# 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

- *abiraterone, submicronized*
- 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 (ACALABRUTINIB MAL)

| 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 |

# ACORAMIDIS

**Products Affected**

- ATTRUBY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | CARDIOMYOPATHY OF WILD TYPE OR VARIANT TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (ATTR-CM): INITIAL: 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE, AND 2) DIAGNOSIS CONFIRMED BY (A) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF TC-99M-PYP, OR (B) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | ATTR-CM: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | ATTR-CM: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER ATTR-CM TTR STABILIZERS (E.G., TAFAMIDIS). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# ADAGRASIB

## Products Affected

- KRAZATI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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 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

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

**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 |

# ADALIMUMAB-BWWD

**Products Affected**

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

| 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 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-HYALURONIDASE-LPUJ

**Products Affected**

- RYBREVANT FASPRO

| 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 |

# 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/HADLIMA, 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** | 12 MONTHS |
| **Other Criteria** | NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC), METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# APOMORPHINE - ONAPGO

## Products Affected

- ONAPGO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | PD: RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# APREMILAST

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: MILD PLAQUE PSORIASIS (PSO): 1) PSORIASIS COVERING LESS THAN 3 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** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# AVACOPAN

## Products Affected

- TAVNEOS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | ANTI-NEUTROPHIL CYTOPLASMIC AUTOANTIBODY (ANCA)-ASSOCIATED VASCULITIS: INITIAL: ANCA SEROPOSITIVE (ANTI-PR3 OR ANTI-MPO). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | ANCA-ASSOCIATED VASCULITIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 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** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 24 WEEKS |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# BELIMUMAB

**Products Affected**

- BENLYSTA SUBCUTANEOUS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **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** | ASTHMA, EGPA: INITIAL/RENEWAL: 12 MO.<br>HYPEREOSINOPHILIC SYNDROME (HES): 12 MO. |

| 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** | Yes |

# 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, 500 MG
- *bosutinib oral tablet 100 mg, 400 mg, 500 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND 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** | Yes |

# BRIGATINIB

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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: 1) TYPE III HAE, OR 2) TYPE I OR II HAE CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q. |
| **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/RENEWAL: 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
- CIMZIA POWDER FOR RECONST
- CIMZIA STARTER KIT

| 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/HADLIMA, XELJANZ, RINVOQ, ORENCIA. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, SELARSDI/YESINTEK/USTEKINUMAB-AAUZ, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, XELJANZ, RINVOQ. CD: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/USTEKINUMAB-AAUZ, HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, SELARSDI/YESINTEK/USTEKINUMAB-AAUZ, 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/HADLIMA, 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** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# CLADRIBINE

## Products Affected

- *cladribine 10 mg x 10 tab pk outer (8 pack), 10 mg (9 pack)*
- *cladribine(multiple sclerosis) oral tablet 10 mg (10 pack), 10 mg (4 pack), 10 mg (5 pack), 10 mg (6 pack), 10 mg (7 pack), 10 mg*

| 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 CLADRIBINE 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** | INITIAL: LENNOX-GASTAUT SYNDROME (LGS): THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS |
| **Other Criteria** | LGS: INITIAL: CONTRAINDICATION TO OR UNABLE TO SWALLOW CLOBAZAM TABLETS OR SUSPENSION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# COBIMETINIB

**Products Affected**

- COTELLIC

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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 TAFINILAR CAPSULES. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# DACOMITINIB

**Products Affected**

- VIZIMPRO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | MULTIPLE SCLEROSIS (MS): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS |
| **Other Criteria** | MS: INITIAL: HAS SYMPTOMS OF A WALKING DISABILITY (E.G., MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS, UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA). RENEWAL: IMPROVEMENT IN WALKING ABILITY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# DAROLUTAMIDE

## Products Affected

- NUBEQA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC), METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | 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** | |
| **Required Medical Information** | INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L. CHRONIC IRON OVERLOAD IN NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT): 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS), AND 2) LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G OF LIVER DRY WEIGHT OR GREATER. RENEWAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L. NTDT: 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR 2) LIC OF 3 MG FE/G OF LIVER DRY WEIGHT OR GREATER. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS OR NTDT: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS OR NTDT: DEFERASIROX SPRINKLE PACKETS: TRIAL OF OR CONTRAINDICATION TO GENERIC DEFERASIROX ORAL TABLET OR TABLET FOR ORAL SUSPENSION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
| --- | --- |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# DENOSUMAB-BMWO - OSENVELT

**Products Affected**

- OSENVELT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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
- 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 1.5% 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** | |
| **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 |

# 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 oral capsule*

| 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** | |
| **Required Medical Information** | INITIAL: EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL OF 150 TO 1500 CELLS/MCL WITHIN THE PAST 12 MONTHS. EOSINOPHILIC ESOPHAGITIS (EOE): DIAGNOSIS CONFIRMED BY ESOPHAGOGASTRODUODENOSCOPY (EGD) WITH BIOPSY. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: AD, PN, CSU: PRESCRIBED OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST OR PULMONOLOGIST. CRSWNP: PRESCRIBED OR IN CONSULTATION WITH OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED OR IN CONSULTATION WITH GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST. COPD: PRESCRIBED OR IN CONSULTATION WITH PULMONOLOGIST. RENEWAL: CSU: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST. |
| **Coverage Duration** | BP, AFRS: 12 MO. AD/CRSWNP/EOE/PN/CSU: INITIAL/RENEWAL: 6 MO/12 MO. ASTHMA/COPD: INIT/RENEW: 12 MO. |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | INITIAL: AD: TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID, CALCINEURIN INHIBITOR, PDE4 INHIBITOR, AHR AGONIST OR JAK INHIBITOR). 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 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. 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. PRURIGO NODULARIS (PN): CHRONIC PRURITUS (ITCH MORE THAN 6 WEEKS), MULTIPLE PRURIGINOUS LESIONS, AND HISTORY OR SIGN OF A PROLONGED SCRATCHING BEHAVIOR. EOSINOPHILIC COPD: USED IN COMBINATION WITH A LAMA/LABA/ICS. CHRONIC SPONTANEOUS URTICARIA (CSU): 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. INITIAL/RENEWAL : ALL INDICATIONS EXCEPT BULLOUS PEMPHIGOID (BP): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: AD, CRSWNP, EOE: |

| PA Criteria | Criteria Details |
|---|---|
| | IMPROVEMENT WHILE ON THERAPY. 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. PN: IMPROVEMENT OR REDUCTION OF PRURITUS OR PRURIGINOUS LESIONS. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, AND 2) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, OR (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS. CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **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** | |
| **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 |
| **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 |

# ELEXACAFTOR-TEZACAFTOR-IVACAFTOR

**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. |
| **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 X 10^9/L, OR 2) PLATELET COUNT IS LESS THAN 50 X 10^9/L 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). RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNT FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **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** | |
| **Required Medical Information** | PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: 1) PLATELET COUNT OF LESS THAN 30 X 10^9/L, OR 2) PLATELET COUNT OF LESS THAN 50 X 10^9/L AND 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 HAD AN INSUFFICIENT RESPONSE TO SPLENECTOMY, AND 2) NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS). ALL INDICATIONS: ELTROMBOPAG ORAL SUSPENSION PACKETS: TRIAL OF A FORMULARY VERSION OF ELTROMBOPAG TABLET OR PATIENT IS UNABLE TO TOLERATE TABLET FORMULATION. RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNTS FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **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 |

# ENSARTINIB

## Products Affected

- ENSACOVE ORAL CAPSULE 100 MG, 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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** | 12 MONTHS |
| **Other Criteria** | NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (NMCSPC): HIGH RISK FOR METASTASIS (I.E. PSA DOUBLING TIME OF 9 MONTHS OR LESS). METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC), NON-METASTATIC CRPC (NMCRPC), METASTATIC CSPC (MCSPC), NMCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | 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** | |
| **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** | |
| **Required Medical Information** | INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE, OR CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL IS LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HEMOGLOBIN LEVEL IS 13G/DL OR LESS. RENEWAL: 1) CKD IN ADULTS NOT ON DIALYSIS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 2) CKD IN PEDIATRIC PATIENTS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS APPROACHED OR EXCEEDS 12G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 3) ANEMIA RELATED TO ZIDOVUDINE: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. 4) CANCER CHEMOTHERAPY: (A) HEMOGLOBIN LEVEL IS LESS THAN 10 G/DL, OR (B) HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: 12 MONTHS. SURGERY: 1 MONTH. |
| **Other Criteria** | RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. |

| PA Criteria | Criteria Details |
| --- | --- |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **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** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# ERLOTINIB

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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 OR OTHER REMS-CERTIFIED PROVIDER. |
| **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 MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
- 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*
- *yulithira oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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** | 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 |

# 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** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS |
| **Other Criteria** | MENOPAUSAL VASOMOTOR SYMPTOMS (VMS): INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO HORMONAL THERAPY (E.G., ESTRADIOL TRANSDERMAL PATCH, ORAL CONJUGATED ESTROGENS), 2) LABORATORY TESTING TO ESTABLISH BASELINE HEPATIC FUNCTION AND CONTINUED MONITORING OF THESE VALUES IN ACCORDANCE WITH THE FDA CURRENT LABEL RECOMMENDATION, AND 3) NO CONCURRENT USE WITH ANOTHER HORMONAL (E.G., PREMPRO) OR NON-HORMONAL (E.G., BRISDELLE) AGENT FOR VMS. RENEWAL: 1) CONTINUED NEED FOR VMS TREATMENT (PERSISTENT HOT FLASHES), 2) REDUCTION IN VMS FREQUENCY OR SEVERITY DUE TO VEOZAH TREATMENT, AND 3) NO NEW SYMPTOMS OF LIVER INJURY AND/OR WORSENING LAB VALUES (E.G., ALT, AST, TOTAL BILIRUBIN). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **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** | |
| **Required Medical Information** | INITIAL: HEART FAILURE (HF): 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS II-IV, AND 2) LEFT VENTRICULAR EJECTION FRACTION OF AT LEAST 40 PERCENT NOT DUE TO AN UNDERLYING CAUSE (E.G., INFILTRATIVE CARDIOMYOPATHY, HYPERTROPHIC CARDIOMYOPATHY, VALVULAR DISEASE, PERICARDIAL DISEASE, HIGH-OUTPUT HEART FAILURE). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: HF: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL:12 MONTHS |
| **Other Criteria** | CHRONIC KIDNEY DISEASE (CKD) ASSOCIATED WITH TYPE 2 DIABETES (T2D): INITIAL: HISTORY OF AND WILL CONTINUE ON, HAS A CONTRAINDICATION, OR INTOLERANCE TO AN ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE-I) OR AN ANGIOTENSIN RECEPTOR BLOCKER (ARB). HF: INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER MINERALOCORTICOID (ALDOSTERONE) RECEPTOR ANTAGONIST. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# FINGOLIMOD

## Products Affected

- *fingolimod*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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: 12 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | PD: INITIAL: ONE OF THE FOLLOWING: 1) UNABLE TO SWALLOW EXTENDED-RELEASE (ER) TABLETS OR ADMINISTER ER CAPSULES VIA A FEEDING TUBE, OR 2) FAILURE TO ADHERE OR TOLERATE VIA A FEEDING TUBE AN ORAL CARBIDOPA/LEVODOPA REGIMEN. RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# FRUQUINTINIB

## Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

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

# FUTIBATINIB

## Products Affected

- LYTGOBI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INTRAHEPATIC CHOLANGIOCARCINOMA (ICCA): COMPLETE A COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: MIGRAINE PREVENTION: 6 MOS. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): 12 MOS. |
| **Other Criteria** | MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY. EPISODIC CLUSTER HEADACHE: RENEWAL: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# 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 |

# GEPIRONE

## Products Affected

- EXXUA ORAL TABLET EXTENDED RELEASE 24 HR
- EXXUA ORAL TABLET, EXT REL 24HR DOSE PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | MAJOR DEPRESSIVE DISORDER: INITIAL: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENTS: TRINTELLIX AND ONE GENERIC ANTIDEPRESSANT. INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER 5-HT1A RECEPTOR AGONIST (E.G., BUSPIRONE). RENEWAL: RESPONSE TO OR REMISSION OF DEPRESSIVE SYMPTOMS WITH THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# 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 ORAL
- OZEMPIC SUBCUTANEOUS
- 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** | |
| **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. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# GUSELKUMAB

**Products Affected**

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

| 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** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | OPIOID TOLERANT: 12 MONTHS. HOSPICE, PALLIATIVE CARE OR END OF LIFE CARE: LIFETIME. |
| **Other Criteria** | 1) OPIOID TOLERANT (I.E. PREVIOUS USE OF 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL PER HOUR, 30 MG ORAL OXYCODONE PER DAY, 8 MG ORAL HYDROMORPHONE PER DAY, 25 MG ORAL OXYMORPHONE PER DAY, 60 MG ORAL HYDROCODONE PER DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID) AND HAS TROUBLE SWALLOWING OPIOID TABLETS, CAPSULES, OR LARGE VOLUMES OF LIQUID, OR 2) ENROLLED IN HOSPICE OR PALLIATIVE CARE OR END OF LIFE CARE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# 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: 1) TYPE III HAE, OR 2) TYPE I OR II HAE CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q. |
| **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. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# IDELALISIB

## 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 |

# IMLUNESTRANT

## Products Affected

- INLURIYO

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

# INSULIN SUPPLIES PAYMENT DETERMINATION

**Products Affected**

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

- CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE
- CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND
- COMFORT EZ 0.3 ML 31G 15/64"
- COMFORT EZ 0.5 ML 31G 15/64"
- COMFORT EZ INS 0.3 ML 30GX1/2"
- COMFORT EZ INS 0.3 ML 30GX5/16"
- COMFORT EZ INS 1 ML 31G 15/64"
- COMFORT EZ INS 1 ML 31GX5/16"
- COMFORT EZ INSULIN SYR 0.3 ML
- COMFORT EZ INSULIN SYR 0.5 ML
- COMFORT EZ PEN NEEDLE 12MM 29G
- COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO
- COMFORT EZ PEN NEEDLES 4MM 33G
- COMFORT EZ PEN NEEDLES 5MM 31G MINI
- COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI
- COMFORT EZ PEN NEEDLES 5MM 33G
- COMFORT EZ PEN NEEDLES 6MM 31G
- COMFORT EZ PEN NEEDLES 6MM 32G
- COMFORT EZ PEN NEEDLES 6MM 33G
- COMFORT EZ PEN NEEDLES 8MM 31G SHORT
- COMFORT EZ PEN NEEDLES 8MM 32G
- COMFORT EZ PEN NEEDLES 8MM 33G
- COMFORT EZ PLS PEN NDL 32G 4MM
- COMFORT EZ PRO PEN NDL 30G 8MM
- COMFORT EZ PRO PEN NDL 31G 4MM
- COMFORT EZ PRO PEN NDL 31G 5MM
- COMFORT EZ SYR 0.3 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 28GX1/2"
- COMFORT EZ SYR 0.5 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 27G 12.7MM
- COMFORT EZ SYR 1 ML 28GX1/2"
- COMFORT EZ SYR 1 ML 29GX1/2"
- COMFORT EZ SYR 1 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 30GX5/16"
- COMFORT POINT PEN NDL 31GX1/3"
- COMFORT POINT PEN NDL 31GX1/6"
- COMFORT TOUCH PEN NDL 31G 4MM
- COMFORT TOUCH PEN NDL 31G 5MM
- COMFORT TOUCH PEN NDL 31G 6MM
- COMFORT TOUCH PEN NDL 31G 8MM
- COMFORT TOUCH PEN NDL 32G 4MM
- COMFORT TOUCH PEN NDL 32G 5MM
- COMFORT TOUCH PEN NDL 32G 6MM
- COMFORT TOUCH PEN NDL 32G 8MM
- COMFORT TOUCH PEN NDL 33G 4MM
- COMFORT TOUCH PEN NDL 33G 6MM
- COMFORT TOUCH PEN NDL 33GX5MM
- CURITY ALCOHOL PREPS 2 PLY,MEDIUM
- CURITY GAUZE PADS
- CURITY GAUZE SPONGES (12 PLY)-200/BAG
- DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII
- DERMACEA GAUZE 2"X2" SPONGE 8 PLY
- DERMACEA NON-WOVEN 2"X2" SPNGE
- DROPLET 0.3 ML 29G 12.7MM(1/2) OUTER
- DROPLET 0.3 ML 30G 12.7MM(1/2) OUTER
- DROPLET 0.5 ML 29GX12.5MM(1/2)
- DROPLET 0.5 ML 30GX12.5MM(1/2)
- DROPLET INS 0.3 ML 29GX12.5MM
- DROPLET INS 0.3 ML 30G 8MM(1/2) OUTER
- DROPLET INS 0.3 ML 30GX12.5MM
- DROPLET INS 0.3 ML 31G 6MM(1/2) OUTER
- DROPLET INS 0.3 ML 31G 8MM(1/2) OUTER
- DROPLET INS 0.5 ML 29G 12.7MM OUTER
- DROPLET INS 0.5 ML 30G 12.7MM OUTER
- DROPLET INS 0.5 ML 30GX6MM(1/2)
- DROPLET INS 0.5 ML 30GX8MM(1/2)
- DROPLET INS 0.5 ML 31GX6MM(1/2)
- DROPLET INS 0.5 ML 31GX8MM(1/2)
- DROPLET INS SYR 0.3 ML 30GX6MM
- DROPLET INS SYR 0.3 ML 30GX8MM
- DROPLET INS SYR 0.3 ML 31GX6MM
- DROPLET INS SYR 0.3 ML 31GX8MM
- DROPLET INS SYR 0.5 ML 30G 8MM OUTER
- DROPLET INS SYR 0.5 ML 31G 6MM

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

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

- INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRING 0.5 ML 27G 1/2" INNER
- INSULIN SYRINGE 0.3 ML
- INSULIN SYRINGE 0.3 ML 31GX1/4
- INSULIN SYRINGE 0.5 ML
- INSULIN SYRINGE 0.5 ML 31GX1/4
- INSULIN SYRINGE 1 ML
- INSULIN SYRINGE 1 ML 27G 1/2" INNER
- INSULIN SYRINGE 1 ML 28GX1/2" (OTC)
- INSULIN SYRINGE 1 ML 30GX1/2" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 31GX1/4"
- INSULIN SYRINGE 1 ML 31GX5/16" SHORT NEEDLE,THIN II (OTC)
- INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE
- INSULIN U-500 SYRINGE-NEEDLE
- INSUPEN PEN NEEDLE 29GX1/2"
- INSUPEN PEN NEEDLE 31G 8MM
- INSUPEN PEN NEEDLE 31GX3/16"
- INSUPEN PEN NEEDLE 32G 4MM
- INSUPEN PEN NEEDLE 32G 6MM (RX)
- IV ANTISEPTIC WIPES
- KENDALL ALCOHOL 70% PREP PAD
- LISCO SPONGES 100/BAG
- 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 5MM
- MINI PEN NEEDLE 32G 8MM
- MINI PEN NEEDLE 33G 5MM
- MINI PEN NEEDLE 33G 6MM
- MINI ULTRA-THIN II PEN NDL 31G STERILE
- MONOJECT 0.5 ML SYRN 28GX1/2"
- MONOJECT 1 ML SYRN 27X1/2"
- MONOJECT 1 ML SYRN 28GX1/2" (OTC)
- MONOJECT INSUL SYR U100 (OTC)
- MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)
- MONOJECT INSUL SYR U100 1 ML
- MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)
- MONOJECT INSULIN SYR 0.3 ML
- MONOJECT INSULIN SYR 0.3 ML (OTC)
- MONOJECT INSULIN SYR 0.5 ML
- MONOJECT INSULIN SYR 0.5 ML (OTC)
- MONOJECT INSULIN SYR 1 ML 3'S (OTC)
- MONOJECT INSULIN SYR U-100
- MONOJECT SYRINGE 0.3 ML
- MONOJECT SYRINGE 0.5 ML
- MONOJECT SYRINGE 1 ML

- NANO 2 GEN PEN NEEDLE 32G 4MM
- NANO PEN NEEDLE 32G 4MM
- NOVOFINE 32G NEEDLES
- NOVOFINE AUTOCOVER 30G NEEDLE
- NOVOFINE PLUS PEN NDL 32GX1/6"
- PEN NEEDLE 30G 5MM OUTER
- PEN NEEDLE 30G 8MM INNER
- PEN NEEDLE 30G X 5/16"
- PEN NEEDLE 31G X 1/4" HRI
- PEN NEEDLE 33G 4MM
- PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLES 12MM 29G 29GX12MM,STRL
- PEN NEEDLES 4MM 32G
- PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC)
- PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC)
- PENTIPS PEN NEEDLE 29G 1/2"
- PENTIPS PEN NEEDLE 31G 1/4"
- PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM
- PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM
- PENTIPS PEN NEEDLE 32G 1/4"
- PENTIPS PEN NEEDLE 32GX5/32"
- PIP PEN NEEDLE 31G X 5MM
- PIP PEN NEEDLE 32G X 4MM
- PREVENT PEN NEEDLE 31GX1/4"
- PREVENT PEN NEEDLE 31GX5/16"
- PRO COMFORT 0.5 ML 30GX1/2"
- PRO COMFORT 0.5 ML 30GX5/16"
- PRO COMFORT 0.5 ML 31GX5/16"
- PRO COMFORT 1 ML 30GX1/2"
- PRO COMFORT 1 ML 30GX5/16"
- PRO COMFORT 1 ML 31GX5/16"
- PRO COMFORT ALCOHOL 70% PADS
- PRO COMFORT PEN NDL 32G 8MM
- PRO COMFORT PEN NDL 32G X 1/4"
- PRO COMFORT PEN NDL 4MM 32G
- PRO COMFORT PEN NDL 5MM 32G
- PRO-COMFORT ALCOHOL 70% PADS
- PRODIGY INS SYR 1 ML 28GX1/2"
- PRODIGY SYRNG 0.5 ML 31GX5/16"
- PRODIGY SYRNGE 0.3 ML 31GX5/16"
- PURE CMFT SFTY PEN NDL 31G 5MM
- PURE CMFT SFTY PEN NDL 31G 6MM
- PURE CMFT SFTY PEN NDL 32G 4MM
- PURE COMFORT ALCOHOL 70% PADS
- PURE COMFORT PEN NDL 32G 4MM
- PURE COMFORT PEN NDL 32G 5MM
- PURE COMFORT PEN NDL 32G 6MM
- PURE COMFORT PEN NDL 32G 8MM
- RA ISOPROPYL ALCOHOL 70% WIPES
- RA STERILE PADS 2"X 2"
- RAYA SURE PEN NEEDLE 29G 12MM
- RAYA SURE PEN NEEDLE 31G 4MM
- RAYA SURE PEN NEEDLE 31G 5MM
- RAYA SURE PEN NEEDLE 31G 6MM
- RELION INS SYR 0.3 ML 31GX6MM
- RELION INS SYR 0.5 ML 31GX6MM
- RELION INS SYR 1 ML 31GX15/64"
- RELION PEN NEEDLE 32GX5/32"
- RELION SYRING 0.3 ML 31GX5/16" INNER
- RELION SYRING 0.5 ML 31GX5/16" INNER (OTC)
- SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10
- SAFETY PEN NEEDLE 31G 4MM
- SAFETY PEN NEEDLE 5MM X 31G
- SAFETY SYRINGE 0.5 ML 30G 1/2"
- SECURESAFE PEN NDL 30GX5/16" OUTER
- SECURESAFE PEN NEEDLE 31G 5MM OUTER
- SECURESAFE SYR 0.5 ML 29G 1/2" OUTER
- SECURESAFE SYRNG 1 ML 29G 1/2" OUTER
- SKY SAFETY PEN NEEDLE 30G 5MM
- SKY SAFETY PEN NEEDLE 30G 8MM
- SURE CMFT SFTY PEN NDL 31G 6MM
- SURE CMFT SFTY PEN NDL 32G 4MM
- SURE COMFORT 0.5 ML SYRINGE

- SURE COMFORT 1 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE
- SURE COMFORT 30G PEN NEEDLE
- SURE COMFORT ALCOHOL PREP PADS
- SURE COMFORT INS 0.3 ML 31GX1/4
- SURE COMFORT INS 0.5 ML 31GX1/4
- SURE COMFORT INS 1 ML 31GX1/4"
- SURE COMFORT PEN NDL 29GX1/2" 12.7MM
- SURE COMFORT PEN NDL 31G 5MM
- SURE COMFORT PEN NDL 31G 8MM
- SURE COMFORT PEN NDL 32G 4MM
- SURE COMFORT PEN NDL 32G 6MM
- SURE-FINE PEN NEEDLES 12.7MM
- SURE-FINE PEN NEEDLES 5MM
- SURE-FINE PEN NEEDLES 8MM
- SURE-JECT INSU SYR U100 0.3 ML
- SURE-JECT INSU SYR U100 0.5 ML
- SURE-JECT INSU SYR U100 1 ML
- SURE-JECT INSUL SYR U100 1 ML
- SURE-JECT INSULIN SYRINGE 1 ML
- SURE-PREP ALCOHOL PREP PADS
- TECHLITE 0.3 ML 29GX12MM (1/2)
- TECHLITE 0.3 ML 30GX8MM (1/2)
- TECHLITE 0.3 ML 31GX6MM (1/2)
- TECHLITE 0.3 ML 31GX8MM (1/2)
- TECHLITE 0.5 ML 30GX12MM (1/2)
- TECHLITE 0.5 ML 30GX8MM (1/2)
- TECHLITE 0.5 ML 31GX6MM (1/2)
- TECHLITE 0.5 ML 31GX8MM (1/2)
- TECHLITE INS SYR 1 ML 29GX12MM
- TECHLITE INS SYR 1 ML 30GX12MM
- TECHLITE INS SYR 1 ML 31GX6MM
- TECHLITE INS SYR 1 ML 31GX8MM
- TECHLITE PEN NEEDLE 29GX1/2"
- TECHLITE PEN NEEDLE 29GX3/8"
- TECHLITE PEN NEEDLE 31GX1/4"
- TECHLITE PEN NEEDLE 31GX3/16"
- TECHLITE PEN NEEDLE 31GX5/16"
- TECHLITE PEN NEEDLE 32GX1/4"
- TECHLITE PEN NEEDLE 32GX5/16"
- TECHLITE PEN NEEDLE 32GX5/32"
- TECHLITE PLUS PEN NDL 32G 4MM
- TERUMO INS SYRINGE U100-1 ML
- TERUMO INS SYRINGE U100-1/2 ML
- TERUMO INS SYRINGE U100-1/3 ML
- TERUMO INS SYRNG U100-1/2 ML
- THINPRO INS SYRIN U100-0.3 ML
- THINPRO INS SYRIN U100-0.5 ML
- THINPRO INS SYRIN U100-1 ML
- TOPFINE INSULN PEN NDL 32G 4MM
- TRUE CMFRT PRO 0.5 ML 30G 5/16"
- TRUE CMFRT PRO 0.5 ML 31G 5/16"
- TRUE CMFRT PRO 0.5 ML 32G 5/16"
- TRUE CMFT SFTY PEN NDL 31G 5MM
- TRUE CMFT SFTY PEN NDL 31G 6MM
- TRUE CMFT SFTY PEN NDL 32G 4MM
- TRUE COMFORT 0.5 ML 30G 1/2"
- TRUE COMFORT 0.5 ML 30G 5/16"
- TRUE COMFORT 0.5 ML 31G 5/16"
- TRUE COMFORT 0.5 ML 31GX5/16"
- TRUE COMFORT 1 ML 31GX5/16"
- TRUE COMFORT ALCOHOL 70% PADS
- TRUE COMFORT PEN NDL 31G 8MM
- TRUE COMFORT PEN NDL 31GX5MM
- TRUE COMFORT PEN NDL 31GX6MM
- TRUE COMFORT PEN NDL 32G 5MM
- TRUE COMFORT PEN NDL 32G 6MM
- TRUE COMFORT PEN NDL 32GX4MM
- TRUE COMFORT PEN NDL 33G 4MM
- TRUE COMFORT PEN NDL 33G 5MM
- TRUE COMFORT PEN NDL 33G 6MM
- TRUE COMFORT PRO 1 ML 30G 1/2"
- TRUE COMFORT PRO 1 ML 30G 5/16"
- TRUE COMFORT PRO 1 ML 31G 5/16"
- TRUE COMFORT PRO 1 ML 32G 5/16"
- TRUE COMFORT PRO ALCOHOL PADS
- TRUE COMFORT SFTY 1 ML 30G 1/2"
- TRUE COMFRT PRO 0.5 ML 30G 1/2"
- TRUE COMFRT SFTY 1 ML 30G 5/16"
- TRUE COMFRT SFTY 1 ML 31G 5/16"
- TRUE COMFRT SFTY 1 ML 32G 5/16"
- TRUE-CMFRT PRO PEN NDL 31G 5MM
- TRUE-CMFRT PRO PEN NDL 31G 6MM
- TRUE-CMFRT PRO PEN NDL 31G 8MM
- TRUE-CMFRT PRO PEN NDL 32G 4MM
- TRUEPLUS PEN NEEDLE 29GX1/2"
- TRUEPLUS PEN NEEDLE 31G X 1/4"
- TRUEPLUS PEN NEEDLE 31GX3/16"
- TRUEPLUS PEN NEEDLE 31GX5/16"
- TRUEPLUS PEN NEEDLE 32GX5/32"
- TRUEPLUS SYR 0.3 ML 29GX1/2"

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN. |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | LIFETIME |
| **Other Criteria** | |
| **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 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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). |
| **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 |

# LAMOTRIGINE

## Products Affected

- SUBVENITE ORAL SUSPENSION

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | ALL INDICATIONS: CONTRAINDICATION TO OR UNABLE TO SWALLOW LAMOTRIGINE TABLETS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# LANREOTIDE

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | ACROMEGALY: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST. |
| **Coverage Duration** | ACROMEGALY: INITIAL/RENEWAL: 12 MOS. GEP-NETS, CARCINOID SYNDROME: 12 MOS. |
| **Other Criteria** | ACROMEGALY: 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. |
| **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** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# LEUPROLIDE MESYLATE

## Products Affected

- CAMCEVI (6 MONTH)

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

# LEUPROLIDE-ELIGARD

## Products Affected

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

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

| PA Criteria | Criteria Details |
| --- | --- |
| **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 LEVEL OF LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVEL OF LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CPP: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 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. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | No |

# L-GLUTAMINE

## Products Affected

- *glutamine (sickle cell)*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **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*
- *tridacaine 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

- LYNOZYFIC 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

- XDEMVY

| 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 |

# LUMACAFTOR-IVACAFTOR

**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

- *macitentan*

| 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** | |
| **Required Medical Information** | OBSTRUCTIVE HYPERTROPHIC CARDIOMYOPATHY(HCM): INITIAL: LEFT VENTRICULAR OUTFLOW TRACK (LVOT) GRADIENT OF 50 MMHG OR HIGHER |
| **Age Restrictions** | |
| **Prescriber Restrictions** | OBSTRUCTIVE HCM: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | OBSTRUCTIVE HCM: INITIAL: TRIAL OF, CONTRAINDICATION, OR INTOLERANCE TO A BETA-BLOCKER OR A NON-DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKER. RENEWAL: CONTINUED CLINICAL BENEFIT (E.G., REDUCTION OF SYMPTOMS, NYHA CLASSIFICATION IMPROVEMENT). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **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. EOSINOPHILIC COPD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. |
| **Coverage Duration** | INITIAL: CRSWNP: 6 MO. OTHERS: 12 MO. RENEWAL: CRSWNP, ASTHMA, COPD, EGPA, HES: 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 THE 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. EOSINOPHILIC COPD: USED IN COMBINATION WITH A LAMA/LABA/ICS. 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 THE SAME INDICATION. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER |

| PA Criteria | Criteria Details |
|---|---|
| | SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE 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 THE SAME INDICATION. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, OR (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# METYROSINE

## Products Affected

- *metyrosine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PHEOCHROMOCYTOMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, ENDOCRINE SURGEON, OR HEMATOLOGIST-ONCOLOGIST. |
| **Coverage Duration** | 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
- LUNSUMIO VELO

| 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. |
| **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 |

# NERANDOMILAST

## Products Affected

- JASCAYD

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): 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. PROGRESSIVE PULMONARY FIBROSIS (PPF): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. PPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |

| 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, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, CANCER), AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: OFEV, PIRFENIDONE. PPF: 1) LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENED/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: OFEV (NINTEDANIB). RENEWAL: IPF, PPF: 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 |

# NERATINIB

## Products Affected

- NERLYNX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | EARLY-STAGE (STAGE I-III) BREAST CANCER: MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# NILOTINIB - TASIGNA

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND MEDICATION IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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

- *nintedanib*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): 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. 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): AT LEAST 10% FIBROSIS ON A CHEST HRCT. |
| **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 WORSENED/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

| 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: 1) ZEJULA WILL BE USED AS MONOTHERAPY, AND 2) ZEJULA IS STARTED NO LATER THAN 8 WEEKS AFTER THE MOST RECENT PLATINUM-CONTAINING REGIMEN. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# NIRAPARIB-ABIRATERONE

## Products Affected

- AKEEGA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC), METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | 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** | |
| **Required Medical Information** | INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL OF AT LEAST 30 IU/ML. FOOD ALLERGY: 1) IGE SERUM LEVEL OF AT LEAST 30 IU/ML, AND 2) POSITIVE SKIN PRICK TEST TO AT LEAST ONE FOOD, OR POSITIVE MEDICALLY MONITORED FOOD CHALLENGE TO AT LEAST ONE FOOD. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL/RENEWAL: CHRONIC SPONTANEOUS URTICARIA (CSU): PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST. INITIAL: CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. FOOD ALLERGY: PRESCRIBED BY OR IN CONSULTATION WITH ALLERGIST OR IMMUNOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: ASTHMA 12 MO/12 MO, CSU 6 MO/12 MO, CRSWNP 6 MO/12 MO, FOOD ALLERGY 12 MO/24 MO |

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

| PA Criteria | Criteria Details |
|---|---|
| | ONE OTHER MAINTENANCE MEDICATION, AND 2) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. FOOD ALLERGY: 1) PERSISTENT IGE-MEDIATED FOOD ALLERGY, AND 2) CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# OMALIZUMAB-IGEC

## Products Affected

- OMLYCLO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL OF AT LEAST 30 IU/ML. FOOD ALLERGY: 1) IGE SERUM LEVEL OF AT LEAST 30 IU/ML, AND 2) POSITIVE SKIN PRICK TEST TO AT LEAST ONE FOOD, OR POSITIVE MEDICALLY MONITORED FOOD CHALLENGE TO AT LEAST ONE FOOD. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL/RENEWAL: CHRONIC SPONTANEOUS URTICARIA (CSU): PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST. INITIAL: CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. FOOD ALLERGY: PRESCRIBED BY OR IN CONSULTATION WITH ALLERGIST OR IMMUNOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: ASTHMA 12 MO/12 MO, CSU 6 MO/12 MO, CRSWNP 6 MO/12 MO, FOOD ALLERGY 12 MO/24 MO |

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

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

# 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 |

# 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** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# PASIREOTIDE DIASPARTATE

## Products Affected

- SIGNIFOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CUSHINGS DISEASE (CD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | CD: RENEWAL: 1) CONTINUED IMPROVEMENT OF CUSHINGS DISEASE, AND 2) MAINTAINED TOLERABILITY TO SIGNIFOR. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# PAZOPANIB

## Products Affected

- *pazopanib oral tablet 200 mg, 400 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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 |

# PEMBROLIZUMAB-BERAHYALURONIDASE ALFA-PMPH

**Products Affected**

- KEYTRUDA QLEX

| 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 |

# 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: 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. |
| **Age Restrictions** | |
| **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

- *pomalidomide*
- 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 |

# RELACORILANT

## Products Affected

- LIFYORLI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | RENEWAL: 1) CLINICAL BENEFIT WHILE ON THERAPY, AND 2) CONTINUATION OF NAB-PACLITAXEL THERAPY. |
| **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** | |
| **Required Medical Information** | NONALCOHOLIC STEATOHEPATITIS (NASH): INITIAL: DIAGNOSIS CONFIRMED BY BIOPSY OR NONINVASIVE TESTING, OBTAINED IN THE PAST 12 MONTHS, DEMONSTRATING: 1) LIVER FIBROSIS STAGE 2 OR 3, OR 2) NONALCOHOLIC FATTY LIVER DISEASE (NAFLD) ACTIVITY SCORE OF 4 OR MORE. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | NASH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST, GASTROENTEROLOGIST, OR ENDOCRINOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS |
| **Other Criteria** | NASH: RENEWAL: CONTINUES TO HAVE NONCIRRHOTIC NASH WITH MODERATE TO ADVANCED LIVER FIBROSIS (CONSISTENT WITH STAGES F2 TO F3 FIBROSIS). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **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 200 MG DAILY DOSE
- 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** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | ACUTE MIGRAINE TREATMENT: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN). INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. RENEWAL: 1) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR 2) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS. EPISODIC MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **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/HADLIMA, 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
- BESREMI 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 |

# 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
- JAKAFI XR

| 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, 100 MCG, 150 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: AGES 18 YEARS OR OLDER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING AGENTS: 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), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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
- KOSELUGO ORAL CAPSULE, SPRINKLE 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 |

# SEVABERTINIB

## Products Affected

- HYRNUO

| 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** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: CATAPLEXY IN NARCOLEPSY, EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS |
| **Other Criteria** | INITIAL: EDS IN NARCOLEPSY: 1) NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT, AND 2) AGES 18 YEARS OR OLDER: TRIAL, FAILURE OF, OR CONTRAINDICATION TO A FORMULARY VERSION OF MODAFINIL, ARMODAFINIL, OR SUNOSI AND ONE GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY. CATAPLEXY IN NARCOLEPSY: NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT. RENEWAL: CATAPLEXY IN NARCOLEPSY, EDS IN NARCOLEPSY: 1) SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **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 |

| PA Criteria | Criteria Details |
| --- | --- |
| **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** | INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES |
| **Required Medical Information** | INITIAL: HIV/WASTING: ONE OF THE FOLLOWING FOR WEIGHT LOSS: 1) 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS OR 5% WEIGHT LOSS OVER 6 MONTHS, 2) 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, 3) BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, 4) BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND BMI LESS THAN 27 KG PER METER SQUARED, OR 5) BMI LESS THAN 20 KG PER METER SQUARED. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | HIV/WASTING: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 9 MONTHS. |
| **Other Criteria** | HIV/WASTING: RENEWAL: 1) CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# 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** | |
| **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) ON BACKGROUND PAH THERAPY (FOR AT LEAST 3 MONTHS) WITH AT LEAST TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: A) ORAL ENDOTHELIN RECEPTOR ANTAGONIST, B) ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, C) ORAL CGMP STIMULATOR, D) IV/SQ PROSTACYCLIN, OR 2) ON ONE AGENT FROM ONE OF THE ABOVE DRUG CLASSES, AND HAS A CONTRAINDICATION OR INTOLERANCE TO ALL OF THE OTHER DRUG CLASSES. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# 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 |

# TAFAMIDIS

## Products Affected

- VYNDAMAX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | CARDIOMYOPATHY ASSOCIATED WITH WILD TYPE OR HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (ATTR-CM): INITIAL: 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE, AND 2) DIAGNOSIS CONFIRMED BY (A) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF TC-99M-PYP, OR (B) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | ATTR-CM: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS |
| **Other Criteria** | ATTR-CM: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER ATTR-CM TTR STABILIZERS (E.G., ACORAMIDIS) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# TALAZOPARIB

## Products Affected

- TALZENNA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **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 |

| PA Criteria | Criteria Details |
| --- | --- |
| **Prerequisite Therapy Required** | Yes |

# TALETRECTINIB

## Products Affected

- IBTROZI

| 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 |

# 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 |

# 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 %)*
- *testosterone transdermal gel in packet 1 %*
- *(25 mg/2.5gram), 1 % (50 mg/5 gram)*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL/RENEWAL: 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 PATIENTS |
| **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/HADLIMA, XELJANZ, RINVOQ, ORENCIA. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOIDS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, 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/HADLIMA, XELJANZ, RINVOQ, ORENCIA. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOIDS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, 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

- *tofacitinib*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. |
| **Coverage Duration** | INITIAL: 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** | |
| **Required Medical Information** | AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD): INITIAL: CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI, OR ULTRASOUND. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | ADPKD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | ADPKD: INITIAL: DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS). RENEWAL: HAS NOT PROGRESSED TO ESRD/DIALYSIS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# TOPICAL TRETINOIN

## Products Affected

- ALTRENO
- *tretinoin topical cream*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | 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** | |
| **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** | |
| **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 |

# TREPROSTINIL-YUTREPIA

## Products Affected

- YUTREPIA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH), PULMONARY HYPERTENSION-INTERSTITIAL LUNG DISEASE (PH-ILD): 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** | INITIAL: PAH, PH-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: PAH: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) ORAL ENDOTHELIN RECEPTOR ANTAGONIST, 2) ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, 3) ORAL CGMP STIMULATOR, 4) IV/SQ PROSTACYCLIN. |
| **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** | |
| **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). |
| **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 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. AD: TRIAL OF OR CONTRAINDICATION TO A TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, TOPICAL AHR AGONIST OR TOPICAL JAK INHIBITOR. AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). GIANT CELL ARTERITIS (GCA): HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOIDS. 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, NR-AXSPA, PJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. AD: IMPROVEMENT WHILE ON THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# USTEKINUMAB-AAUZ SQ

## Products Affected

- *ustekinumab-aauz*

| 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 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 |

# VEPDEGESTRANT

## Products Affected

- VEPPANU

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | ADVANCED OR METASTATIC BREAST CANCER: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGY SPECIALIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | ADVANCED OR METASTATIC BREAST CANCER: INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER SELECTIVE ESTROGEN RECEPTOR DEGRADER (SERD). RENEWAL: DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS SHOWN BY A PARTIAL OR COMPLETE RESPONSE OR STABLE DISEASE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | No |

# VERICIGUAT

## Products Affected

- VERQUVO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL/RENEWAL:12 MONTHS. |
| **Other Criteria** | HEART FAILURE (HF): INITIAL: 1) TRIAL OF, CONTRAINDICATION, OR INTOLERANCE TO ONE PREFERRED SGLT-2 INHIBITOR, AND 2) TRIAL OF, CONTRAINDICATION, OR INTOLERANCE TO ONE AGENT FROM ANY OF THE FOLLOWING STANDARD OF CARE CLASSES: (A) ACE INHIBITOR, ARB, OR ARNI, (B) BETA BLOCKER (BISOPROLOL, CARVEDILOL, METOPROLOL SUCCINATE), OR (C) ALDOSTERONE ANTAGONIST (SPIRONOLACTONE, EPLERENONE). INITIAL/RENEWAL: NO CONCURRENT USE WITH RIOCIGUAT OR PDE-5 INHIBITORS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# VIGABATRIN

## Products Affected

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

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

# VIMSELTINIB

## Products Affected

- ROMVIMZA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: H PYLORI: 30 DAYS. EE: 8 WEEKS. NERD: 4 WEEKS. RENEWAL: EE: 24 WEEKS. |
| **Other Criteria** | INITIAL: EROSIVE ESOPHAGITIS (EE): TRIAL OF OR CONTRAINDICATION TO TWO PROTON PUMP INHIBITORS AT MAXIMUM DOSE FOR 8 WEEKS EACH. NON-EROSIVE GASTROESOPHAGEAL REFLUX DISEASE (NERD): 1) NO PREVIOUS TREATMENT FAILURE WITH VOQUEZNA IN THE LAST 12 MONTHS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE PROTON PUMP INHIBITOR AT MAXIMUM DOSE FOR 8 WEEKS. 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-HRII

## 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** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | MANTLE CELL LYMPHOMA: INTOLERANCE TO CALQUENCE. CHRONIC LYMPHOCYTIC LEUKEMIA, SMALL LYMPHOCYTIC LYMPHOMA: INTOLERANCE TO CALQUENCE OR IMBRUVICA. WALDENSTROMS MACROGLOBULINEMIA: NO STEP REQUIRED. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |
| **Prerequisite Therapy Required** | Yes |

# 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 |

# ZIFTOMENIB

## Products Affected

- KOMZIFTI

| 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** | |
| **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 |

# 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... 166
1ST TIER UNIFINE PNTIP 4MM 32G.....166
1ST TIER UNIFINE PNTIP 6MM 31G.....166
1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT..... 166
1ST TIER UNIFINE PNTP 29GX1/2"..... 166
1ST TIER UNIFINE PNTP 31GX3/16..... 166
1ST TIER UNIFINE PNTP 32GX5/32..... 166
*abiraterone*..... 7
*abiraterone, submicronized*..... 8
*abirtega*.....7
ACTIMMUNE.....179
*adalimumab-aaty*..... 15
*adalimumab-aaty(cf) ai crohns*..... 15
ADEMPAS..... 295
ADVOCATE INS 0.3 ML 30GX5/16"..... 166
ADVOCATE INS 0.3 ML 31GX5/16"..... 166
ADVOCATE INS 0.5 ML 30GX5/16"..... 166
ADVOCATE INS 0.5 ML 31GX5/16"..... 166
ADVOCATE INS 1 ML 31GX5/16"..... 166
ADVOCATE INS SYR 1 ML 30GX5/16.. 166
ADVOCATE PEN NEEDLE 32G 4MM... 166
ADVOCATE PEN NEEDLE 4MM 33G... 166
ADVOCATE PEN NEEDLES 5MM 31G. 166
ADVOCATE PEN NEEDLES 8MM 31G. 166
AIMOVIG AUTOINJECTOR..... 122
AKEEGA.....238
ALCOHOL PADS..... 166
ALECENSA..... 22
ALTRENO.....363
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG..... 60
ALUNBRIG ORAL TABLETS,DOSE PACK..... 60
ALVAIZ..... 109
ALYFTREK ORAL TABLET 10-50-125 MG, 4-20-50 MG.....392
*alyq*..... 334
ANKTIVA..... 244
AQINJECT PEN NEEDLE 31G 5MM..... 166
AQINJECT PEN NEEDLE 32G 4MM..... 166
ARCALYST..... 291
ARIKAYCE.....24
*armodafinil*..... 228
ASSURE ID DUO PRO NDL 31G 5MM.. 166
ASSURE ID DUO-SHIELD 30GX3/16"... 166
ASSURE ID DUO-SHIELD 30GX5/16"... 166
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"..... 166
ASSURE ID PEN NEEDLE 30GX5/16"... 166
ASSURE ID PRO PEN NDL 30G 5MM... 166
ASSURE ID SYR 0.5 ML 31GX15/64".... 166
ASSURE ID SYR 1 ML 31GX15/64"..... 166
ATTRUBY..... 10
AUGTYRO ORAL CAPSULE 160 MG, 40 MG.....284
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG..... 90
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG..... 90
AUSTEDO XR TITRATION KT(WK1-4)..90
AUTOKEEPER SAF PEN NDL 30G 8MM..... 166
AVMAPKI.....41
AVMAPKI-FAKZYNJA.....41
AVONEX INTRAMUSCULAR PEN INJECTOR KIT.....176
AVONEX INTRAMUSCULAR SYRINGE KIT..... 176
AYVAKIT.....40
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG..... 121
BD AUTOSHIELD DUO NDL 5MMX30G..... 166
BD ECLIPSE 30GX1/2" SYRINGE..... 166
BD INS SYR 0.3 ML 8MMX31G(1/2)..... 166
BD INS SYR UF 0.3 ML 12.7MMX30G.. 166
BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE..... 166
BD INSULIN SYR 1 ML 27GX12.7MM.. 166
BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE..... 166
BD SAFETGLD INS 0.3 ML 29G 13MM. 166
BD SAFETYGLD INS 0.3 ML 31G 8MM 166
BD SAFETYGLD INS 0.5 ML 30G 8MM 166
BD SAFETYGLD INS 1 ML 29G 13MM. 166
BD SAFETYGLID INS 1 ML 6MMX31G 166
BD SAFETYGLIDE SYRINGE 27GX5/8 166

BD SAFTYGLD INS 0.3 ML 6MMX31G 166
BD SAFTYGLD INS 0.5 ML 29G 13MM 166
BD SAFTYGLD INS 0.5 ML 6MMX31G 166
BD SINGLE USE SWAB ..... 166
BD UF MICRO PEN NEEDLE 6MMX32G ..... 166
BD UF MINI PEN NEEDLE 5MMX31G. 166
BD UF NANO PEN NEEDLE 4MMX32G ..... 166
BD UF ORIG PEN NDL 12.7MMX29G... 166
BD UF SHORT PEN NEEDLE 8MMX31G ..... 166
BD VEO INS 0.3 ML 6MMX31G (1/2).... 166
BD VEO INS SYRING 1 ML 6MMX31G 166
BD VEO INS SYRN 0.3 ML 6MMX31G. 166
BD VEO INS SYRN 0.5 ML 6MMX31G. 166
*bendamustine intravenous recon soln* ..... 50
BENDAMUSTINE INTRAVENOUS SOLUTION ..... 50
BENDEKA ..... 50
BENLYSTA SUBCUTANEOUS ..... 47
BESREMI ..... 303
BESREMI PEN ..... 303
*betaine* ..... 53
BETASERON SUBCUTANEOUS KIT .... 177
*bexarotene* ..... 55
BIZENGRI ..... 405
BORDERED GAUZE 2"X2" ..... 166
*bortezomib injection* ..... 57
BORUZU ..... 57
*bosentan oral tablet* ..... 58
BOSULIF ORAL CAPSULE 100 MG, 50 MG ..... 59
BOSULIF ORAL TABLET 100 MG, 500 MG ..... 59
*bosutinib oral tablet 100 mg, 400 mg, 500 mg* ..... 59
BRAFTOVI ..... 113
BRUKINSA ORAL CAPSULE ..... 404
BRUKINSA ORAL TABLET ..... 404
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG ..... 63
CALQUENCE (ACALABRUTINIB MAL) ..... 9
CAMCEVI (6 MONTH) ..... 196
CAMZYOS ..... 214
CAPRELSA ORAL TABLET 100 MG, 300 MG ..... 391
CAREFINE PEN NEEDLE 12.7MM 29G HRI ..... 166
CAREFINE PEN NEEDLE 4MM 32G ..... 166
CAREFINE PEN NEEDLE 5MM 32G ..... 166
CAREFINE PEN NEEDLE 6MM 31G HRI ..... 166
CAREFINE PEN NEEDLE 8MM 30G HRI ..... 166
CAREFINE PEN NEEDLES 6MM 32G... 166
CAREFINE PEN NEEDLES 8MM 31G... 166
CARETOUCH ALCOHOL 70% PREP PAD ..... 166
CARETOUCH PEN NEEDLE 29G 12MM ..... 166
CARETOUCH PEN NEEDLE 31GX1/4". 166
CARETOUCH PEN NEEDLE 31GX3/16" ..... 166
CARETOUCH PEN NEEDLE 31GX5/16" ..... 166
CARETOUCH PEN NEEDLE 32GX3/16" ..... 166
CARETOUCH PEN NEEDLE 32GX5/32" ..... 166
CARETOUCH SYR 0.3 ML 31GX5/16".. 166
CARETOUCH SYR 0.5 ML 30GX5/16".. 166
CARETOUCH SYR 0.5 ML 31GX5/16".. 166
CARETOUCH SYR 1 ML 28GX5/16"..... 166
CARETOUCH SYR 1 ML 29GX5/16"..... 166
CARETOUCH SYR 1 ML 30GX5/16"..... 166
CARETOUCH SYR 1 ML 31GX5/16"..... 166
*carglumic acid* ..... 67
CAYSTON ..... 45
CIMZIA ..... 69
CIMZIA POWDER FOR RECONST ..... 69
CIMZIA STARTER KIT ..... 69
*cladribine 10 mg x 10 tab pk outer* ..... 72
*cladribine(multiple sclerosis) oral tablet 10 mg (10 pack), 10 mg (4 pack), 10 mg (5 pack), 10 mg (6 pack), 10 mg (7 pack), 10 mg (8 pack), 10 mg (9 pack)* ..... 72
CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE ..... 166
CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND ..... 166

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) ..... 62
COMFORT EZ 0.3 ML 31G 15/64" ..... 166
COMFORT EZ 0.5 ML 31G 15/64" ..... 166
COMFORT EZ INS 0.3 ML 30GX1/2" ..... 166
COMFORT EZ INS 0.3 ML 30GX5/16" ... 166
COMFORT EZ INS 1 ML 31G 15/64" ..... 166
COMFORT EZ INS 1 ML 31GX5/16" ..... 166
COMFORT EZ INSULIN SYR 0.3 ML .... 166
COMFORT EZ INSULIN SYR 0.5 ML .... 166
COMFORT EZ PEN NEEDLE 12MM 29G ..... 166
COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO ..... 166
COMFORT EZ PEN NEEDLES 4MM 33G ..... 166
COMFORT EZ PEN NEEDLES 5MM 31G MINI ..... 166
COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI .....166
COMFORT EZ PEN NEEDLES 5MM 33G ..... 166
COMFORT EZ PEN NEEDLES 6MM 31G ..... 166
COMFORT EZ PEN NEEDLES 6MM 32G ..... 166
COMFORT EZ PEN NEEDLES 6MM 33G ..... 166
COMFORT EZ PEN NEEDLES 8MM 31G SHORT ..... 166
COMFORT EZ PEN NEEDLES 8MM 32G ..... 166
COMFORT EZ PEN NEEDLES 8MM 33G ..... 166
COMFORT EZ PLS PEN NDL 32G 4MM166
COMFORT EZ PRO PEN NDL 30G 8MM ..... 166
COMFORT EZ PRO PEN NDL 31G 4MM ..... 166
COMFORT EZ PRO PEN NDL 31G 5MM ..... 166
COMFORT EZ SYR 0.3 ML 29GX1/2" ....166
COMFORT EZ SYR 0.5 ML 28GX1/2" ....166
COMFORT EZ SYR 0.5 ML 29GX1/2" ....166
COMFORT EZ SYR 0.5 ML 30GX1/2" ....166
COMFORT EZ SYR 1 ML 27G 12.7MM . 166
COMFORT EZ SYR 1 ML 28GX1/2" .....166
COMFORT EZ SYR 1 ML 29GX1/2" .....166
COMFORT EZ SYR 1 ML 30GX1/2" .....166
COMFORT EZ SYR 1 ML 30GX5/16" .....166
COMFORT POINT PEN NDL 31GX1/3" . 166
COMFORT POINT PEN NDL 31GX1/6" . 166
COMFORT TOUCH PEN NDL 31G 4MM ..... 166
COMFORT TOUCH PEN NDL 31G 5MM ..... 166
COMFORT TOUCH PEN NDL 31G 6MM ..... 166
COMFORT TOUCH PEN NDL 31G 8MM ..... 166
COMFORT TOUCH PEN NDL 32G 4MM ..... 166
COMFORT TOUCH PEN NDL 32G 5MM ..... 166
COMFORT TOUCH PEN NDL 32G 6MM ..... 166
COMFORT TOUCH PEN NDL 32G 8MM ..... 166
COMFORT TOUCH PEN NDL 33G 4MM ..... 166
COMFORT TOUCH PEN NDL 33G 6MM ..... 166
COMFORT TOUCH PEN NDL 33GX5MM ..... 166
COPIKTRA ..... 102
CORTROPHIN GEL INJECTION ..... 75
COSENTYX (2 SYRINGES) .....307
COSENTYX PEN (2 PENS) .....307
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML ..... 307
COSENTYX UNOREADY PEN .....307
COTELLIC .....74
CRESEMBA ORAL .....181
CURITY ALCOHOL PREPS 2 PLY,MEDIUM .....166
CURITY GAUZE PADS .....166
CURITY GAUZE SPONGES (12 PLY)-200/BAG .....166
CYLTEZO(CF) ..... 17
CYLTEZO(CF) PEN .....17
CYLTEZO(CF) PEN CROHN'S-UC-HS .....17
CYLTEZO(CF) PEN PSORIASIS-UV .....17

*dalfampridine* ..... 82
DANYELZA ..... 229
DANZITEN ..... 234
*dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg* ..... 84
DATROWAY ..... 85
DAURISMO ORAL TABLET 100 MG, 25 MG ..... 147
*deferasirox oral granules in packet* ..... 87
*deferasirox oral tablet* ..... 87
DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII ..... 166
DERMACEA GAUZE 2"X2" SPONGE 8 PLY ..... 166
DERMACEA NON-WOVEN 2"X2" SPNGE ..... 166
*dermacinrx lidocan 5% patch outer* ..... 204
DIACOMIT ORAL CAPSULE 250 MG, 500 MG ..... 332
DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG ..... 332
*diclofenac epolamine* ..... 92
*diclofenac sodium topical solution in metered-dose pump* ..... 91
*dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg* ..... 93
*dronabinol oral capsule* ..... 97
DROPLET 0.3 ML 29G 12.7MM(1/2) OUTER ..... 166
DROPLET 0.3 ML 30G 12.7MM(1/2) OUTER ..... 166
DROPLET 0.5 ML 29GX12.5MM(1/2) ..... 166
DROPLET 0.5 ML 30GX12.5MM(1/2) ..... 166
DROPLET INS 0.3 ML 29GX12.5MM ..... 166
DROPLET INS 0.3 ML 30G 8MM(1/2) OUTER ..... 166
DROPLET INS 0.3 ML 30GX12.5MM ..... 166
DROPLET INS 0.3 ML 31G 6MM(1/2) OUTER ..... 166
DROPLET INS 0.3 ML 31G 8MM(1/2) OUTER ..... 166
DROPLET INS 0.5 ML 29G 12.7MM OUTER ..... 166
DROPLET INS 0.5 ML 30G 12.7MM OUTER ..... 166
DROPLET INS 0.5 ML 30GX6MM(1/2) .. 166
DROPLET INS 0.5 ML 30GX8MM(1/2) .. 166
DROPLET INS 0.5 ML 31GX6MM(1/2) .. 166
DROPLET INS 0.5 ML 31GX8MM(1/2) .. 166
DROPLET INS SYR 0.3 ML 30GX6MM . 166
DROPLET INS SYR 0.3 ML 30GX8MM . 166
DROPLET INS SYR 0.3 ML 31GX6MM . 166
DROPLET INS SYR 0.3 ML 31GX8MM . 166
DROPLET INS SYR 0.5 ML 30G 8MM OUTER ..... 166
DROPLET INS SYR 0.5 ML 31G 6MM OUTER ..... 166
DROPLET INS SYR 0.5 ML 31G 8MM OUTER ..... 166
DROPLET INS SYR 1 ML 29G 12.7MM OUTER ..... 166
DROPLET INS SYR 1 ML 30G 12.5MM . 166
DROPLET INS SYR 1 ML 30G 6MM ..... 166
DROPLET INS SYR 1 ML 30G 8MM OUTER ..... 166
DROPLET INS SYR 1 ML 31G 6MM OUTER ..... 166
DROPLET INS SYR 1 ML 31G 8MM ..... 166
DROPLET MICRON 34G X 9/64" ..... 166
DROPLET PEN NEEDLE 29G 10MM ..... 166
DROPLET PEN NEEDLE 29G 12MM ..... 166
DROPLET PEN NEEDLE 30G 8MM ..... 166
DROPLET PEN NEEDLE 31G 5MM ..... 166
DROPLET PEN NEEDLE 31G 6MM ..... 166
DROPLET PEN NEEDLE 31G 8MM ..... 166
DROPLET PEN NEEDLE 32G 4MM ..... 166
DROPLET PEN NEEDLE 32G 5MM ..... 166
DROPLET PEN NEEDLE 32G 6MM ..... 166
DROPLET PEN NEEDLE 32G 8MM ..... 166
DROPSAFE ALCOHOL 70% PREP PADS ..... 166
DROPSAFE INS SYR 0.3 ML 31G 6MM 166
DROPSAFE INS SYR 0.3 ML 31G 8MM 166
DROPSAFE INS SYR 0.5 ML 31G 6MM 166
DROPSAFE INS SYR 0.5 ML 31G 8MM 166
DROPSAFE INSUL SYR 1 ML 31G 6MM ..... 166
DROPSAFE INSUL SYR 1 ML 31G 8MM ..... 166
DROPSAFE INSULN 1 ML 29G 12.5MM ..... 166
DROPSAFE PEN NEEDLE 31G 4MM ..... 166
DROPSAFE PEN NEEDLE 31G 5MM ..... 166

DROPSAFE PEN NEEDLE 31G 8MM.....166
DROPSAFE PEN NEEDLE 31GX1/4"..... 166
*droxidopa*.....98
DUPIXENT PEN.....99
DUPIXENT SYRINGE.....99
EASY CMFT SFTY PEN NDL 31G 5MM166
EASY CMFT SFTY PEN NDL 31G 6MM166
EASY CMFT SFTY PEN NDL 32G 4MM166
EASY COMFORT 0.3 ML 31G 1/2".....166
EASY COMFORT 0.3 ML 31G 5/16".....166
EASY COMFORT 0.5 ML 30GX1/2".....166
EASY COMFORT 0.5 ML 31GX5/16".....166
EASY COMFORT 0.5 ML 32GX5/16".....166
EASY COMFORT 0.5 ML SYRINGE..... 166
EASY COMFORT 1 ML 31GX5/16".....166
EASY COMFORT 1 ML 32GX5/16".....166
EASY COMFORT ALCOHOL 70% PAD 166
EASY COMFORT INSULIN 1 ML SYR..166
EASY COMFORT PEN NDL 29G 4MM..166
EASY COMFORT PEN NDL 29G 5MM..166
EASY COMFORT PEN NDL 31GX1/4".. 166
EASY COMFORT PEN NDL 31GX3/16" 166
EASY COMFORT PEN NDL 31GX5/16" 166
EASY COMFORT PEN NDL 32GX5/32" 166
EASY COMFORT PEN NDL 33G 4MM..166
EASY COMFORT PEN NDL 33G 5MM..166
EASY COMFORT PEN NDL 33G 6MM..166
EASY COMFORT SYR 0.5 ML 29G
8MM..... 166
EASY COMFORT SYR 1 ML 29G 8MM.166
EASY COMFORT SYR 1 ML 30GX1/2". 166
EASY GLIDE INS 0.3 ML 31GX6MM.... 166
EASY GLIDE INS 0.5 ML 31GX6MM.... 166
EASY GLIDE INS 1 ML 31GX6MM..... 166
EASY GLIDE PEN NEEDLE 4MM 33G..166
EASY TOUCH 0.3 ML 30G 8MM(1/2).... 166
EASY TOUCH 0.3 ML 31G 6MM(1/2).... 166
EASY TOUCH 0.3 ML 31G 8MM(1/2).... 166
EASY TOUCH 0.3 ML SYR 30GX1/2"....166
EASY TOUCH 0.5 ML SYR 27GX1/2"....166
EASY TOUCH 0.5 ML SYR 29GX1/2"....166
EASY TOUCH 0.5 ML SYR 30GX1/2"....166
EASY TOUCH 0.5 ML SYR 30GX5/16... 166
EASY TOUCH 1 ML SYR 29GX1/2".....166
EASY TOUCH 1 ML SYR 30GX1/2".....166
EASY TOUCH ALCOHOL 70% PADS
GAMMA-STERILIZED..... 166
EASY TOUCH AUTO 0.5 ML 30G 6MM 166
EASY TOUCH AUTO 0.5 ML 30G 8MM 166
EASY TOUCH AUTORET 1 ML 30G
6MM..... 166
EASY TOUCH AUTORET 1 ML 30G
8MM..... 166
EASY TOUCH FLIPLOK 1 ML 27GX0.5 166
EASY TOUCH INS 0.3 ML 30G 8MM.....166
EASY TOUCH INS 0.3 ML 31G 8MM.....166
EASY TOUCH INS 0.5 ML 30G 8MM.....166
EASY TOUCH INS 0.5 ML 31G 6MM.....166
EASY TOUCH INS 0.5 ML 31G 8MM.....166
EASY TOUCH INS 1 ML 27G 1/2".....166
EASY TOUCH INS 1 ML 28G 12.7MM...166
EASY TOUCH INS SYR 1 ML 30G 8MM
..... 166
EASY TOUCH INS SYR 1 ML 31G 6MM
..... 166
EASY TOUCH INS SYR 1 ML 31G 8MM
..... 166
EASY TOUCH INSULIN 1 ML 29GX1/2 166
EASY TOUCH INSULIN 1 ML 30GX1/2 166
EASY TOUCH INSULIN SYR 1 ML..... 166
EASY TOUCH INSULIN SYR 1 ML
RETRACTABLE..... 166
EASY TOUCH INSULN 1 ML 29GX1/2" 166
EASY TOUCH INSULN 1 ML 30GX1/2" 166
EASY TOUCH INSULN 1 ML 30GX5/16166
EASY TOUCH INSULN 1 ML 31GX5/16166
EASY TOUCH LUER LOK INSUL 1 ML166
EASY TOUCH PEN NEEDLE 29GX1/2" 166
EASY TOUCH PEN NEEDLE 30GX5/16 166
EASY TOUCH PEN NEEDLE 31GX1/4" 166
EASY TOUCH PEN NEEDLE 31GX3/16 166
EASY TOUCH PEN NEEDLE 31GX5/16 166
EASY TOUCH PEN NEEDLE 32GX1/4" 166
EASY TOUCH PEN NEEDLE 32GX3/16 166
EASY TOUCH PEN NEEDLE 32GX5/32 166
EASY TOUCH SAF PEN NDL 29G 5MM
..... 166
EASY TOUCH SAF PEN NDL 29G 8MM
..... 166
EASY TOUCH SAF PEN NDL 30G 5MM
..... 166
EASY TOUCH SAF PEN NDL 30G 8MM
..... 166

EASY TOUCH SYR 0.5 ML 28G 12.7MM ..... 166
EASY TOUCH SYR 0.5 ML 29G 12.7MM ..... 166
EASY TOUCH SYR 1 ML 27G 16MM .... 166
EASY TOUCH UNI-SLIP SYR 1 ML .....166
EASYLIFE ALCOHOL 70% PADS .....166
EASYLIFE INS PEN NDL 29G 12MM .... 166
EASYLIFE INS PEN NDL 31G 4MM ..... 166
EASYLIFE INS PEN NDL 31G 5MM ..... 166
EASYLIFE INS PEN NDL 31G 6MM ..... 166
EASYLIFE INS PEN NDL 31G 8MM ..... 166
EASYLIFE INS PEN NDL 32G 4MM ..... 166
EASYLIFE INS PEN NDL 32G 5MM ..... 166
EASYLIFE INS PEN NDL 32G 6MM ..... 166
EASYLIFE INS PEN NDL 32G 8MM ..... 166
EASYLIFE INS PEN NDL 33G 4MM ..... 166
EASYLIFE INS PEN NDL 33G 5MM ..... 166
EASYLIFE INS PEN NDL 33G 6MM ..... 166
EASYLIFE INS PEN NDL 33G 8MM ..... 166
EASYLIFE INS SYR 0.5 ML 30G 8MM .. 166
EASYLIFE INS SYR 1 ML 30G 8MM ..... 166
EASYLIFE INS SYR 1 ML 31G 8MM ..... 166
EASYLIFE SAFTY PEN NDL 31G 4MM 166
EASYLIFE SAFTY PEN NDL 31G 5MM 166
EASYLIFE SYR 1 ML 30G 12.7MM ..... 166
EASYTOUCH SAF PEN NDL 30G 6MM 166
ELAHERE .....225
ELIGARD .....197
ELIGARD (3 MONTH) ..... 197
ELIGARD (4 MONTH) ..... 197
ELIGARD (6 MONTH) ..... 197
ELREXFIO 44 MG/1.1 ML VIAL INNER, SUV, P/F .....108
ELREXFIO SUBCUTANEOUS SOLUTION 40 MG/ML .....108
*eltrombopag olamine oral powder in packet 12.5 mg, 25 mg* .....110
*eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg* .....110
EMBRACE PEN NEEDLE 29G 12MM ....166
EMBRACE PEN NEEDLE 30G 5MM .....166
EMBRACE PEN NEEDLE 30G 8MM .....166
EMBRACE PEN NEEDLE 31G 5MM .....166
EMBRACE PEN NEEDLE 31G 6MM .....166
EMBRACE PEN NEEDLE 31G 8MM .....166
EMBRACE PEN NEEDLE 32G 4MM .....166
EMGALITY PEN .....142
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML, 300 MG/3 ML (100 MG/ML X 3) .....142
EMRELIS .....344
ENBREL MINI .....125
ENBREL SUBCUTANEOUS SOLUTION ..... 125
ENBREL SUBCUTANEOUS SYRINGE . 125
ENBREL SURECLICK ..... 125
ENSACOVE ORAL CAPSULE 100 MG, 25 MG .....114
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG .....320
EPCLUSA ORAL TABLET ..... 320
EPIDIOLEX ..... 64
EPKINLY ..... 118
ERBITUX .....71
ERIVEDGE ..... 399
ERLEADA ORAL TABLET 240 MG, 60 MG .....29
*erlotinib oral tablet 100 mg, 150 mg, 25 mg* ..... 123
*everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg* .....127
*everolimus (antineoplastic) oral tablet for suspension* .....128
EXEL U100 0.3 ML 29GX1/2" .....166
EXEL U100 0.3 ML 30GX5/16" .....166
EXXUA ORAL TABLET EXTENDED RELEASE 24 HR ..... 145
EXXUA ORAL TABLET, EXT REL 24HR DOSE PACK ..... 145
FAKZYNJA .....41
FASENRA .....51
FASENRA PEN ..... 51
*fentanyl citrate buccal lozenge on a handle* ..... 132
*fingolimod* .....138
FINTEPLA ..... 131
FOTIVDA .....355
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG .....140
FT STERILE PADS 2" X 2" ..... 166
FYARRO .....317

GAUZE PAD TOPICAL BANDAGE 2 X 2 " ....166
GAVRETO ....277
*gefitinib* ....144
GILOTRIF ....21
*glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml* ....148
*glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml* ....148
*glutamine (sickle cell)* ....202
GNP ALCOHOL SWAB STERILE, TWO PLY ....166
GNP PEN NEEDLE 31G 5MM ....166
GNP PEN NEEDLE 32G 6MM ....166
GNP SIMPLI PEN NEEDLE 32G 4MM ....166
GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT ....166
GNP ULT CMFRT 0.5 ML 29GX1/2" ....166
GNP ULTR CMFRT 0.5 ML 30GX5/16 ....166
GNP ULTRA COMFORT 1 ML SYRINGE ....166
GNP ULTRA COMFORT 3/10 ML SYR ....166
GOMEKLI ORAL CAPSULE 1 MG, 2 MG ....224
GOMEKLI ORAL TABLET FOR SUSPENSION ....224
GS PEN NEEDLE 31G X 8MM ....166
HADLIMA ....19
HADLIMA PUSHTOUCH ....19
HADLIMA(CF) ....19
HADLIMA(CF) PUSHTOUCH ....19
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT ....61
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG ....190
HARVONI ORAL TABLET ....190
HEALTHWISE INS 0.3 ML 30GX5/16" ....166
HEALTHWISE INS 0.3 ML 31GX5/16" ....166
HEALTHWISE INS 0.5 ML 30GX5/16" ....166
HEALTHWISE INS 0.5 ML 31GX5/16" ....166
HEALTHWISE INS 1 ML 30GX5/16" ....166
HEALTHWISE INS 1 ML 31GX5/16" ....166
HEALTHWISE PEN NEEDLE 31G 5MM ....166
HEALTHWISE PEN NEEDLE 31G 8MM ....166
HEALTHWISE PEN NEEDLE 32G 4MM ....166
HEALTHY ACCENTS PENTIP 5MM 31G ....166
HEALTHY ACCENTS PENTIP 6MM 31G ....166
HEALTHY ACCENTS PENTIP 8MM 31G ....166
HEALTHY ACCENTS PENTP 12MM 29G ....166
HEB INCONTROL ALCOHOL 70% PADS ....166
HERCEPTIN HYLECTA ....369
HERNEXEOS ....408
HUMIRA PEN ....12
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML ....12
HUMIRA(CF) ....12
HUMIRA(CF) PEDI CROHNS STARTER 12
HUMIRA(CF) PEN ....12
HUMIRA(CF) PEN CROHNS-UC-HS ....12
HUMIRA(CF) PEN PEDIATRIC UC ....12
HUMIRA(CF) PEN PSOR-UV-ADOL HS ....12
HYRNUO ....313
IBRANCE ....257
IBTROZI ....339
*icatibant* ....157
ICLUSIG ....275
IDHIFA ....112
*imatinib oral tablet 100 mg, 400 mg* ....159
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG ....156
IMBRUVICA ORAL SUSPENSION ....156
IMBRUVICA ORAL TABLET ....156
IMDELLTRA ....341
IMJUDO ....371
IMKELDI ....160
IMPAVIDO ....223
INCONTROL PEN NEEDLE 12MM 29G 166
INCONTROL PEN NEEDLE 4MM 32G ....166
INCONTROL PEN NEEDLE 5MM 31G ....166
INCONTROL PEN NEEDLE 6MM 31G ....166
INCONTROL PEN NEEDLE 8MM 31G ....166
INCRELEX ....215
*infliximab* ....164
INGREZZA ....390
INGREZZA INITIATION PK(TARDIV) ....390
INGREZZA SPRINKLE ....390
INLURIYO ....162
INLYTA ORAL TABLET 1 MG, 5 MG ....43
INQOVI ....86

INREBIC ..... 130
INSULIN 1 ML SYRINGE ..... 166
INSULIN 1/2 ML SYRINGE ..... 166
INSULIN 3/10 ML SYRINGE ..... 166
INSULIN SYR 0.3 ML 31GX1/4(1/2) ..... 166
INSULIN SYRIN 0.5 ML 28GX1/2" (OTC) ..... 166
INSULIN SYRIN 0.5 ML 29GX1/2" (OTC) ..... 166
INSULIN SYRIN 0.5 ML 30GX1/2" (RX) 166
INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC) ..... 166
INSULIN SYRING 0.5 ML 27G 1/2" INNER ..... 166
INSULIN SYRINGE 0.3 ML ..... 166
INSULIN SYRINGE 0.3 ML 31GX1/4 ..... 166
INSULIN SYRINGE 0.5 ML ..... 166
INSULIN SYRINGE 0.5 ML 31GX1/4 ..... 166
INSULIN SYRINGE 1 ML ..... 166
INSULIN SYRINGE 1 ML 27G 1/2" INNER ..... 166
INSULIN SYRINGE 1 ML 28GX1/2" (OTC) ..... 166
INSULIN SYRINGE 1 ML 30GX1/2" SHORT NEEDLE (OTC) ..... 166
INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC) ..... 166
INSULIN SYRINGE 1 ML 31GX1/4" ..... 166
INSULIN SYRINGE 1 ML 31GX5/16" SHORT NEEDLE,THIN II (OTC) ..... 166
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE ..... 166
INSULIN U-500 SYRINGE-NEEDLE ..... 166
INSUPEN PEN NEEDLE 29GX1/2" ..... 166
INSUPEN PEN NEEDLE 31G 8MM ..... 166
INSUPEN PEN NEEDLE 31GX3/16" ..... 166
INSUPEN PEN NEEDLE 32G 4MM ..... 166
INSUPEN PEN NEEDLE 32G 6MM (RX) ..... 166
ITOVEBI ORAL TABLET 3 MG, 9 MG .. 163
IV ANTISEPTIC WIPES ..... 166
IWILFIN ..... 103
JAKAFI ..... 305
JAKAFI XR ..... 305
JASCAYD ..... 230
*javygtor oral tablet,soluble* ..... 306
JAYPIRCA ORAL TABLET 100 MG, 50 MG ..... 273
JEMPERLI ..... 96
JYNARQUE ORAL TABLET ..... 362
KALYDECO ..... 182
KENDALL ALCOHOL 70% PREP PAD . 166
KERENDIA ..... 136
KESIMPTA PEN ..... 245
KEYTRUDA ..... 264
KEYTRUDA QLEX ..... 265
KIMMTRAK ..... 342
KINERET ..... 27
KISQALI 200 MG DAILY DOSE ..... 288
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 ..... 289
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3) ..... 288
KOMZIFTI ..... 406
KOSELUGO ORAL CAPSULE 10 MG, 25 MG ..... 312
KOSELUGO ORAL CAPSULE, SPRINKLE 5 MG, 7.5 MG ..... 312
KRAZATI ..... 11
*lanreotide subcutaneous syringe 120 mg/0.5 ml* ..... 186
*lapatinib* ..... 187
LAZCLUZE ORAL TABLET 240 MG, 80 MG ..... 189
*lenalidomide* ..... 191
LENVIMA ..... 192
*leuprolide acetate (3 month)* ..... 195
*leuprolide subcutaneous kit* ..... 194
*lidocaine topical adhesive patch,medicated 5 %* ..... 204
*lidocaine topical ointment* ..... 203
*lidocaine-prilocaine topical cream* ..... 205
*lidocan iii* ..... 204
LIFYORLI ..... 282
LISCO SPONGES 100/BAG ..... 166
LITE TOUCH 31GX1/4" PEN NEEDLE .. 166
LITE TOUCH INSULIN 0.5 ML SYR ..... 166
LITE TOUCH INSULIN 1 ML SYR ..... 166
LITE TOUCH INSULIN SYR 1 ML ..... 166
LITE TOUCH PEN NEEDLE 29G ..... 166

LITE TOUCH PEN NEEDLE 31G.....166
LITETOUCH INS 0.3 ML 29GX1/2".....166
LITETOUCH INS 0.3 ML 30GX5/16".....166
LITETOUCH INS 0.3 ML 31GX5/16".....166
LITETOUCH INS 0.5 ML 31GX5/16".....166
LITETOUCH SYR 0.5 ML 28GX1/2"..... 166
LITETOUCH SYR 0.5 ML 29GX1/2"..... 166
LITETOUCH SYR 0.5 ML 30GX5/16".... 166
LITETOUCH SYRIN 1 ML 28GX1/2"..... 166
LITETOUCH SYRIN 1 ML 29GX1/2"..... 166
LITETOUCH SYRIN 1 ML 30GX5/16"... 166
LIVTENCITY..... 213
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG..... 374
LOQTORZI..... 364
LORBRENA ORAL TABLET 100 MG, 25 MG.....208
LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG..... 331
LUNSUMIO.....227
LUNSUMIO VELO..... 227
LUPRON DEPOT..... 198
LUPRON DEPOT (3 MONTH).....198
LUPRON DEPOT (4 MONTH).....198
LUPRON DEPOT (6 MONTH).....198
LUPRON DEPOT-PED (3 MONTH).....200
LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT.....200
LUTRATE DEPOT (3 MONTH).....195
LYNOZYFIC INTRAVENOUS SOLUTION 2 MG/ML, 20 MG/ML.....206
LYNPARZA.....246
LYTGOBI.....141
*macitentan*..... 211
MAGELLAN INSUL SYRINGE 0.3 ML..166
MAGELLAN INSUL SYRINGE 0.5 ML..166
MAGELLAN INSULIN SYR 0.3 ML.....166
MAGELLAN INSULIN SYR 0.5 ML.....166
MAGELLAN INSULIN SYRINGE 1 ML 166
MARGENZA.....212
MAXICOMFORT II PEN NDL 31GX6MM..... 166
MAXICOMFORT INS 0.5 ML 27GX1/2" 166
MAXI-COMFORT INS 0.5 ML 28G.....166
MAXICOMFORT INS 1 ML 27GX1/2"... 166
MAXI-COMFORT INS 1 ML 28GX1/2"..166
MAXICOMFORT PEN NDL 29G X 5MM ..... 166
MAXICOMFORT PEN NDL 29G X 8MM ..... 166
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG..... 316
MAYZENT STARTER(FOR 1MG MAINT).....316
MAYZENT STARTER(FOR 2MG MAINT).....316
MEKINIST ORAL RECON SOLN..... 366
MEKINIST ORAL TABLET 0.5 MG, 2 MG.....367
MEKTOVI.....56
*metyrosine*.....220
MICRODOT PEN NEEDLE 31GX6MM..166
MICRODOT PEN NEEDLE 32GX4MM..166
MICRODOT PEN NEEDLE 33GX4MM..166
MICRODOT READYGARD NDL 31G 5MM OUTER.....166
*mifepristone oral tablet 300 mg*..... 222
MINI PEN NEEDLE 32G 5MM.....166
MINI PEN NEEDLE 32G 8MM.....166
MINI PEN NEEDLE 33G 5MM.....166
MINI PEN NEEDLE 33G 6MM.....166
MINI ULTRA-THIN II PEN NDL 31G STERILE..... 166
MIPLYFFA..... 33
*modafinil oral tablet 100 mg, 200 mg*..... 228
MODEYSO..... 95
MONOJECT 0.5 ML SYRN 28GX1/2".....166
MONOJECT 1 ML SYRN 27X1/2".....166
MONOJECT 1 ML SYRN 28GX1/2" (OTC).....166
MONOJECT INSUL SYR U100 (OTC)....166
MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC).....166
MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)..... 166
MONOJECT INSUL SYR U100 1 ML..... 166
MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC).....166
MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)..... 166
MONOJECT INSULIN SYR 0.3 ML..... 166
MONOJECT INSULIN SYR 0.3 ML (OTC).....166

MONOJECT INSULIN SYR 0.5 ML..... 166
MONOJECT INSULIN SYR 0.5 ML (OTC).....166
MONOJECT INSULIN SYR 1 ML 3'S (OTC).....166
MONOJECT INSULIN SYR U-100.....166
MONOJECT SYRINGE 0.3 ML.....166
MONOJECT SYRINGE 0.5 ML.....166
MONOJECT SYRINGE 1 ML.....166
*morphine concentrate oral solution*..... 155
MOUNJARO.....151
NANO 2 GEN PEN NEEDLE 32G 4MM. 166
NANO PEN NEEDLE 32G 4MM.....166
NERLYNX.....232
NIKTIMVO.....42
*nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg*..... 233
NINLARO..... 184
*nintedanib*.....235
*nitisinone*..... 240
NIVESTYM.....135
NORDITROPIN FLEXPRO..... 324
NOVOFINE 32G NEEDLES..... 166
NOVOFINE AUTOCOVER 30G NEEDLE.....166
NOVOFINE PLUS PEN NDL 32GX1/6"..166
NUBEQA.....83
NUCALA SUBCUTANEOUS AUTO-INJECTOR..... 217
NUCALA SUBCUTANEOUS RECON SOLN.....217
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML.....217
NUPLAZID..... 270
NURTEC ODT.....293
NYVEPRIA.....260
ODOMZO.....327
OGIVRI..... 368
OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG..... 239
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION.....365
OJEMDA ORAL TABLET.....365
OJJAARA.....226
OMLYCLO..... 252
ONAPGO.....30
ONUREG.....44
OPDIVO.....241
OPDIVO QVANTIG.....242
OPDUALAG..... 243
ORENCIA..... 4
ORENCIA (WITH MALTOSE)..... 2
ORENCIA CLICKJECT..... 4
ORFADIN ORAL SUSPENSION..... 240
ORGOVYX..... 283
ORILISSA ORAL TABLET 150 MG, 200 MG.....105
ORKAMBI ORAL TABLET.....210
ORSERDU ORAL TABLET 345 MG, 86 MG.....104
OSENVELT.....89
OTEZLA.....31
OTEZLA STARTER.....31
OTEZLA XR.....31
OTEZLA XR INITIATION..... 31
OZEMPIC ORAL.....150
OZEMPIC SUBCUTANEOUS.....150
*pazopanib oral tablet 200 mg, 400 mg*.....259
PEGASYS..... 262
PEMAZYRE.....266
PEN NEEDLE 30G 5MM OUTER.....166
PEN NEEDLE 30G 8MM INNER.....166
PEN NEEDLE 30G X 5/16".....166
PEN NEEDLE 31G X 1/4" HRI.....166
PEN NEEDLE 33G 4MM..... 166
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2".....166
PEN NEEDLES 12MM 29G 29GX12MM,STRL..... 166
PEN NEEDLES 4MM 32G.....166
PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC).....166
PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC).....166
*penicillamine oral tablet*.....267
PENTIPS PEN NEEDLE 29G 1/2".....166
PENTIPS PEN NEEDLE 31G 1/4".....166
PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM.....166
PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM.....166
PENTIPS PEN NEEDLE 32G 1/4".....166
PENTIPS PEN NEEDLE 32GX5/32".....166
PIP PEN NEEDLE 31G X 5MM..... 166

PIP PEN NEEDLE 32G X 4MM..... 166
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).....23
*pirfenidone oral capsule*.....271
*pirfenidone oral tablet 267 mg, 534 mg, 801 mg*..... 271
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML..... 178
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML.....178
*pomalidomide*..... 274
POMALYST.....274
*posaconazole oral tablet,delayed release (dr/ec)*..... 276
PREVENT PEN NEEDLE 31GX1/4".....166
PREVENT PEN NEEDLE 31GX5/16".....166
PREVYMIS ORAL TABLET.....193
PRO COMFORT 0.5 ML 30GX1/2".....166
PRO COMFORT 0.5 ML 30GX5/16".....166
PRO COMFORT 0.5 ML 31GX5/16".....166
PRO COMFORT 1 ML 30GX1/2".....166
PRO COMFORT 1 ML 30GX5/16".....166
PRO COMFORT 1 ML 31GX5/16".....166
PRO COMFORT ALCOHOL 70% PADS 166
PRO COMFORT PEN NDL 32G 8MM.... 166
PRO COMFORT PEN NDL 32G X 1/4"...166
PRO COMFORT PEN NDL 4MM 32G.... 166
PRO COMFORT PEN NDL 5MM 32G.... 166
PRO-COMFORT ALCOHOL 70% PADS 166
PRODIGY INS SYR 1 ML 28GX1/2".....166
PRODIGY SYRNG 0.5 ML 31GX5/16"... 166
PRODIGY SYRNGE 0.3 ML 31GX5/16".166
PURE CMFT SFTY PEN NDL 31G 5MM166
PURE CMFT SFTY PEN NDL 31G 6MM166
PURE CMFT SFTY PEN NDL 32G 4MM166
PURE COMFORT ALCOHOL 70% PADS.....166
PURE COMFORT PEN NDL 32G 4MM..166
PURE COMFORT PEN NDL 32G 5MM..166
PURE COMFORT PEN NDL 32G 6MM..166
PURE COMFORT PEN NDL 32G 8MM..166
*pyrimethamine*..... 278
QINLOCK..... 297
*quinine sulfate*..... 279
QULIPTA.....38
RA ISOPROPYL ALCOHOL 70% WIPES ..... 166
RA STERILE PADS 2"X 2"..... 166
RALDESY.....370
RAYA SURE PEN NEEDLE 29G 12MM.166
RAYA SURE PEN NEEDLE 31G 4MM...166
RAYA SURE PEN NEEDLE 31G 5MM...166
RAYA SURE PEN NEEDLE 31G 6MM...166
RELION INS SYR 0.3 ML 31GX6MM.... 166
RELION INS SYR 0.5 ML 31GX6MM.... 166
RELION INS SYR 1 ML 31GX15/64".....166
RELION PEN NEEDLE 32GX5/32".....166
RELION SYRING 0.3 ML 31GX5/16" INNER.....166
RELION SYRING 0.5 ML 31GX5/16" INNER (OTC)..... 166
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.....119
RETEVMO ORAL CAPSULE 40 MG, 80 MG.....311
RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG.....311
REVCOVI..... 106
REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG..... 287
REZDIFFRA..... 285
REZLIDHIA.....247
REZUROCK.....48
RINVOQ.....378
RINVOQ LQ..... 378
RITUXAN HYCELA.....300
ROMVIMZA.....398
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG.....115
ROZLYTREK ORAL PELLETS IN PACKET.....116
RUBRACA.....304
RYBELSUS.....150
RYBREVANT.....26
RYBREVANT FASPRO.....25
RYDAPT..... 221
RYTELO..... 161

SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10 ..... 166
SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10 ..... 166
SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10 ..... 166
SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10 ..... 166
SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10 ..... 166
SAFETY PEN NEEDLE 31G 4MM ..... 166
SAFETY PEN NEEDLE 5MM X 31G ..... 166
SAFETY SYRINGE 0.5 ML 30G 1/2" ..... 166
*sapropterin oral tablet,soluble* ..... 306
SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG ..... 34
SECURESAFE PEN NDL 30GX5/16" OUTER ..... 166
SECURESAFE PEN NEEDLE 31G 5MM OUTER ..... 166
SECURESAFE SYR 0.5 ML 29G 1/2" OUTER ..... 166
SECURESAFE SYRNG 1 ML 29G 1/2" OUTER ..... 166
SELARSDI ..... 382, 384
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG ..... 326
SIGNIFOR ..... 258
*sildenafil (pulm.hypertension) oral tablet* .. 314
SIRTURO ..... 46
SKY SAFETY PEN NEEDLE 30G 5MM . 166
SKY SAFETY PEN NEEDLE 30G 8MM . 166
SKYRIZI ..... 298
*sodium oxybate* ..... 318
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 60 MG/0.2 ML, 90 MG/0.3 ML ..... 186
SOMAVERT ..... 263
*sorafenib* ..... 328
SPRAVATO ..... 124
STIVARGA ..... 281
STRENSIQ ..... 35
SUBVENITE ORAL SUSPENSION ..... 185
*sunitinib malate* ..... 333
SURE CMFT SFTY PEN NDL 31G 6MM 166
SURE CMFT SFTY PEN NDL 32G 4MM 166
SURE COMFORT 0.5 ML SYRINGE ..... 166
SURE COMFORT 1 ML SYRINGE ..... 166
SURE COMFORT 3/10 ML SYRINGE .... 166
SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE ..... 166
SURE COMFORT 30G PEN NEEDLE ..... 166
SURE COMFORT ALCOHOL PREP PADS ..... 166
SURE COMFORT INS 0.3 ML 31GX1/4 . 166
SURE COMFORT INS 0.5 ML 31GX1/4 . 166
SURE COMFORT INS 1 ML 31GX1/4" ... 166
SURE COMFORT PEN NDL 29GX1/2" 12.7MM ..... 166
SURE COMFORT PEN NDL 31G 5MM .. 166
SURE COMFORT PEN NDL 31G 8MM .. 166
SURE COMFORT PEN NDL 32G 4MM .. 166
SURE COMFORT PEN NDL 32G 6MM .. 166
SURE-FINE PEN NEEDLES 12.7MM ..... 166
SURE-FINE PEN NEEDLES 5MM ..... 166
SURE-FINE PEN NEEDLES 8MM ..... 166
SURE-JECT INSU SYR U100 0.3 ML ..... 166
SURE-JECT INSU SYR U100 0.5 ML ..... 166
SURE-JECT INSU SYR U100 1 ML ..... 166
SURE-JECT INSUL SYR U100 1 ML ..... 166
SURE-JECT INSULIN SYRINGE 1 ML .. 166
SURE-PREP ALCOHOL PREP PADS ..... 166
SYMPAZAN ..... 73
SYNRIBO ..... 248
TABRECTA ..... 66
*tadalafil oral tablet 2.5 mg, 5 mg* ..... 335
TAFINLAR ORAL CAPSULE ..... 79
TAFINLAR ORAL TABLET FOR SUSPENSION ..... 80
TAGRISSO ..... 255
TALVEY ..... 340
TALZENNA ..... 337
TAVNEOS ..... 39
TECHLITE 0.3 ML 29GX12MM (1/2) ..... 166
TECHLITE 0.3 ML 30GX8MM (1/2) ..... 166
TECHLITE 0.3 ML 31GX6MM (1/2) ..... 166
TECHLITE 0.3 ML 31GX8MM (1/2) ..... 166
TECHLITE 0.5 ML 30GX12MM (1/2) ..... 166
TECHLITE 0.5 ML 30GX8MM (1/2) ..... 166
TECHLITE 0.5 ML 31GX6MM (1/2) ..... 166
TECHLITE 0.5 ML 31GX8MM (1/2) ..... 166
TECHLITE INS SYR 1 ML 29GX12MM . 166
TECHLITE INS SYR 1 ML 30GX12MM . 166
TECHLITE INS SYR 1 ML 31GX6MM ... 166

TECHLITE INS SYR 1 ML 31GX8MM...166
TECHLITE PEN NEEDLE 29GX1/2"..... 166
TECHLITE PEN NEEDLE 29GX3/8"..... 166
TECHLITE PEN NEEDLE 31GX1/4"..... 166
TECHLITE PEN NEEDLE 31GX3/16".... 166
TECHLITE PEN NEEDLE 31GX5/16".... 166
TECHLITE PEN NEEDLE 32GX1/4"..... 166
TECHLITE PEN NEEDLE 32GX5/16".... 166
TECHLITE PEN NEEDLE 32GX5/32".... 166
TECHLITE PLUS PEN NDL 32G 4MM...166
TECVAYLI..... 343
TEPMETKO.....346
*teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)*.....347
TERUMO INS SYRINGE U100-1 ML..... 166
TERUMO INS SYRINGE U100-1/2 ML.. 166
TERUMO INS SYRINGE U100-1/3 ML.. 166
TERUMO INS SYRNG U100-1/2 ML.....166
*testosterone cypionate*..... 349
*testosterone enanthate*.....350
*testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)*.....348
*testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)*.....348
*tetrabenazine*..... 351
TEVIMBRA..... 353
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG.....352
THINPRO INS SYRIN U100-0.3 ML..... 166
THINPRO INS SYRIN U100-0.5 ML..... 166
THINPRO INS SYRIN U100-1 ML..... 166
TIBSOVO.....183
TIVDAK.....354
*tofacitinib*.....360
*tolvaptan (polycys kidney dis) oral tablets, sequential*.....362
TOPFINE INSULN PEN NDL 32G 4MM 166
*torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*..... 127
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 375
TREMFYA INTRAVENOUS.....153
TREMFYA ONE-PRESS.....153
TREMFYA PEN INDUCTION PK(2PEN) ..... 153
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML.....153
TREMFYA SUBCUTANEOUS SYRINGE.....153
*tretinoin topical cream*..... 363
*tridacaine iii*..... 204
*trientine oral capsule 250 mg*.....373
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL.....107
TRIKAFTA ORAL TABLETS, SEQUENTIAL..... 107
TRUE CMFRT PRO 0.5 ML 30G 5/16"....166
TRUE CMFRT PRO 0.5 ML 31G 5/16"....166
TRUE CMFRT PRO 0.5 ML 32G 5/16"....166
TRUE CMFT SFTY PEN NDL 31G 5MM166
TRUE CMFT SFTY PEN NDL 31G 6MM166
TRUE CMFT SFTY PEN NDL 32G 4MM166
TRUE COMFORT 0.5 ML 30G 1/2".....166
TRUE COMFORT 0.5 ML 30G 5/16".....166
TRUE COMFORT 0.5 ML 31G 5/16".....166
TRUE COMFORT 0.5 ML 31GX5/16".....166
TRUE COMFORT 1 ML 31GX5/16".....166
TRUE COMFORT ALCOHOL 70% PADS.....166
TRUE COMFORT PEN NDL 31G 8MM..166
TRUE COMFORT PEN NDL 31GX5MM 166
TRUE COMFORT PEN NDL 31GX6MM 166
TRUE COMFORT PEN NDL 32G 5MM..166
TRUE COMFORT PEN NDL 32G 6MM..166
TRUE COMFORT PEN NDL 32GX4MM 166
TRUE COMFORT PEN NDL 33G 4MM..166
TRUE COMFORT PEN NDL 33G 5MM..166
TRUE COMFORT PEN NDL 33G 6MM..166
TRUE COMFORT PRO 1 ML 30G 1/2"...166
TRUE COMFORT PRO 1 ML 30G 5/16".166
TRUE COMFORT PRO 1 ML 31G 5/16".166
TRUE COMFORT PRO 1 ML 32G 5/16".166
TRUE COMFORT PRO ALCOHOL PADS.....166
TRUE COMFORT SFTY 1 ML 30G 1/2".166
TRUE COMFRT PRO 0.5 ML 30G 1/2"...166
TRUE COMFRT SFTY 1 ML 30G 5/16"..166
TRUE COMFRT SFTY 1 ML 31G 5/16"..166
TRUE COMFRT SFTY 1 ML 32G 5/16"..166
TRUE-CMFRT PRO PEN NDL 31G 5MM ..... 166

TRUE-CMFRT PRO PEN NDL 31G 6MM ..... 166
TRUE-CMFRT PRO PEN NDL 31G 8MM ..... 166
TRUE-CMFRT PRO PEN NDL 32G 4MM ..... 166
TRUEPLUS PEN NEEDLE 29GX1/2" ..... 166
TRUEPLUS PEN NEEDLE 31G X 1/4" ... 166
TRUEPLUS PEN NEEDLE 31GX3/16" ... 166
TRUEPLUS PEN NEEDLE 31GX5/16" ... 166
TRUEPLUS PEN NEEDLE 32GX5/32" ... 166
TRUEPLUS SYR 0.3 ML 29GX1/2" .....166
TRUEPLUS SYR 0.3 ML 30GX5/16" .....166
TRUEPLUS SYR 0.3 ML 31GX5/16" .....166
TRUEPLUS SYR 0.5 ML 28GX1/2" .....166
TRUEPLUS SYR 0.5 ML 29GX1/2" .....166
TRUEPLUS SYR 0.5 ML 30GX5/16" .....166
TRUEPLUS SYR 0.5 ML 31GX5/16" .....166
TRUEPLUS SYR 1 ML 28GX1/2" .....166
TRUEPLUS SYR 1 ML 29GX1/2" .....166
TRUEPLUS SYR 1 ML 30GX5/16" .....166
TRUEPLUS SYR 1 ML 31GX5/16" .....166
TRULICITY ..... 149
TRUQAP ..... 65
TRUXIMA .....301
TUKYSA ORAL TABLET 150 MG, 50 MG .....376
TURALIO .....269
TYENNE ..... 356, 358
TYENNE AUTOINJECTOR ..... 358
TYMLOS .....1
UBRELVY ..... 377
UDENYCA ONBODY .....261
ULT CFT 0.3 ML 31GX5/16" (1/2) 1/2 UNIT .....166
ULTICAR INS 0.3 ML 31GX1/4(1/2) .....166
ULTICARE INS 0.3 ML 31GX1/4" ..... 166
ULTICARE INS 0.5 ML 31GX1/4" ..... 166
ULTICARE INS 1 ML 31GX1/4" ..... 166
ULTICARE INS SYR 1 ML 30GX1/2" .....166
ULTICARE PEN NEEDLE 31GX3/16" ....166
ULTICARE PEN NEEDLE 6MM 31G ..... 166
ULTICARE PEN NEEDLE 8MM 31G ..... 166
ULTICARE PEN NEEDLES 12MM 29G . 166
ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM ..... 166
ULTICARE PEN NEEDLES 6MM 32G ... 166
ULTICARE SAFE PEN NDL 30G 8MM .. 166
ULTICARE SAFE PEN NDL 5MM 30G .. 166
ULTICARE SYR 0.3 ML 30GX1/2" ..... 166
ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL .....166
ULTICARE SYR 0.5 ML 30GX1/2" ..... 166
ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL .....166
ULTICARE SYR 1 ML 31GX5/16" ..... 166
ULTIGUARD SAFE 1 ML 30G 12.7MM . 166
ULTIGUARD SAFE0.3 ML 30G 12.7MM ..... 166
ULTIGUARD SAFE0.5 ML 30G 12.7MM ..... 166
ULTIGUARD SAFEPACK 1 ML 31G 8MM ..... 166
ULTIGUARD SAFEPACK 29G 12.7MM 166
ULTIGUARD SAFEPACK 31G 5MM ..... 166
ULTIGUARD SAFEPACK 31G 6MM ..... 166
ULTIGUARD SAFEPACK 31G 8MM ..... 166
ULTIGUARD SAFEPACK 32G 4MM ..... 166
ULTIGUARD SAFEPACK 32G 6MM ..... 166
ULTIGUARD SAFEPK 0.3 ML 31G 8MM ..... 166
ULTIGUARD SAFEPK 0.5 ML 31G 8MM ..... 166
ULTILET ALCOHOL STERL SWAB .....166
ULTILET INSULIN SYRINGE 0.3 ML ... 166
ULTILET INSULIN SYRINGE 0.5 ML ... 166
ULTILET INSULIN SYRINGE 1 ML ..... 166
ULTILET PEN NEEDLE .....166
ULTILET PEN NEEDLE 4MM 32G .....166
ULTRA COMFORT 0.3 ML 29GX1/2" .... 166
ULTRA COMFORT 0.3 ML SYRINGE ... 166
ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G .....166
ULTRA COMFORT 0.5 ML 29GX1/2" .... 166
ULTRA COMFORT 0.5 ML 31GX5/16" .. 166
ULTRA COMFORT 0.5 ML SYRINGE ... 166
ULTRA COMFORT 1 ML 29GX1/2" ..... 166
ULTRA COMFORT 1 ML 30GX5/16" ..... 166
ULTRA COMFORT 1 ML 31GX5/16" ..... 166
ULTRA COMFORT 1 ML SYRINGE ..... 166
ULTRA FLO 0.3 ML 30G 1/2" (1/2) ..... 166
ULTRA FLO 0.3 ML 30G 5/16"(1/2) ..... 166
ULTRA FLO 0.3 ML 31G 5/16"(1/2) ..... 166
ULTRA FLO PEN NEEDLE 31G 5MM ... 166

ULTRA FLO PEN NEEDLE 31G 8MM... 166
ULTRA FLO PEN NEEDLE 32G 4MM... 166
ULTRA FLO PEN NEEDLE 33G 4MM... 166
ULTRA FLO PEN NEEDLES 12MM 29G
..... 166
ULTRA FLO SYR 0.3 ML 29GX1/2".....166
ULTRA FLO SYR 0.3 ML 30G 5/16".....166
ULTRA FLO SYR 0.3 ML 31G 5/16".....166
ULTRA FLO SYR 0.5 ML 29G 1/2".....166
ULTRA THIN PEN NDL 32G X 4MM.....166
ULTRACARE INS 0.3 ML 30GX5/16".... 166
ULTRACARE INS 0.3 ML 31GX5/16".... 166
ULTRACARE INS 0.5 ML 30GX1/2"..... 166
ULTRACARE INS 0.5 ML 30GX5/16".... 166
ULTRACARE INS 0.5 ML 31GX5/16".... 166
ULTRACARE INS 1 ML 30G X 5/16"..... 166
ULTRACARE INS 1 ML 30GX1/2"..... 166
ULTRACARE INS 1 ML 31G X 5/16"..... 166
ULTRACARE PEN NEEDLE 31GX1/4"..166
ULTRACARE PEN NEEDLE 31GX3/16"166
ULTRACARE PEN NEEDLE 31GX5/16"166
ULTRACARE PEN NEEDLE 32GX1/4"..166
ULTRACARE PEN NEEDLE 32GX3/16"166
ULTRACARE PEN NEEDLE 32GX5/32"166
ULTRACARE PEN NEEDLE 33GX5/32"166
ULTRA-FINE 0.3 ML 30G 12.7MM.....166
ULTRA-FINE 0.3 ML 31G 6MM (1/2).....166
ULTRA-FINE 0.3 ML 31G 8MM (1/2).....166
ULTRA-FINE 0.5 ML 30G 12.7MM.....166
ULTRA-FINE INS 0.5 ML 31G 6MM..... 166
ULTRA-FINE INS SYR 1 ML 31G 6MM 166
ULTRA-FINE INS SYR 1 ML 31G 8MM 166
ULTRA-FINE PEN NDL 29G 12.7MM....166
ULTRA-FINE PEN NEEDLE 31G 5MM..166
ULTRA-FINE PEN NEEDLE 31G 8MM..166
ULTRA-FINE PEN NEEDLE 32G 6MM..166
ULTRA-FINE SYR 0.3 ML 31G 6MM.....166
ULTRA-FINE SYR 0.3 ML 31G 8MM.....166
ULTRA-FINE SYR 0.5 ML 31G 6MM.....166
ULTRA-FINE SYR 0.5 ML 31G 8MM.....166
ULTRA-FINE SYR 1 ML 30G 12.7MM...166
ULTRA-THIN II 1 ML 31GX5/16".....166
ULTRA-THIN II INS 0.3 ML 30G.....166
ULTRA-THIN II INS 0.3 ML 31G.....166
ULTRA-THIN II INS 0.5 ML 29G.....166
ULTRA-THIN II INS 0.5 ML 30G.....166
ULTRA-THIN II INS 0.5 ML 31G.....166
ULTRA-THIN II INS SYR 1 ML 29G..... 166
ULTRA-THIN II INS SYR 1 ML 30G..... 166
ULTRA-THIN II PEN NDL 29GX1/2"..... 166
ULTRA-THIN II PEN NDL 31GX5/16.....166
UNIFINE OTC PEN NEEDLE 31G 5MM 166
UNIFINE OTC PEN NEEDLE 32G 4MM 166
UNIFINE PENTIPS 12MM 29G
29GX12MM, STRL..... 166
UNIFINE PENTIPS 31GX3/16"
31GX5MM,STRL,MINI..... 166
UNIFINE PENTIPS 32G 4MM..... 166
UNIFINE PENTIPS 32GX1/4".....166
UNIFINE PENTIPS 33GX5/32".....166
UNIFINE PENTIPS 6MM 31G..... 166
UNIFINE PENTIPS 8MM 31G
31GX8MM, SHORT, STRL..... 166
UNIFINE PENTIPS MAX 30GX3/16".....166
UNIFINE PENTIPS PLUS 29GX1/2"
12MM..... 166
UNIFINE PENTIPS PLUS 30GX3/16"..... 166
UNIFINE PENTIPS PLUS 31G 5MM.....166
UNIFINE PENTIPS PLUS 31GX1/4"
ULTRA SHORT, 6MM.....166
UNIFINE PENTIPS PLUS 32GX5/32"..... 166
UNIFINE PENTIPS PLUS 33GX5/32"..... 166
UNIFINE PROTECT 30G 5MM..... 166
UNIFINE PROTECT 30G 8MM..... 166
UNIFINE PROTECT 32G 4MM..... 166
UNIFINE SAFECONTROL 30G 5MM.....166
UNIFINE SAFECONTROL 30G 8MM.....166
UNIFINE SAFECONTROL 31G 5MM.....166
UNIFINE SAFECONTROL 31G 6MM.....166
UNIFINE SAFECONTROL 31G 8MM.....166
UNIFINE SAFECONTROL 32G 4MM.....166
UNIFINE ULTR PEN NDL 34G 3.5MM..166
UNIFINE ULTRA PEN NDL 29G 12MM 166
UNIFINE ULTRA PEN NDL 31G 5MM.. 166
UNIFINE ULTRA PEN NDL 31G 6MM.. 166
UNIFINE ULTRA PEN NDL 31G 8MM.. 166
UNIFINE ULTRA PEN NDL 32G 4MM.. 166
UNIFINE ULTRA PEN NDL 32G 6MM.. 166
UPTRAVI ORAL TABLET 1,000 MCG,
1,200 MCG, 1,400 MCG, 1,600 MCG, 100
MCG, 150 MCG, 200 MCG, 400 MCG,
600 MCG, 800 MCG.....309
UPTRAVI ORAL TABLETS,DOSE
PACK..... 309

*ustekinumab-aauz* ..... 380
VALCHLOR ..... 216
VANFLYTA ..... 280
VANISHPOINT 0.5 ML 30GX1/2" SY OUTER ..... 166
VANISHPOINT INS 0.5 ML 30G 8MM OUTER ..... 166
VANISHPOINT INS 1 ML 30GX3/16" .... 166
VANISHPOINT U-100 29X1/2 SYR ..... 166
VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG ..... 394
VENCLEXTA STARTING PACK ..... 394
VEOZAH ..... 133
VEPPANU ..... 395
VERIFINE INS SYR 1 ML 29G 1/2" ..... 166
VERIFINE PEN NEEDLE 29G 12MM ..... 166
VERIFINE PEN NEEDLE 31G 5MM ..... 166
VERIFINE PEN NEEDLE 31G X 6MM ... 166
VERIFINE PEN NEEDLE 31G X 8MM ... 166
VERIFINE PEN NEEDLE 32G 6MM ..... 166
VERIFINE PEN NEEDLE 32G X 4MM ... 166
VERIFINE PEN NEEDLE 32G X 5MM ... 166
VERIFINE PLUS PEN NDL 31G 5MM ... 166
VERIFINE PLUS PEN NDL 31G 8MM ... 166
VERIFINE PLUS PEN NDL 32G 4MM ... 166
VERIFINE PLUS PEN NDL 32G 4MM-SHARPS CONTAINER ..... 166
VERIFINE SYRING 0.5 ML 29G 1/2" ..... 166
VERIFINE SYRING 1 ML 31G 5/16" ..... 166
VERIFINE SYRNG 0.3 ML 31G 5/16" ..... 166
VERIFINE SYRNG 0.5 ML 31G 5/16" ..... 166
VERQUVO ..... 396
VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY ..... 166
VERZENIO ..... 6
*vigabatrin* ..... 397
*vigadrone* ..... 397
*vigpoder* ..... 397
VITRAKVI ORAL CAPSULE 100 MG, 25 MG ..... 188
VITRAKVI ORAL SOLUTION ..... 188
VIVIMUSTA ..... 50
VIZIMPRO ..... 81
VONJO ..... 256
VOQUEZNA ..... 400
VORANIGO ..... 401
*voriconazole oral suspension for reconstitution* ..... 402
VOSEVI ..... 322
VOWST ..... 129
VUMERITY ..... 94
VYALEV ..... 139
VYLOY ..... 407
VYNDAMAX ..... 336
WEBCOL ALCOHOL PREPS 20'S,LARGE ..... 166
WELIREG ..... 49
WINREVAIR ..... 329
WM UNIFINE PENTIP PLUS 8MM 31G W/ SAFETY CLICK ..... 166
XALKORI ORAL CAPSULE ..... 77
XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG ..... 78
XDEMVY ..... 209
XERMELO ..... 345
XIFAXAN ORAL TABLET 200 MG, 550 MG ..... 290
XOLAIR ..... 249
XOSPATA ..... 146
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK) ..... 310
XTANDI ORAL CAPSULE ..... 117
XTANDI ORAL TABLET 40 MG, 80 MG ..... 117
YERVOY ..... 180
YESINTEK ..... 386, 388
YONSA ..... 8
YUFLYMA(CF) ..... 15
YUFLYMA(CF) AI CROHN'S-UC-HS ..... 15
YUFLYMA(CF) AUTOINJECTOR ..... 15
*yulithira oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg* ..... 127
YUTREPIA ..... 372
ZEJULA ..... 237
ZELBORAF ..... 393
ZIIHERA ..... 403

ZIRABEV ..... 54
ZOLADEX ..... 152
ZTALMY ..... 143
ZTLIDO ..... 204
ZURZUVAE ORAL CAPSULE 20 MG,
25 MG, 30 MG ..... 409
ZYDELIG ..... 158
ZYKADIA ..... 68
ZYNLONTA ..... 207
ZYNYZ ..... 286