 5MM...	158	<i>sapropterin oral tablet, soluble</i>	288
RAYA SURE PEN NEEDLE 31G 6MM...	158	SCSEMBLIX ORAL TABLET 100 MG, 20	
RELION INS SYR 0.3 ML 31GX6MM....	158	MG, 40 MG.....	31
RELION INS SYR 0.5 ML 31GX6MM....	158	SECURESAFE PEN NDL 30GX5/16"	
RELION INS SYR 1 ML 31GX15/64".....	158	OUTER.....	158
RELI-ON INSULIN 1 ML SYR.....	158	SECURESAFE SYR 0.5 ML 29G 1/2"	
RETACRIT INJECTION SOLUTION		OUTER.....	158
10,000 UNIT/ML, 2,000 UNIT/ML,		SECURESAFE SYRNG 1 ML 29G 1/2"	
20,000 UNIT/2 ML, 20,000 UNIT/ML,		OUTER.....	158
3,000 UNIT/ML, 4,000 UNIT/ML, 40,000		SELARSDI.....	361, 363
UNIT/ML.....	116	SEROSTIM SUBCUTANEOUS RECON	
RETEVMO ORAL CAPSULE 40 MG, 80		SOLN 4 MG, 5 MG, 6 MG.....	305
MG.....	293	SIGNIFOR.....	243
RETEVMO ORAL TABLET 120 MG, 160		<i>sildenafil (pulm.hypertension) oral tablet..</i>	295
MG, 40 MG, 80 MG.....	293	SIRTURO.....	43
REVCIVI.....	103	SKY SAFETY PEN NEEDLE 30G 5MM.	158
REVUFORJ ORAL TABLET 110 MG,		SKY SAFETY PEN NEEDLE 30G 8MM.	158
160 MG, 25 MG.....	270	SKYRIZI.....	280
REZDIFFRA.....	268	SM ULT CFT 0.3 ML 31GX5/16(1/2).....	158
REZLIDHIA.....	235	<i>sodium oxybate</i>	299
REZUROCK.....	45	SOMATULINE DEPOT	
RINVOQ.....	354	SUBCUTANEOUS SYRINGE 60 MG/0.2	
RINVOQ LQ.....	354	ML, 90 MG/0.3 ML.....	177
RITUXAN HYCELA.....	282	SOMAVERT.....	248
ROMVIMZA.....	376	<i>sorafenib</i>	307
ROZLYTREK ORAL CAPSULE 100 MG,		SPRAVATO.....	120
200 MG.....	111	STELARA.....	357, 359
ROZLYTREK ORAL PELLETS IN		STERILE PADS 2" X 2".....	158
PACKET.....	112	STIVARGA.....	265
RUBRACA.....	286	STRENSIQ.....	32
RYBELSUS.....	143	<i>sunitinib malate</i>	311
RYBREVANT.....	21	SURE CMFT SFTY PEN NDL 31G 6MM	158
RYDAPT.....	211	SURE CMFT SFTY PEN NDL 32G 4MM	158
RYTELO.....	154	SURE COMFORT 0.5 ML SYRINGE.....	158
SAFESNAP INS SYR UNITS-100 0.3 ML		SURE COMFORT 1 ML SYRINGE.....	158
30GX5/16", 10X10.....	158	SURE COMFORT 3/10 ML SYRINGE....	158
SAFESNAP INS SYR UNITS-100 0.5 ML		SURE COMFORT 3/10 ML SYRINGE	
29GX1/2", 10X10.....	158	INSULIN SYRINGE.....	158
SAFESNAP INS SYR UNITS-100 0.5 ML		SURE COMFORT 30G PEN NEEDLE.....	158
30GX5/16", 10X10.....	158	SURE COMFORT INS 0.3 ML 31GX1/4.	158
SAFESNAP INS SYR UNITS-100 1 ML		SURE COMFORT INS 0.5 ML 31GX1/4.	158
28GX1/2", 10X10.....	158	SURE COMFORT INS 1 ML 31GX1/4"...	158
SAFESNAP INS SYR UNITS-100 1 ML		SURE COMFORT PEN NDL 29GX1/2"	
29GX1/2", 10X10.....	158	12.7MM.....	158
SAFETY PEN NEEDLE 31G 4MM.....	158	SURE COMFORT PEN NDL 31G 5MM..	158
SAFETY PEN NEEDLE 5MM X 31G.....	158	SURE COMFORT PEN NDL 31G 8MM..	158
SAFETY SYRINGE 0.5 ML 30G 1/2".....	158	SURE COMFORT PEN NDL 32G 4MM..	158

SURE COMFORT PEN NDL 32G 6MM..	158	<i>teriparatide subcutaneous pen injector 20</i>	
SURE-FINE PEN NEEDLES 12.7MM.....	158	<i>mcg/dose (560mcg/2.24ml)</i>	324
SURE-FINE PEN NEEDLES 5MM.....	158	TERUMO INS SYRINGE U100-1 ML.....	158
SURE-FINE PEN NEEDLES 8MM.....	158	TERUMO INS SYRINGE U100-1/2 ML..	158
SURE-JECT INSU SYR U100 0.3 ML.....	158	TERUMO INS SYRINGE U100-1/3 ML..	158
SURE-JECT INSU SYR U100 0.5 ML.....	158	TERUMO INS SYRNG U100-1/2 ML.....	158
SURE-JECT INSU SYR U100 1 ML.....	158	<i>testosterone cypionate</i>	326
SURE-JECT INSUL SYR U100 1 ML.....	158	<i>testosterone enanthate</i>	327
SURE-JECT INSULIN SYRINGE 1 ML..	158	<i>testosterone transdermal gel in metered-</i>	
SURE-PREP ALCOHOL PREP PADS.....	158	<i>dose pump 12.5 mg/ 1.25 gram (1 %),</i>	
SYMPAZAN	70	<i>20.25 mg/1.25 gram (1.62 %)</i>	325
SYNRIBO	236	<i>testosterone transdermal gel in packet 1 %</i>	
TABRECTA.....	63	<i>(25 mg/2.5gram), 1 % (50 mg/5 gram)</i>	325
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	313	<i>tetrabenazine</i>	328
TAFINLAR ORAL CAPSULE.....	76	TEVIMBRA.....	330
TAFINLAR ORAL TABLET FOR		THALOMID ORAL CAPSULE 100 MG,	
SUSPENSION	77	150 MG, 200 MG, 50 MG	329
TAGRISSO	238	THINPRO INS SYRIN U100-0.3 ML.....	158
TALVEY	316	THINPRO INS SYRIN U100-0.5 ML.....	158
TALZENNA	314	THINPRO INS SYRIN U100-1 ML.....	158
TASIGNA ORAL CAPSULE 150 MG,		TIBSOVO.....	175
200 MG, 50 MG.....	221	TIVDAK.....	331
TAVNEOS.....	36	<i>tolvaptan (polycys kidney dis) oral tablets,</i>	
TAZVERIK.....	318	<i>sequential</i>	339
TECHLITE 0.3 ML 29GX12MM (1/2).....	158	TOPCARE CLICKFINE 31G X 1/4"	158
TECHLITE 0.3 ML 30GX8MM (1/2).....	158	TOPCARE CLICKFINE 31G X 5/16"	158
TECHLITE 0.3 ML 31GX6MM (1/2).....	158	TOPCARE ULTRA COMFORT	
TECHLITE 0.3 ML 31GX8MM (1/2).....	158	SYRINGE.....	158
TECHLITE 0.5 ML 30GX12MM (1/2).....	158	<i>torpenz oral tablet 10 mg, 2.5 mg, 5 mg,</i>	
TECHLITE 0.5 ML 30GX8MM (1/2).....	158	<i>7.5 mg.....</i>	123
TECHLITE 0.5 ML 31GX6MM (1/2).....	158	TRELSTAR INTRAMUSCULAR	
TECHLITE 0.5 ML 31GX8MM (1/2).....	158	SUSPENSION FOR RECONSTITUTION	351
TECHLITE INS SYR 1 ML 29GX12MM.	158	TREMFYA.....	146
TECHLITE INS SYR 1 ML 30GX12MM.	158	TREMFYA 100 MG/ML ONE-PRESS.....	146
TECHLITE INS SYR 1 ML 31GX6MM...	158	TREMFYA PEN INDUCTION PK-	
TECHLITE INS SYR 1 ML 31GX8MM...	158	CROHN	146
TECHLITE PEN NEEDLE 29GX1/2"	158	TREMFYA PEN SUBCUTANEOUS PEN	
TECHLITE PEN NEEDLE 29GX3/8"	158	INJECTOR 200 MG/2 ML	146
TECHLITE PEN NEEDLE 31GX1/4"	158	<i>tretinoin topical cream.....</i>	340
TECHLITE PEN NEEDLE 31GX3/16"	158	<i>trientine oral capsule 250 mg</i>	349
TECHLITE PEN NEEDLE 31GX5/16"	158	TRIKAFTA ORAL GRANULES IN	
TECHLITE PEN NEEDLE 32GX1/4"	158	PACKET, SEQUENTIAL	104
TECHLITE PEN NEEDLE 32GX5/16"	158	TRIKAFTA ORAL TABLETS,	
TECHLITE PEN NEEDLE 32GX5/32"	158	SEQUENTIAL	104
TECHLITE PLUS PEN NDL 32G 4MM..	158	TRUE CMFRT PRO 0.5 ML 30G 5/16"	158
TECVAYLI.....	320	TRUE CMFRT PRO 0.5 ML 31G 5/16"	158
TEPMETKO.....	323	TRUE CMFRT PRO 0.5 ML 32G 5/16"	158

TRUE CMFT SFTY PEN NDL 31G 5MM	158	TRUQAP.....	62
TRUE CMFT SFTY PEN NDL 31G 6MM	158	TRUXIMA.....	283
TRUE CMFT SFTY PEN NDL 32G 4MM	158	TUKYSA ORAL TABLET 150 MG, 50	
TRUE COMFORT 0.5 ML 30G 1/2"	158	MG.....	352
TRUE COMFORT 0.5 ML 30G 5/16"	158	TURALIO.....	253
TRUE COMFORT 0.5 ML 31G 5/16"	158	TYENNE.....	333, 335
TRUE COMFORT 0.5 ML 31GX5/16"	158	TYENNE AUTOINJECTOR.....	335
TRUE COMFORT 1 ML 31GX5/16"	158	TYMLOS.....	1
TRUE COMFORT ALCOHOL 70%		UBRELVY.....	353
PADS.....	158	UDENYCA ONBODY.....	246
TRUE COMFORT PEN NDL 31G 8MM	158	ULTICAR INS 0.3 ML 31GX1/4(1/2).....	158
TRUE COMFORT PEN NDL 31GX5MM	158	ULTICARE INS 1 ML 31GX1/4".....	158
TRUE COMFORT PEN NDL 31GX6MM	158	ULTICARE INS SYR 0.3 ML 30G 8MM	158
TRUE COMFORT PEN NDL 32G 5MM	158	ULTICARE INS SYR 0.3 ML 31G 6MM	158
TRUE COMFORT PEN NDL 32G 6MM	158	ULTICARE INS SYR 0.3 ML 31G 8MM	158
TRUE COMFORT PEN NDL 32GX4MM	158	ULTICARE INS SYR 0.5 ML 30G 8MM	
TRUE COMFORT PEN NDL 33G 4MM	158	(OTC).....	158
TRUE COMFORT PEN NDL 33G 5MM	158	ULTICARE INS SYR 0.5 ML 31G 6MM	158
TRUE COMFORT PEN NDL 33G 6MM	158	ULTICARE INS SYR 0.5 ML 31G 8MM	
TRUE COMFORT PRO 1 ML 30G 1/2"	158	(OTC).....	158
TRUE COMFORT PRO 1 ML 30G 5/16"	158	ULTICARE INS SYR 1 ML 30GX1/2".....	158
TRUE COMFORT PRO 1 ML 31G 5/16"	158	ULTICARE PEN NEEDLE 31GX3/16".....	158
TRUE COMFORT PRO 1 ML 32G 5/16"	158	ULTICARE PEN NEEDLE 6MM 31G.....	158
TRUE COMFORT PRO ALCOHOL		ULTICARE PEN NEEDLE 8MM 31G.....	158
PADS.....	158	ULTICARE PEN NEEDLES 12MM 29G	158
TRUE COMFORT SFTY 1 ML 30G 1/2"	158	ULTICARE PEN NEEDLES 4MM 32G	
TRUE COMFORT PRO 0.5 ML 30G 1/2"	158	MICRO, 32GX4MM.....	158
TRUE COMFORT SFTY 1 ML 30G 5/16"	158	ULTICARE PEN NEEDLES 6MM 32G...	158
TRUE COMFORT SFTY 1 ML 31G 5/16"	158	ULTICARE SAFE PEN NDL 30G 8MM	158
TRUE COMFORT SFTY 1 ML 32G 5/16"	158	ULTICARE SAFE PEN NDL 5MM 30G	158
TRUEPLUS PEN NEEDLE 29GX1/2".....	158	ULTICARE SAFETY 0.5 ML 29GX1/2	
TRUEPLUS PEN NEEDLE 31G X 1/4"...	158	(RX).....	158
TRUEPLUS PEN NEEDLE 31GX3/16"...	158	ULTICARE SYR 0.3 ML 29G 12.7MM....	158
TRUEPLUS PEN NEEDLE 31GX5/16"...	158	ULTICARE SYR 0.3 ML 30GX1/2".....	158
TRUEPLUS PEN NEEDLE 32GX5/32"...	158	ULTICARE SYR 0.3 ML 31GX5/16"	
TRUEPLUS SYR 0.3 ML 29GX1/2".....	158	SHORT NDL.....	158
TRUEPLUS SYR 0.3 ML 30GX5/16".....	158	ULTICARE SYR 0.5 ML 30GX1/2".....	158
TRUEPLUS SYR 0.3 ML 31GX5/16".....	158	ULTICARE SYR 0.5 ML 31GX5/16"	
TRUEPLUS SYR 0.5 ML 28GX1/2".....	158	SHORT NDL.....	158
TRUEPLUS SYR 0.5 ML 29GX1/2".....	158	ULTICARE SYR 1 ML 31GX5/16".....	158
TRUEPLUS SYR 0.5 ML 30GX5/16".....	158	ULTIGUARD SAFE 1 ML 30G 12.7MM	158
TRUEPLUS SYR 0.5 ML 31GX5/16".....	158	ULTIGUARD SAFE0.3 ML 30G 12.7MM	
TRUEPLUS SYR 1 ML 28GX1/2".....	158	.....	158
TRUEPLUS SYR 1 ML 29GX1/2".....	158	ULTIGUARD SAFE0.5 ML 30G 12.7MM	
TRUEPLUS SYR 1 ML 30GX5/16".....	158	.....	158
TRUEPLUS SYR 1 ML 31GX5/16".....	158	ULTIGUARD SAFEPACK 1 ML 31G	
TRULICITY.....	142	8MM.....	158

ULTIGUARD SAFEPAK 29G 12.7MM	158	ULTRACARE PEN NEEDLE 31GX5/16"	158
ULTIGUARD SAFEPAK 31G 5MM.....	158	ULTRACARE PEN NEEDLE 32GX1/4" ..	158
ULTIGUARD SAFEPAK 31G 6MM.....	158	ULTRACARE PEN NEEDLE 32GX3/16"	158
ULTIGUARD SAFEPAK 31G 8MM.....	158	ULTRACARE PEN NEEDLE 32GX5/32"	158
ULTIGUARD SAFEPAK 32G 4MM.....	158	ULTRACARE PEN NEEDLE 33GX5/32"	158
ULTIGUARD SAFEPAK 32G 6MM.....	158	ULTRA-FINE 0.3 ML 30G 12.7MM.....	158
ULTIGUARD SAFEPAK 0.3 ML 31G		ULTRA-FINE 0.3 ML 31G 6MM (1/2).....	158
8MM.....	158	ULTRA-FINE 0.3 ML 31G 8MM (1/2).....	158
ULTIGUARD SAFEPAK 0.5 ML 31G		ULTRA-FINE 0.5 ML 30G 12.7MM.....	158
8MM.....	158	ULTRA-FINE INS SYR 1 ML 31G 6MM	158
ULTILET ALCOHOL STERL SWAB.....	158	ULTRA-FINE INS SYR 1 ML 31G 8MM	158
ULTILET INSULIN SYRINGE 0.3 ML...	158	ULTRA-FINE PEN NDL 29G 12.7MM....	158
ULTILET INSULIN SYRINGE 0.5 ML...	158	ULTRA-FINE PEN NEEDLE 31G 5MM..	158
ULTILET INSULIN SYRINGE 1 ML.....	158	ULTRA-FINE PEN NEEDLE 31G 8MM..	158
ULTILET PEN NEEDLE	158	ULTRA-FINE PEN NEEDLE 32G 6MM..	158
ULTILET PEN NEEDLE 4MM 32G.....	158	ULTRA-FINE SYR 0.3 ML 31G 8MM.....	158
ULTRA COMFORT 0.3 ML SYRINGE...	158	ULTRA-FINE SYR 0.5 ML 31G 6MM.....	158
ULTRA COMFORT 0.5 ML 28GX1/2"		ULTRA-FINE SYR 0.5 ML 31G 8MM.....	158
CONVERTS TO 29G.....	158	ULTRA-FINE SYR 1 ML 30G 12.7MM...	158
ULTRA COMFORT 0.5 ML 29GX1/2"	158	ULTRA-THIN II 1 ML 31GX5/16"	158
ULTRA COMFORT 0.5 ML SYRINGE...	158	ULTRA-THIN II INS 0.3 ML 30G	158
ULTRA COMFORT 1 ML 31GX5/16".....	158	ULTRA-THIN II INS 0.3 ML 31G	158
ULTRA COMFORT 1 ML SYRINGE.....	158	ULTRA-THIN II INS 0.5 ML 29G	158
ULTRA FLO 0.3 ML 30G 1/2" (1/2).....	158	ULTRA-THIN II INS 0.5 ML 30G	158
ULTRA FLO 0.3 ML 30G 5/16"(1/2).....	158	ULTRA-THIN II INS 0.5 ML 31G	158
ULTRA FLO 0.3 ML 31G 5/16"(1/2).....	158	ULTRA-THIN II INS SYR 1 ML 29G	158
ULTRA FLO PEN NEEDLE 31G 5MM...	158	ULTRA-THIN II INS SYR 1 ML 30G	158
ULTRA FLO PEN NEEDLE 31G 8MM...	158	ULTRA-THIN II PEN NDL 29GX1/2".....	158
ULTRA FLO PEN NEEDLE 32G 4MM...	158	ULTRA-THIN II PEN NDL 31GX5/16.....	158
ULTRA FLO PEN NEEDLE 33G 4MM...	158	UNIFINE OTC PEN NEEDLE 32G 4MM	158
ULTRA FLO PEN NEEDLES 12MM 29G		UNIFINE OTC PEN NEEDLE NEEDLE	
.....	158	31 GAUGE X 3/16"	158
ULTRA FLO SYR 0.3 ML 29GX1/2"	158	UNIFINE PEN NEEDLE 32G 4MM.....	158
ULTRA FLO SYR 0.3 ML 30G 5/16".....	158	UNIFINE PENTIPS 12MM 29G	
ULTRA FLO SYR 0.3 ML 31G 5/16".....	158	29GX12MM, STRL	158
ULTRA FLO SYR 0.5 ML 29G 1/2"	158	UNIFINE PENTIPS 31GX3/16"	
ULTRA THIN PEN NDL 32G X 4MM.....	158	31GX5MM,STRL,MINI.....	158
ULTRACARE INS 0.3 ML 30GX5/16"	158	UNIFINE PENTIPS 32G 4MM.....	158
ULTRACARE INS 0.3 ML 31GX5/16"	158	UNIFINE PENTIPS 32GX1/4"	158
ULTRACARE INS 0.5 ML 30GX1/2"	158	UNIFINE PENTIPS 33GX5/32"	158
ULTRACARE INS 0.5 ML 30GX5/16"	158	UNIFINE PENTIPS 6MM 31G.....	158
ULTRACARE INS 0.5 ML 31GX5/16"	158	UNIFINE PENTIPS MAX 30GX3/16"	158
ULTRACARE INS 1 ML 30G X 5/16"	158	UNIFINE PENTIPS NEEDLES 29G.....	158
ULTRACARE INS 1 ML 30GX1/2"	158	UNIFINE PENTIPS PLUS 29GX1/2"	
ULTRACARE INS 1 ML 31G X 5/16"	158	12MM.....	158
ULTRACARE PEN NEEDLE 31GX1/4" ..	158	UNIFINE PENTIPS PLUS 30GX3/16"	158
ULTRACARE PEN NEEDLE 31GX3/16"	158		

UNIFINE PENTIPS PLUS 31GX1/4"	
ULTRA SHORT, 6MM.....	158
UNIFINE PENTIPS PLUS 31GX3/16"	
MINI.....	158
UNIFINE PENTIPS PLUS 31GX5/16"	
SHORT.....	158
UNIFINE PENTIPS PLUS 32GX5/32".....	158
UNIFINE PENTIPS PLUS 33GX5/32".....	158
UNIFINE PROTECT 30G 5MM.....	158
UNIFINE PROTECT 30G 8MM.....	158
UNIFINE PROTECT 32G 4MM.....	158
UNIFINE SAFECONTROL 30G 5MM.....	158
UNIFINE SAFECONTROL 30G 8MM.....	158
UNIFINE SAFECONTROL 31G 5MM.....	158
UNIFINE SAFECONTROL 31G 6MM.....	158
UNIFINE SAFECONTROL 31G 8MM.....	158
UNIFINE SAFECONTROL 32G 4MM.....	158
UNIFINE ULTRA PEN NDL 31G 5MM..	158
UNIFINE ULTRA PEN NDL 31G 6MM..	158
UNIFINE ULTRA PEN NDL 31G 8MM..	158
UNIFINE ULTRA PEN NDL 32G 4MM..	158
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG.....	291
UPTRAVI ORAL TABLETS,DOSE PACK.....	291
<i>ustekinumab</i>	357, 359
VALCHLOR.....	206
VANFLYTA.....	264
VANISHPOINT 0.5 ML 30GX1/2" SY OUTER.....	158
VANISHPOINT INS 1 ML 30GX3/16"....	158
VANISHPOINT U-100 29X1/2 SYR.....	158
VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG.....	373
VENCLEXTA STARTING PACK.....	373
VEOZAH.....	129
VERIFINE INS SYR 1 ML 29G 1/2".....	158
VERIFINE PEN NEEDLE 29G 12MM.....	158
VERIFINE PEN NEEDLE 31G 5MM.....	158
VERIFINE PEN NEEDLE 31G X 6MM...	158
VERIFINE PEN NEEDLE 31G X 8MM...	158
VERIFINE PEN NEEDLE 32G 6MM.....	158
VERIFINE PEN NEEDLE 32G X 4MM...	158
VERIFINE PEN NEEDLE 32G X 5MM...	158
VERIFINE PLUS PEN NDL 31G 5MM...	158
VERIFINE PLUS PEN NDL 31G 8MM...	158
VERIFINE PLUS PEN NDL 32G 4MM...	158
VERIFINE PLUS PEN NDL 32G 4MM- SHARPS CONTAINER.....	158
VERIFINE SYRING 0.5 ML 29G 1/2".....	158
VERIFINE SYRING 1 ML 31G 5/16".....	158
VERIFINE SYRNG 0.3 ML 31G 5/16".....	158
VERIFINE SYRNG 0.5 ML 31G 5/16".....	158
VERQUVO.....	374
VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY.....	158
VERZENIO.....	6
<i>vigabatrin</i>	375
<i>vigadrone</i>	375
<i>vigpoder</i>	375
VITRAKVI ORAL CAPSULE 100 MG, 25 MG.....	179
VITRAKVI ORAL SOLUTION.....	179
VIVIMUSTA.....	47
VIZIMPRO.....	78
VONJO.....	240
VOQUEZNA.....	378
VORANIGO.....	379
<i>voriconazole oral suspension for reconstitution</i>	380
VOSEVI.....	301
VOWST.....	125
VUMERITY.....	92
VYALEV.....	133
VYLOY.....	384
WEBCOL ALCOHOL PREPS 20'S,LARGE.....	158
WELIREG.....	46
WINREVAIR.....	308
XALKORI ORAL CAPSULE.....	74
XALKORI ORAL PELLETT 150 MG, 20 MG, 50 MG.....	75
XDEMVEY.....	199
XELJANZ.....	337
XELJANZ XR.....	337
XERMELO.....	322
XGEVA.....	87
XIFAXAN ORAL TABLET 200 MG, 550 MG.....	273
XOLAIR.....	237
XOSPATA.....	139

XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK).....	292
XTANDI ORAL CAPSULE.....	113
XTANDI ORAL TABLET 40 MG, 80 MG	113
YERVOY	172
YESINTEK.....	365, 367
YONSA.....	8
YUFLYMA(CF).....	13
YUFLYMA(CF) AI CROHN'S-UC-HS.....	13
YUFLYMA(CF) AUTOINJECTOR.....	13
ZEJULA ORAL CAPSULE.....	225
ZEJULA ORAL TABLET.....	225
ZELBORAF	372
ZIIHERA.....	381
ZIRABEV	51
ZOLADEX.....	145
ZTALMY	137
ZTLIDO	194
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG.....	386
ZYDELIG	151
ZYKADIA.....	65
ZYNLONTA.....	197
ZYNYZ.....	269