Cox HealthPlans Medicare Part D Plan

ABALOPARATIDE

Products Affected

- TYMLOS

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

Formulary ID: 27347 version 6
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ABEMACICLIB

Products Affected

- VERZENIO

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

ABIRATERONE

Products Affected

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

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

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

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

ACALABRUTINIB

Products Affected

- CALQUENCE ORAL TABLET

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

ADAGRASIB

Products Affected

- KRAZATI

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

ADALIMUMAB

Products Affected

- HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT
- HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML
- HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML
- HUMIRA-PED>/=40KG UC STARTER SUBCUTANEOUS AUTO-INJECTOR KIT
- HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR 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.
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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC

PA Criteria	Criteria Details
	DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: 1) DOES NOT HAVE ISOLATED ANTERIOR UVEITIS, AND 2) FOR POSTERIOR UVEITIS, TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A GLUCOCORTICOID. 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 (1 pen) auto-injector kit 40 mg/0.4ml subcutaneous*
- *adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml*
- *adalimumab-aaty (2 pen)*
- *adalimumab-aaty (2 syringe)*
- *adalimumab-aaty cd/uc/hs start*

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL

PA Criteria	Criteria Details
	IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: 1) DOES NOT HAVE ISOLATED ANTERIOR UVEITIS, AND 2) FOR POSTERIOR UVEITIS, TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A GLUCOCORTICOID. 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

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2)

PA Criteria	Criteria Details
	CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: 1) DOES NOT HAVE ISOLATED ANTERIOR UVEITIS, AND 2) FOR POSTERIOR UVEITIS, TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A GLUCOCORTICOID. 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	PLAN YEAR
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ALECTINIB

Products Affected

- ALECENSA

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

ALPELISIB-PIQRAY

Products Affected

- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)

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

AMBRISENTAN

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
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: PLAN YEAR.
Other Criteria	PAH: INITIAL: DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS.
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: PLAN YEAR.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AMIVANTAMAB-HYALURONIDASE-LPUJ

Products Affected

- RYBREVANT FASPRO

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

AMIVANTAMAB-VMJW

Products Affected

- RYBREVANT

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

ANAKINRA

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. RENEWAL: RA: 1) CONTINUES TO BENEFIT FROM THE

PA Criteria	Criteria Details
	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

ANIFROLUMAB-FNIA

Products Affected

- SAPHNELO PEN

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

APALUTAMIDE

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

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

APOMORPHINE - ONAPGO

Products Affected

- ONAPGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PD: 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 XR
- OTEZLA/OTEZLA XR INITIATION PK

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: A CONVENTIONAL SYSTEMIC THERAPY (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE), A CONVENTIONAL TOPICAL THERAPY (E.G., TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS:

PA Criteria	Criteria Details
	IMMUNOSUPPRESSANT, 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

ARMODAFINIL

Products Affected

- *armodafinil*

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

ASCIMINIB

Products Affected

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

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

ASFOTASE ALFA

Products Affected

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

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

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

ATOGEPANT

Products Affected

- QULIPTA

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

AVACOPAN

Products Affected

- TAVNEOS

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

AVAPRITINIB

Products Affected

- AYVAKIT

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

AVUTOMETINIB-DEFACTINIB

Products Affected

- AVMAPKI FAKZYNJA CO-PACK

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

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AXATILIMAB-CSFR

Products Affected

- NIKTIMVO INTRAVENOUS SOLUTION 22 MG/2.2ML, 9 MG/0.9ML

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

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

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

AZACITIDINE

Products Affected

- ONUREG

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

AZTREONAM INHALED

Products Affected

- CAYSTON

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

BEDAQUILINE

Products Affected

- SIRTURO

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

BELIMUMAB

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: SLE: CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: CLINICAL IMPROVEMENT WHILE ON THERAPY. LN: CLINICAL IMPROVEMENT IN RENAL RESPONSE FROM BASELINE LABORATORY VALUES (I.E., EGFR OR PROTEINURIA) AND/OR CLINICAL PARAMETERS. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

BELUMOSUDIL

Products Affected

- REZUROCK

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

BELZUTIFAN

Products Affected

- WELIREG

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

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BENDAMUSTINE

Products Affected

- *bendamustine hcl intravenous solution reconstituted 25 mg*

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

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

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

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

BEXAROTENE

Products Affected

- *bexarotene*

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

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BINIMETINIB

Products Affected

- MEKTOVI

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

BORTEZOMIB

Products Affected

- BORTEZOMIB INJECTION

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

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BOSUTINIB

Products Affected

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

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

BRIGATINIB

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLET THERAPY PACK

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

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BUDESONIDE-TARPEYO

Products Affected
- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IGAN): INITIAL: 1) DIAGNOSIS IS CONFIRMED BY A RENAL BIOPSY, 2) EGFR OF AT LEAST 35 ML/MIN/1.73 M2, AND 3) PROGRESSIVELY DECLINING GLOMERULAR FILTRATION RATE AND/OR WORSENING PROTEINURIA.
Age Restrictions	
Prescriber Restrictions	PRIMARY IGAN: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PRIMARY IGAN: INITIAL: 1) TRIAL AND CONTINUATION OF AN ACE INHIBITOR OR AN ARB AT MAXIMUM TOLERATED DOSE FOR AT LEAST 3 MONTHS OR CONTRAINDICATION TO BOTH CLASSES, AND 2) TRIAL AND CONTINUATION OF OR CONTRAINDICATION TO SGLT2 INHIBITOR. RENEWAL: 1) IMPROVED OR STABLE KIDNEY FUNCTION COMPARED TO BASELINE, OR 2) REDUCTION IN PROTEINURIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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C1 ESTERASE INHIBITOR-HAEGARDA

Products Affected

- HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) TYPE I OR II HAE CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q, OR 2) TYPE III HAE CONFIRMED BY: (A) RECURRENT, NON-URTICARIAL ANGIOEDEMA INVOLVING THE SKIN, GASTROINTESTINAL TRACT, OR AIRWAY, CONSISTENT WITH BRADYKININ-MEDIATED HAE AND ATTACKS NOT EXPLAINED BY HISTAMINERGIC/URTICARIAL ANGIOEDEMA, AND (B) OTHER CAUSES OF ANGIOEDEMA HAVE BEEN EXCLUDED, INCLUDING ACE-INHIBITOR/ARB-ASSOCIATED ANGIOEDEMA, ACQUIRED C1-INH DEFICIENCY, AND MAST-CELL/HISTAMINERGIC ANGIOEDEMA.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, ALLERGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HAE: INITIAL/RENEWAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	

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

CABOZANTINIB CAPSULE

Products Affected

- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)

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

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CABOZANTINIB TABLET

Products Affected

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

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

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CANNABIDIOL

Products Affected

- EPIDIOLEX

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

CAPIVASERTIB

Products Affected

- TRUQAP ORAL TABLET 200 MG
- TRUQAP ORAL TABLET THERAPY PACK 160 MG

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

CAPMATINIB

Products Affected

- TABRECTA

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

CARGLUMIC ACID

Products Affected

- *carglumic acid oral tablet soluble*

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/RENEWAL: PLAN YEAR.
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

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CERITINIB

Products Affected

- ZYKADIA ORAL TABLET

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

CLOBAZAM-SYMPAZAN

Products Affected
- SYMPAZAN

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

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COBIMETINIB

Products Affected

- COTELLIC

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

CORTICOTROPIN-CORTROPHIN

Products Affected

- CORTROPHIN

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: PLAN YEAR.
Other Criteria	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO THE CLINICAL STANDARD OF CARE AGENT: 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

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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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CRIZOTINIB PELLETS

Products Affected

- XALKORI ORAL CAPSULE SPRINKLE
  150 MG, 20 MG, 50 MG

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

DABRAFENIB CAPSULES

Products Affected

- TAFINLAR ORAL CAPSULE

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

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DABRAFENIB SUSPENSION

Products Affected

- TAFINLAR ORAL TABLET SOLUBLE

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

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DACOMITINIB

Products Affected

- VIZIMPRO

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

DALFAMPRIDINE

Products Affected

- *dalfampridine er*

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

DARAXONRASIB

Products Affected

- RASONQUE

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

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DAROLUTAMIDE

Products Affected
- NUBEQA

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

DASATINIB-SPRYCEL

Products Affected

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

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

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DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

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

DEFERASIROX

Products Affected

- *deferasirox granules*
- *deferasirox oral tablet*

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

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

DENOSUMAB-BMWO - OSENVELT

Products Affected

- OSENVELT

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

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DEUTETRABENAZINE

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR PATIENT TITRATION

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

DIAZEPAM

Products Affected

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

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

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DICLOFENAC TOPICAL SOLUTION

Products Affected

- *diclofenac sodium external solution 2 %*

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

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DIHYDROERGOTAMINE - NASAL

Products Affected

- *dihydroergotamine mesylate nasal*

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

DIMETHYL FUMARATE

Products Affected

- *dimethyl fumarate oral capsule delayed release 120 mg, 240 mg*
- *dimethyl fumarate starter pack oral capsule delayed release therapy pack*

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

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DIROXIMEL FUMARATE

Products Affected

- VUMERITY

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

DORDAVIPRONE

Products Affected

- MODEYSO

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

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DRONABINOL CAPSULE

Products Affected

- *dronabinol oral capsule*

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

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

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. EOSINOPHILIC CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): BLOOD EOSINOPHIL LEVEL OF AT LEAST 300 CELLS/MCL.
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,AFRS: 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	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID, CALCINEURIN INHIBITOR, PDE4 INHIBITOR, OR JAK INHIBITOR). ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-

PA Criteria	Criteria Details
	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 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. 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, FOUR TIMES THE MAXIMALLY LABELED DOSE OF A SECOND GENERATION H1 ANTI-HISTAMINE, AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. ALLERGIC FUNGAL RHINOSINUSITIS (AFRS): 1) INADEQUATELY CONTROLLED DISEASE POST ENDOSCOPIC SINUS SURGERY, AND 2) A 56 DAY TRIAL OF ONE CLINICAL STANDARD OF CARE AGENT: A TOPICAL NASAL CORTICOSTEROID. INITIAL/RENEWAL: ALL INDICATIONS EXCEPT BULLOUS PEMPHIGOID (BP) AND AFRS: 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: 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

PA Criteria	Criteria Details
	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. AFRS: CONTINUES TO BENEFIT FROM THE MEDICATION.
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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

EFLORNITHINE

Products Affected

- IWILFIN

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

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ELACESTRANT

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

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

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ELAGOLIX

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ELAPEGADEMASE-LVLR

Products Affected

- REVCOVI

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

ELEXACAFTOR-TEZACAFTOR-IVACAFTOR

Products Affected

- TRIKAFTA ORAL TABLET THERAPY PACK
- TRIKAFTA ORAL THERAPY PACK

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/RENEWAL: PLAN YEAR.
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

ELTROMBOPAG - PROMACTA

Products Affected

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

PA Criteria	Criteria Details
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/RENEWAL: PLAN YEAR. HEPATITIS C, SEVERE APLASTIC ANEMIA: PLAN YEAR.
Other Criteria	INITIAL: ITP: 1) INSUFFICIENT RESPONSE TO SPLENECTOMY, OR TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: CORTICOSTEROID, INTRAVENOUS IMMUNOGLOBULIN (IVIG). ALL INDICATIONS: REQUESTS FOR BRAND PROMACTA REQUIRE A TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: GENERIC ELTROMBOPAG OLAMINE. INITIAL/RENEWAL: ITP: NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS). RENEWAL: ITP: IMPROVEMENT IN PLATELET COUNTS FROM BASELINE OR REDUCTION IN BLEEDING EVENTS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ENCORAFENIB

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

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

ENSARTINIB

Products Affected

- ENSACOVE ORAL CAPSULE 100 MG, 25 MG

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

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ENTRECTINIB CAPSULES

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

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

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ENTRECTINIB PELLETS

Products Affected

- ROZLYTREK ORAL PACKET

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

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ENZALUTAMIDE

Products Affected

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

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

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EPOETIN ALFA-EPBX

Products Affected

- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ANEMIA DUE TO CHRONIC KIDNEY DISEASE (CKD), ZIDOVUDINE OR CANCER CHEMOTHERAPY: HEMOGLOBIN (HGB) LEVEL IS LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HGB LEVEL IS 13G/DL OR LESS. RENEWAL: ANEMIA DUE TO CKD: 1) ADULTS: (A) HGB LEVEL IS LESS THAN 10G/DL, OR (B) HGB LEVEL HAS REACHED 10G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS, OR 2) PEDIATRICS: (A) HGB LEVEL IS LESS THAN 10G/DL, OR (B) HGB LEVEL HAS APPROACHED OR EXCEEDS 12G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA RELATED TO ZIDOVUDINE: HGB LEVEL IS BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO CHEMO: 1) HGB LEVEL IS LESS THAN 10G/DL, OR 2) HGB LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RED BLOOD CELL (RBC) TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: PLAN YEAR. SURGERY: 1 MONTH.
Other Criteria	INITIAL: SURGERY: NO CONCURRENT USE WITH ANOTHER ERYTHROPOIESIS-STIMULATING AGENT (ESA) OR A HYPOXIA-INDUCIBLE FACTOR PROLYL HYDROXYLASE INHIBITOR (HIF-PHI). INITIAL/RENEWAL: ANEMIA DUE TO CKD/ZIDOVUDINE/CHEMO: NO CONCURRENT USE WITH

PA Criteria	Criteria Details
	ANOTHER ESA OR A HIF-PHI. RENEWAL: ANEMIA DUE TO CKD: NOT RECEIVING DIALYSIS TREATMENT.
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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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ERENUMAB-AOOE

Products Affected

- AIMOVIG

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

ERLOTINIB

Products Affected

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

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

ETANERCEPT

Products Affected

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

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: 1) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: ADALIMUMAB-AATY, HADLIMA. PJIA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: ADALIMUMAB-AATY, HADLIMA. PSA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN:

PA Criteria	Criteria Details
	ADALIMUMAB-AATY, HADLIMA. AS: 1) TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: ADALIMUMAB-AATY, HADLIMA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), (B) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: ADALIMUMAB-AATY, HADLIMA. 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

ETRASIMOD

Products Affected

- VELSIPITY

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

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EVEROLIMUS-AFINITOR

Products Affected

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

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

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EVEROLIMUS-AFINITOR DISPERZ

Products Affected

- *everolimus oral tablet soluble*

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

FECAL MICROBIOTA CAPSULE

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CLOSTRIDIOIDES DIFFICILE INFECTION (CDI): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	30 DAYS
Other Criteria	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	Yes

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FEDRATINIB

Products Affected

- INREBIC

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

FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

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

FEZOLINETANT

Products Affected
- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

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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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

FINERENONE

Products Affected
- KERENDIA

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

FINGOLIMOD

Products Affected

- *fingolimod hcl*

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

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FOSCARBIDOPA-FOSLEVODOPA

Products Affected

- VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML

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

FRUQUINTINIB

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

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

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FUTIBATINIB

Products Affected

- LYTGOBI (12 MG DAILY DOSE)
- LYTGOBI (16 MG DAILY DOSE)
- LYTGOBI (20 MG DAILY DOSE)

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

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GALCANEZUMAB-GNLM

Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINE PREVENTION: PLAN YEAR. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): PLAN YEAR.
Other Criteria	MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY. EPISODIC CLUSTER HEADACHE: INITIAL: SYMPTOMS WERE NOT ADEQUATELY MANAGED WITH ABORTIVE THERAPIES (E.G., IMITREX, ZOMIG). 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	Yes

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GANAXOLONE

Products Affected

- ZTALMY

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

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GEFITINIB

Products Affected

- *gefitinib*

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

GEPIRONE

Products Affected

- EXXUA
- EXXUA TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

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GILTERITINIB

Products Affected

- XOSPATA

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

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

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

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GLATIRAMER

Products Affected

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

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

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GLP1-DULAGLUTIDE

Products Affected

- TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR

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

GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)
- RYBELSUS
- RYBELSUS (FORMULATION R2)

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

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GLP1-TIRZEPATIDE

Products Affected

- MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR

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

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GUSELKUMAB

Products Affected

- TREMFYA INTRAVENOUS
- TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR
- TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML
- TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- TREMFYA-CD/UC INDUCTION

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G.,

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

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

Products Affected

- *butalbital-apap-caffeine oral tablet 50-325-40 mg*

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

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

Products Affected

- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*

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

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HIGH RISK DRUGS IN THE ELDERLY - DIPYRIDAMOLE

Products Affected

- *dipyridamole oral*

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

HIGH RISK DRUGS IN THE ELDERLY - ESTRADIOL-NORETHINDRONE

Products Affected

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

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

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HIGH RISK DRUGS IN THE ELDERLY - ESTROGEN-MEDROXYPROGESTERONE

Products Affected

- PREMPHASE
- PREMPRO

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

HIGH RISK DRUGS IN THE ELDERLY - GLYBURIDE

Products Affected

- *glyburide micronized*
- *glyburide oral*

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

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HIGH RISK DRUGS IN THE ELDERLY - GLYBURIDE/METFORMIN

Products Affected

- *glyburide-metformin*

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

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HIGH RISK DRUGS IN THE ELDERLY - KETOROLAC

Products Affected

- *ketorolac tromethamine oral*

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

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HIGH RISK DRUGS IN THE ELDERLY - PHENOBARBITAL

Products Affected

- *phenobarbital oral elixir 20 mg/5ml*
- *phenobarbital oral tablet*

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

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HIGH RISK DRUGS IN THE ELDERLY - PROMETHAZINE

Products Affected

- *promethazine hcl oral tablet*

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

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

HIGH RISK DRUGS IN THE ELDERLY - SCOPOLAMINE

Products Affected

- *scopolamine*

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

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HIGH RISK DRUGS IN THE ELDERLY-DIPHENOXYLATE-ATROPINE

Products Affected

- *diphenoxylate-atropine oral tablet 2.5-0.025 mg*

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

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HIGH RISK DRUGS IN THE ELDERLY-INDOMETHACIN

Products Affected

- *indomethacin oral capsule 25 mg, 50 mg*

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

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HIGH RISK DRUGS IN THE ELDERLY-MEGESTROL

Products Affected

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

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

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HIGH RISK DRUGS IN THE ELDERLY-PAROXETINE

Products Affected

- *paroxetine hcl*
- *paroxetine hcl er*

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

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IBERDOMIDE

Products Affected

- ZENBEXUS

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

IBRUTINIB

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG

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

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ICATIBANT

Products Affected

- *icatibant acetate*

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	No

IDELALISIB

Products Affected

- ZYDELIG

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

IMATINIB

Products Affected

- *imatinib mesylate oral tablet 100 mg, 400 mg*

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

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IMATINIB SOLUTION

Products Affected
- IMKELDI

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

IMLUNESTRANT

Products Affected

- INLURIYO

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

INAVOLISIB

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

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

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INFLIXIMAB

Products Affected

- *infliximab*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/ADALIMUMAB-AATY/HADLIMA, SELARSDI/YESINTEK/OTULFI, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, OTEZLA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/ADALIMUMAB-AATY/HADLIMA, SELARSDI/YESINTEK/OTULFI, SKYRIZI, TREMFYA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ.

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

INFLIXIMAB-DYYB SQ

Products Affected

- ZYMFENTRA (1 PEN) AUTO-INJECTOR KIT 120 MG/ML SUBCUTANEOUS
- ZYMFENTRA (2 PEN)
- ZYMFENTRA (2 SYRINGE)

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

INSULIN SUPPLIES PAYMENT DETERMINATION

Products Affected

- 1ST TIER UNIFINE PENTIPS 29G X 12MM
- 1ST TIER UNIFINE PENTIPS 31G X 5 MM
- 1ST TIER UNIFINE PENTIPS 31G X 6 MM
- 1ST TIER UNIFINE PENTIPS 31G X 8 MM
- 1ST TIER UNIFINE PENTIPS 32G X 4 MM
- 1ST TIER UNIFINE PENTIPS 32G X 6 MM
- 1ST TIER UNIFINE PENTIPS 33G X 4 MM
- 1ST TIER UNIFINE PENTIPS PLUS 29G X 12MM
- 1ST TIER UNIFINE PENTIPS PLUS 31G X 5 MM
- 1ST TIER UNIFINE PENTIPS PLUS 31G X 6 MM
- 1ST TIER UNIFINE PENTIPS PLUS 31G X 8 MM
- 1ST TIER UNIFINE PENTIPS PLUS 32G X 4 MM
- 1ST TIER UNIFINE PENTIPS PLUS 33G X 4 MM
- ABOUTTIME PEN NEEDLE 30G X 8 MM
- ABOUTTIME PEN NEEDLE 31G X 5 MM
- ABOUTTIME PEN NEEDLE 31G X 8 MM
- ABOUTTIME PEN NEEDLE 32G X 4 MM
- ADVOCATE ALCOHOL PREP PADS PAD 70 %
- ADVOCATE INSULIN PEN NEEDLE 32G X 4 MM
- ADVOCATE INSULIN PEN NEEDLES 29G X 12.7MM
- ADVOCATE INSULIN PEN NEEDLES 31G X 5 MM
- ADVOCATE INSULIN PEN NEEDLES 31G X 8 MM
- ADVOCATE INSULIN PEN NEEDLES 33G X 4 MM
- ADVOCATE INSULIN SYRINGE 29G X 1/2" 0.3 ML
- ADVOCATE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ADVOCATE INSULIN SYRINGE 29G X 1/2" 1 ML
- ADVOCATE INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ADVOCATE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ADVOCATE INSULIN SYRINGE 30G X 5/16" 1 ML
- ADVOCATE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- ADVOCATE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- ADVOCATE INSULIN SYRINGE 31G X 5/16" 1 ML
- ALCOHOL PADS PAD 70 %
- ALCOHOL PREP PAD
- ALCOHOL PREP PAD 70 %
- ALCOHOL PREP PADS PAD 70 %
- ALCOHOL SWABS PAD
- ALCOHOL SWABS PAD 70 %
- AQ INSULIN SYRINGE 29G X 1/2" 1 ML
- AQ INSULIN SYRINGE 30G X 5/16" 0.5 ML
- AQ INSULIN SYRINGE 31G X 5/16" 1 ML

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- AQINJECT PEN NEEDLE 31G X 5 MM
- AQINJECT PEN NEEDLE 32G X 4 MM
- ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM
- ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 1 ML
- ASSURE ID PRO PEN NEEDLES 30G X 5 MM
- ASSURE ID SAFETY PEN NEEDLES 30G X 8 MM
- AUM ALCOHOL PREP PADS PAD 70 %
- AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM
- AUM INSULIN SAFETY PEN NEEDLE 31G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 4 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 6 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 8 MM
- AUM MINI INSULIN PEN NEEDLE 33G X 4 MM
- AUM MINI INSULIN PEN NEEDLE 33G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 33G X 6 MM
- AUM PEN NEEDLE 32G X 4 MM
- AUM PEN NEEDLE 32G X 5 MM
- AUM PEN NEEDLE 32G X 6 MM
- AUM PEN NEEDLE 33G X 4 MM
- AUM PEN NEEDLE 33G X 5 MM
- AUM PEN NEEDLE 33G X 6 MM
- AUM READYGARD DUO PEN NEEDLE 32G X 4 MM
- AUM SAFETY PEN NEEDLE 31G X 4 MM
- AUM SAFETY PEN NEEDLE 31G X 5 MM
- AURORA PEN NEEDLES 29G X 12MM
- AURORA PEN NEEDLES 31G X 6 MM
- AURORA PEN NEEDLES 31G X 8 MM
- AUTOKEEPER SAFETY PEN NEEDLE 30G X 5 MM
- AUTOKEEPER SAFETY PEN NEEDLE 30G X 8 MM
- BD AUTOSHIELD DUO 30G X 5 MM
- BD ECLIPSE SYRINGE 30G X 1/2" 1 ML
- BD INS SYR ULTRAFINE 1/2UNIT 31G X 5/16" 0.3 ML
- BD INSULIN SYR ULTRAFINE II 31G X 5/16" 0.3 ML
- BD INSULIN SYR ULTRAFINE II 31G X 5/16" 0.5 ML
- BD INSULIN SYR ULTRAFINE II 31G X 5/16" 1 ML
- BD INSULIN SYRINGE 27.5G X 5/8" 2 ML
- BD INSULIN SYRINGE 27G X 1/2" 1 ML
- BD INSULIN SYRINGE 29G X 1/2" 0.3 ML
- BD INSULIN SYRINGE 29G X 1/2" 0.5 ML (OTC)
- BD INSULIN SYRINGE 29G X 1/2" 0.5 ML (RX)
- BD INSULIN SYRINGE 29G X 1/2" 1 ML (OTC)
- BD INSULIN SYRINGE 29G X 1/2" 1 ML (RX)
- BD INSULIN SYRINGE HALF-UNIT 31G X 5/16" 0.3 ML
- BD INSULIN SYRINGE MICROFINE 27G X 5/8" 1 ML
- BD INSULIN SYRINGE MICROFINE 28G X 1/2" 0.5 ML
- BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (OTC)
- BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (RX)
- BD INSULIN SYRINGE U-100 1 ML
- BD INSULIN SYRINGE U/F 30G X 1/2" 1 ML

- BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 0.3 ML
- BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 0.5 ML
- BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.3 ML
- BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.5 ML
- BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 1 ML
- BD INSULIN SYRINGE ULTRAFINE 31G X 5/16" 0.3 ML
- BD INSULIN SYRINGE ULTRAFINE 31G X 5/16" 0.5 ML
- BD INSULIN SYRINGE ULTRAFINE 31G X 5/16" 1 ML
- BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM
- BD PEN NEEDLE MINI U/F 31G X 5 MM
- BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM
- BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM
- BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM
- BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM
- BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM
- BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.3 ML
- BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 1 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- BD SAFETYGLIDE SYRINGE/NEEDLE 27G X 5/8" 1 ML
- BD SWAB SINGLE USE REGULAR PAD
- BD VEO INSULIN SYR U/F 1/2UNIT 31G X 15/64" 0.3 ML
- BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.3 ML
- BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.5 ML
- BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 1 ML
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.3 ML
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.5 ML
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 1 ML
- CAREFINE PEN NEEDLES 29G X 12MM
- CAREFINE PEN NEEDLES 30G X 8 MM
- CAREFINE PEN NEEDLES 31G X 6 MM
- CAREFINE PEN NEEDLES 31G X 8 MM
- CAREFINE PEN NEEDLES 32G X 4 MM
- CAREFINE PEN NEEDLES 32G X 5 MM
- CAREFINE PEN NEEDLES 32G X 6 MM
- CAREONE INSULIN SYRINGE 30G X 1/2" 0.3 ML
- CAREONE INSULIN SYRINGE 30G X 1/2" 0.5 ML
- CAREONE INSULIN SYRINGE 30G X 1/2" 1 ML
- CAREONE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- CAREONE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- CAREONE INSULIN SYRINGE 31G X 5/16" 1 ML

- CAREONE UNIFINE PENTIPS PLUS 29G X 12MM
- CAREONE UNIFINE PENTIPS PLUS 31G X 5 MM
- CAREONE UNIFINE PENTIPS PLUS 31G X 6 MM
- CAREONE UNIFINE PENTIPS PLUS 31G X 8 MM
- CAREONE UNIFINE PENTIPS PLUS 32G X 4 MM
- CAREONE UNIFINE PENTIPS PLUS 33G X 4 MM
- CARETOUCH ALCOHOL PREP PAD 70 %
- CARETOUCH INSULIN SYRINGE 28G X 5/16" 1 ML
- CARETOUCH INSULIN SYRINGE 29G X 5/16" 1 ML
- CARETOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML
- CARETOUCH INSULIN SYRINGE 30G X 5/16" 1 ML
- CARETOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML
- CARETOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML
- CARETOUCH INSULIN SYRINGE 31G X 5/16" 1 ML
- CARETOUCH PEN NEEDLES 29G X 12MM
- CARETOUCH PEN NEEDLES 31G X 5 MM
- CARETOUCH PEN NEEDLES 31G X 6 MM
- CARETOUCH PEN NEEDLES 31G X 8 MM
- CARETOUCH PEN NEEDLES 32G X 4 MM
- CARETOUCH PEN NEEDLES 32G X 5 MM
- CARETOUCH PEN NEEDLES 33G X 4 MM
- CLEVER CHOICE COMFORT EZ 29G X 12MM
- CLEVER CHOICE COMFORT EZ 33G X 4 MM
- CLICKFINE PEN NEEDLES 31G X 5 MM
- CLICKFINE PEN NEEDLES 31G X 6 MM
- CLICKFINE PEN NEEDLES 31G X 8 MM
- CLICKFINE PEN NEEDLES 32G X 4 MM
- COMFORT ASSIST INSULIN SYRINGE 29G X 1/2" 1 ML
- COMFORT ASSIST INSULIN SYRINGE 31G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 27G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 1 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 1 ML

- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 1 ML
- COMFORT EZ MICRO PEN NEEDLES 32G X 4 MM
- COMFORT EZ PEN NEEDLES 31G X 5 MM
- COMFORT EZ PEN NEEDLES 31G X 6 MM
- COMFORT EZ PEN NEEDLES 31G X 8 MM
- COMFORT EZ PEN NEEDLES 32G X 4 MM
- COMFORT EZ PEN NEEDLES 32G X 5 MM
- COMFORT EZ PEN NEEDLES 32G X 6 MM
- COMFORT EZ PEN NEEDLES 32G X 8 MM
- COMFORT EZ PEN NEEDLES 33G X 4 MM
- COMFORT EZ PEN NEEDLES 33G X 5 MM
- COMFORT EZ PEN NEEDLES 33G X 6 MM
- COMFORT EZ PEN NEEDLES 33G X 8 MM
- COMFORT EZ PRO PEN NEEDLES 30G X 8 MM
- COMFORT EZ PRO PEN NEEDLES 31G X 4 MM
- COMFORT EZ PRO PEN NEEDLES 31G X 5 MM
- COMFORT EZ SHORT PEN NEEDLES 31G X 8 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 4 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 6 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 8 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 4 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 6 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 8 MM
- COMFORT TOUCH INSULIN PEN NEED 33G X 4 MM
- COMFORT TOUCH INSULIN PEN NEED 33G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 33G X 6 MM
- CURITY ALCOHOL PREPS PAD 70 %
- CURITY ALL PURPOSE SPONGES PAD 2"X2"
- CURITY GAUZE PAD 2"X2"
- CURITY GAUZE SPONGE PAD 2"X2"
- CURITY SPONGES PAD 2"X2"
- CVS ALCOHOL PREP PADS PAD 70 %
- CVS GAUZE PAD 2"X2"
- CVS GAUZE STERILE PAD 2"X2"
- *cvs isopropyl alcohol wipes*
- CVS PREP PAD 70 %
- DERMACEA GAUZE SPONGE PAD 2"X2"
- DERMACEA IV DRAIN SPONGES PAD 2"X2"
- DERMACEA NON-WOVEN SPONGES PAD 2"X2"
- DERMACEA TYPE VII GAUZE PAD 2"X2"
- DIATHRIVE PEN NEEDLE 31G X 5 MM
- DIATHRIVE PEN NEEDLE 31G X 6 MM
- DIATHRIVE PEN NEEDLE 31G X 8 MM
- DIATHRIVE PEN NEEDLE 32G X 4 MM

- DROPLET INSULIN SYRINGE 29G X 1/2" 0.3 ML
- DROPLET INSULIN SYRINGE 29G X 1/2" 0.5 ML
- DROPLET INSULIN SYRINGE 29G X 1/2" 1 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 1 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 1 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 1 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 0.3 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 0.5 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 1 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 0.3 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 0.5 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 1 ML
- DROPLET MICRON 34G X 3.5 MM
- DROPLET PEN NEEDLES 29G X 10MM
- DROPLET PEN NEEDLES 29G X 12MM
- DROPLET PEN NEEDLES 30G X 8 MM
- DROPLET PEN NEEDLES 31G X 5 MM
- DROPLET PEN NEEDLES 31G X 6 MM
- DROPLET PEN NEEDLES 31G X 8 MM
- DROPLET PEN NEEDLES 32G X 4 MM
- DROPLET PEN NEEDLES 32G X 5 MM
- DROPLET PEN NEEDLES 32G X 6 MM
- DROPLET PEN NEEDLES 32G X 8 MM
- DROPSAFE ALCOHOL PREP PAD 70 %
- DROPSAFE AUTOPROTECT DUO 31G X 4 MM
- DROPSAFE AUTOPROTECT DUO 31G X 5 MM
- DROPSAFE AUTOPROTECT DUO 31G X 8 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 5 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 6 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 8 MM
- DROPSAFE SAFETY SYRINGE/NEEDLE 29G X 1/2" 1 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.3 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.5 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 1 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.3 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.5 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 1 ML
- DRUG MART UNIFINE PENTIPS 29G X 12MM
- DRUG MART UNIFINE PENTIPS 31G X 6 MM
- DRUG MART UNIFINE PENTIPS 31G X 8 MM
- DRUG MART UNIFINE PENTIPS PLUS 32G X 4 MM

- EASY COMFORT ALCOHOL PADS PAD
- EASY COMFORT INSULIN SYRINGE 29G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 29G X 5/16" 1 ML
- EASY COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML
- EASY COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- EASY COMFORT INSULIN SYRINGE 31G X 1/2" 0.3 ML
- EASY COMFORT INSULIN SYRINGE 31G X 5/16" 0.3 ML
- EASY COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- EASY COMFORT INSULIN SYRINGE 32G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 32G X 5/16" 1 ML
- EASY COMFORT PEN NEEDLES 29G X 4MM
- EASY COMFORT PEN NEEDLES 29G X 5MM
- EASY COMFORT PEN NEEDLES 31G X 5 MM
- EASY COMFORT PEN NEEDLES 31G X 6 MM
- EASY COMFORT PEN NEEDLES 31G X 8 MM
- EASY COMFORT PEN NEEDLES 32G X 4 MM
- EASY COMFORT PEN NEEDLES 33G X 4 MM
- EASY COMFORT PEN NEEDLES 33G X 5 MM
- EASY COMFORT PEN NEEDLES 33G X 6 MM
- EASY GLIDE PEN NEEDLES 33G X 4 MM
- EASY TOUCH ALCOHOL PREP MEDIUM PAD 70 %
- EASY TOUCH FLIPLOCK INSULIN SY 29G X 1/2" 1 ML
- EASY TOUCH FLIPLOCK INSULIN SY 30G X 1/2" 1 ML
- EASY TOUCH FLIPLOCK INSULIN SY 30G X 5/16" 1 ML
- EASY TOUCH FLIPLOCK INSULIN SY 31G X 5/16" 1 ML
- EASY TOUCH FLIPLOCK SAFETY SYR 27G X 1/2" 1 ML
- EASY TOUCH INSULIN BARRELS U-100 1 ML
- EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 1 ML
- EASY TOUCH INSULIN SAFETY SYR 30G X 1/2" 1 ML
- EASY TOUCH INSULIN SAFETY SYR 30G X 5/16" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 27G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 27G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML
- EASY TOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 28G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 29G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 1 ML

- EASY TOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 30G X 5/16" 1 ML
- EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 31G X 5/16" 1 ML
- EASY TOUCH PEN NEEDLES 29G X 12MM
- EASY TOUCH PEN NEEDLES 30G X 5 MM
- EASY TOUCH PEN NEEDLES 30G X 6 MM
- EASY TOUCH PEN NEEDLES 30G X 8 MM
- EASY TOUCH PEN NEEDLES 31G X 5 MM
- EASY TOUCH PEN NEEDLES 31G X 6 MM
- EASY TOUCH PEN NEEDLES 31G X 8 MM
- EASY TOUCH PEN NEEDLES 32G X 4 MM
- EASY TOUCH PEN NEEDLES 32G X 5 MM
- EASY TOUCH PEN NEEDLES 32G X 6 MM
- EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM
- EASY TOUCH SAFETY PEN NEEDLES 29G X 8MM
- EASY TOUCH SAFETY PEN NEEDLES 30G X 8 MM
- EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2" 1 ML
- EASY TOUCH SHEATHLOCK SYRINGE 30G X 1/2" 1 ML
- EASY TOUCH SHEATHLOCK SYRINGE 30G X 5/16" 1 ML
- EASY TOUCH SHEATHLOCK SYRINGE 31G X 5/16" 1 ML
- EMBECTA AUTOSHIELD DUO 30G X 5 MM
- EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML
- EMBECTA INS SYR U/F 1/2 UNIT 31G X 5/16" 0.3 ML
- EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.3 ML
- EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.5 ML
- EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 1 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64" 0.3 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64" 0.5 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64" 1 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16" 0.3 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16" 0.5 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16" 1 ML
- EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML
- EMBECTA INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)
- EMBECTA INSULIN SYRINGE 28G X 1/2" 1 ML (RX)
- EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML
- EMBECTA INSULIN SYRINGE U-500
- EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM
- EMBECTA PEN NEEDLE NANO 32G X 4 MM
- EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM
- EMBECTA PEN NEEDLE ULTRAFINE 31G X 5 MM

- EMBECTA PEN NEEDLE ULTRAFINE 31G X 8 MM
- EMBECTA PEN NEEDLE ULTRAFINE 32G X 6 MM
- EMBRACE PEN NEEDLES 29G X 12MM
- EMBRACE PEN NEEDLES 30G X 5 MM
- EMBRACE PEN NEEDLES 30G X 8 MM
- EMBRACE PEN NEEDLES 31G X 5 MM
- EMBRACE PEN NEEDLES 31G X 6 MM
- EMBRACE PEN NEEDLES 31G X 8 MM
- EMBRACE PEN NEEDLES 32G X 4 MM
- EQL ALCOHOL SWABS PAD 70 %
- EQL GAUZE PAD 2"X2"
- EQL INSULIN SYRINGE 29G X 1/2" 0.3 ML
- EQL INSULIN SYRINGE 29G X 1/2" 0.5 ML
- EQL INSULIN SYRINGE 29G X 1/2" 1 ML
- EQL INSULIN SYRINGE 30G X 5/16" 0.3 ML
- EQL INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EQL INSULIN SYRINGE 30G X 5/16" 1 ML
- EQL INSULIN SYRINGE 31G X 5/16" 0.3 ML
- EQL INSULIN SYRINGE 31G X 5/16" 0.5 ML
- EQL INSULIN SYRINGE 31G X 5/16" 1 ML
- EXEL COMFORT POINT PEN NEEDLE 29G X 12MM
- FIFTY50 ALCOHOL PREP PAD 70 %
- FIFTY50 PEN NEEDLES 31G X 5 MM
- FIFTY50 PEN NEEDLES 31G X 8 MM
- FIFTY50 PEN NEEDLES 32G X 4 MM
- FIFTY50 PEN NEEDLES 32G X 6 MM
- FIFTY50 SUPERIOR COMFORT SYR 31G X 5/16" 0.3 ML
- FIFTY50 SUPERIOR COMFORT SYR 31G X 5/16" 0.5 ML
- FIFTY50 SUPERIOR COMFORT SYR 31G X 5/16" 1 ML
- GAUZE PADS PAD 2"X2"
- GAUZE TYPE VII MEDI-PAK PAD 2"X2"
- GLOBAL ALCOHOL PREP EASE
- GLOBAL EASE INJECT PEN NEEDLES 29G X 12MM
- GLOBAL EASE INJECT PEN NEEDLES 31G X 5 MM
- GLOBAL EASE INJECT PEN NEEDLES 31G X 8 MM
- GLOBAL EASE INJECT PEN NEEDLES 32G X 4 MM
- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 0.3 ML
- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 0.5 ML
- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 1 ML
- GLOBAL EASY GLIDE INSULIN SYR 31G X 5/16" 0.3 ML
- GLOBAL EASY GLIDE PEN NEEDLES 32G X 4 MM
- GLOBAL INJECT EASE INSULIN SYR 28G X 1/2" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 28G X 1/2" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 29G X 1/2" 0.3 ML
- GLOBAL INJECT EASE INSULIN SYR 29G X 1/2" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 29G X 1/2" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 1/2" 0.3 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 1/2" 0.5 ML

- GLOBAL INJECT EASE INSULIN SYR 30G X 1/2" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 5/16" 0.3 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 5/16" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 5/16" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 31G X 5/16" 0.3 ML
- GLOBAL INJECT EASE INSULIN SYR 31G X 5/16" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 31G X 5/16" 1 ML
- GLOBAL INSULIN SYRINGES 30G X 1/2" 0.3 ML
- GLOBAL INSULIN SYRINGES 30G X 5/16" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 30G X 1/2" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 30G X 1/2" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 30G X 1/2" 1 ML
- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 1 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 1 ML
- GNP ALCOHOL SWABS PAD 70 %
- GNP CLICKFINE PEN NEEDLES 31G X 6 MM
- GNP CLICKFINE PEN NEEDLES 31G X 8 MM
- GNP INSULIN SYRINGE 28G X 1/2" 0.5 ML
- GNP INSULIN SYRINGE 29G X 1/2" 0.3 ML
- GNP INSULIN SYRINGE 29G X 1/2" 0.5 ML
- GNP INSULIN SYRINGE 29G X 1/2" 1 ML
- GNP INSULIN SYRINGE 30G X 5/16" 0.3 ML
- GNP INSULIN SYRINGE 30G X 5/16" 0.5 ML
- GNP INSULIN SYRINGE 30G X 5/16" 1 ML
- GNP INSULIN SYRINGE 31G X 5/16" 0.3 ML
- GNP INSULIN SYRINGE 31G X 5/16" 0.5 ML
- GNP INSULIN SYRINGE 31G X 5/16" 1 ML
- GNP INSULIN SYRINGES 28GX1/2" 28G X 1/2" 1 ML
- GNP INSULIN SYRINGES 29GX1/2" 29G X 1/2" 0.5 ML
- GNP INSULIN SYRINGES 29GX1/2" 29G X 1/2" 1 ML
- GNP INSULIN SYRINGES 30G X 5/16" 1 ML
- GNP INSULIN SYRINGES 30GX5/16" 30G X 5/16" 0.3 ML
- GNP INSULIN SYRINGES 31GX5/16" 31G X 5/16" 0.3 ML
- GNP PEN NEEDLES 31G X 5 MM
- GNP PEN NEEDLES 31G X 8 MM
- GNP PEN NEEDLES 32G X 4 MM
- GNP PEN NEEDLES 32G X 6 MM
- GNP STERILE GAUZE PAD 2"X2"
- GNP ULTICARE PEN NEEDLES 31G X 5 MM
- GNP ULTICARE PEN NEEDLES 31G X 8 MM
- GNP ULTICARE PEN NEEDLES 32G X 4 MM
- GNP ULTICARE PEN NEEDLES 32G X 6 MM

- GNP ULTIGUARD SAFEPACK NEEDLE 31G X 5 MM
- GNP ULTIGUARD SAFEPACK NEEDLE 31G X 8 MM
- GNP ULTIGUARD SAFEPACK NEEDLE 32G X 4 MM
- GNP ULTIGUARD SAFEPACK NEEDLE 32G X 6 MM
- GNP ULTRA COM INSULIN SYRINGE 28G X 1/2" 1 ML
- GOODSENSE ALCOHOL SWABS PAD 70 %
- GOODSENSE CLICKFINE PEN NEEDLE 31G X 5 MM
- GOODSENSE PEN NEEDLE PENFINE 31G X 5 MM
- GOODSENSE PEN NEEDLE PENFINE 31G X 8 MM
- GOODSENSE PEN NEEDLE PENFINE 32G X 4 MM
- GOODSENSE PEN NEEDLE PENFINE 32G X 6 MM
- H-E-B INCONTROL ALCOHOL PAD
- H-E-B INCONTROL PEN NEEDLES 29G X 12MM
- H-E-B INCONTROL PEN NEEDLES 31G X 5 MM
- H-E-B INCONTROL PEN NEEDLES 31G X 6 MM
- H-E-B INCONTROL PEN NEEDLES 31G X 8 MM
- H-E-B INCONTROL PEN NEEDLES 32G X 4 MM
- H-E-B INCONTROL UNIFINE PENTIP 31G X 5 MM
- H-E-B INCONTROL UNIFINE PENTIP 31G X 6 MM
- H-E-B INCONTROL UNIFINE PENTIP 31G X 8 MM
- H-E-B INCONTROL UNIFINE PENTIP 32G X 4 MM
- H-E-B INCONTROL UNIFINE PENTIP 33G X 4 MM
- HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 0.3 ML
- HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 0.5 ML
- HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 1 ML
- HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 0.3 ML
- HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 0.5 ML
- HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 1 ML
- HEALTHWISE MICRON PEN NEEDLES 32G X 4 MM
- HEALTHWISE SHORT PEN NEEDLES 31G X 5 MM
- HEALTHWISE SHORT PEN NEEDLES 31G X 8 MM
- HM STERILE PADS PAD 2"X2"
- HM ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML
- HM ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- HM ULTICARE MINI PEN NEEDLES 31G X 5 MM
- HM ULTICARE SHORT PEN NEEDLES 31G X 8 MM
- INCONTROL ULTICARE PEN NEEDLES 31G X 6 MM
- INCONTROL ULTICARE PEN NEEDLES 31G X 8 MM
- INCONTROL ULTICARE PEN NEEDLES 32G X 4 MM
- INSULIN SYRINGE 28G X 1/2" 0.5 ML
- INSULIN SYRINGE 29G X 1/2" 0.3 ML
- INSULIN SYRINGE 29G X 1/2" 0.5 ML
- INSULIN SYRINGE 29G X 1/2" 1 ML
- INSULIN SYRINGE 30G X 5/16" 0.3 ML
- INSULIN SYRINGE 30G X 5/16" 0.5 ML
- INSULIN SYRINGE 30G X 5/16" 1 ML
- INSULIN SYRINGE 31G X 5/16" 0.3 ML

- INSULIN SYRINGE 31G X 5/16" 0.5 ML
- INSULIN SYRINGE 31G X 5/16" 1 ML
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 1 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 30G X 1/2" 1 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 30G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 30G X 5/16" 0.3 ML
- INSULIN SYRINGE-NEEDLE U-100 30G X 5/16" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 30G X 5/16" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 30G X 5/16" 1 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 0.3 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 0.5 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 1 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 0.3 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 1 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 1 ML (RX)
- INSUPEN PEN NEEDLES 29G X 12MM
- INSUPEN PEN NEEDLES 31G X 5 MM
- INSUPEN PEN NEEDLES 31G X 8 MM
- INSUPEN PEN NEEDLES 32G X 4 MM
- INSUPEN PEN NEEDLES 33G X 4 MM
- INSUPEN SENSITIVE 32G X 6 MM
- INSUPEN SENSITIVE 32G X 8 MM
- INSUPEN ULTRAFIN 30G X 8 MM
- INSUPEN ULTRAFIN 31G X 6 MM
- INSUPEN ULTRAFIN 31G X 8 MM
- INSUPEN32G EXTR3ME 32G X 6 MM
- J & J GAUZE PAD 2"X2"
- KENDALL HYDROPHILIC FOAM DRESS PAD 2"X2"
- KENDALL HYDROPHILIC FOAM PLUS PAD 2"X2"
- KINRAY INSULIN SYRINGE 29G X 1/2" 0.5 ML
- KINRAY INSULIN SYRINGE 31G X 5/16" 0.3 ML
- KINRAY INSULIN SYRINGE 31G X 5/16" 0.5 ML
- KINRAY INSULIN SYRINGE 31G X 5/16" 1 ML
- KMART VALU INSULIN SYRINGE 29G U-100 0.5 ML
- KMART VALU INSULIN SYRINGE 29G U-100 1 ML
- KMART VALU INSULIN SYRINGE 30G U-100 0.3 ML
- KMART VALU INSULIN SYRINGE 30G U-100 0.5 ML

- KMART VALU INSULIN SYRINGE 30G U-100 1 ML
- KROGER INSULIN SYRINGE 29G X 1/2" 0.3 ML
- KROGER INSULIN SYRINGE 29G X 1/2" 0.5 ML
- KROGER INSULIN SYRINGE 29G X 1/2" 1 ML
- KROGER INSULIN SYRINGE 30G X 5/16" 0.3 ML
- KROGER INSULIN SYRINGE 30G X 5/16" 0.5 ML
- KROGER INSULIN SYRINGE 30G X 5/16" 1 ML
- KROGER INSULIN SYRINGE 31G X 5/16" 0.3 ML
- KROGER INSULIN SYRINGE 31G X 5/16" 0.5 ML
- KROGER INSULIN SYRINGE 31G X 5/16" 1 ML
- KROGER PEN NEEDLES 29G X 12MM
- KROGER PEN NEEDLES 31G X 5 MM
- KROGER PEN NEEDLES 31G X 6 MM
- KROGER PEN NEEDLES 31G X 8 MM
- KROGER PEN NEEDLES 32G X 4 MM
- KROGER PEN NEEDLES 33G X 4 MM
- LEADER INSULIN SYRINGE 28G X 1/2" 0.5 ML
- LEADER INSULIN SYRINGE 28G X 1/2" 1 ML
- LEADER INSULIN SYRINGE 29G X 1/2" 0.3 ML
- LEADER INSULIN SYRINGE 29G X 1/2" 0.5 ML
- LEADER INSULIN SYRINGE 29G X 1/2" 1 ML
- LEADER INSULIN SYRINGE 30G X 5/16" 0.3 ML
- LEADER INSULIN SYRINGE 30G X 5/16" 0.5 ML
- LEADER INSULIN SYRINGE 30G X 5/16" 1 ML
- LEADER INSULIN SYRINGE 31G X 5/16" 0.3 ML
- LEADER INSULIN SYRINGE 31G X 5/16" 0.5 ML
- LEADER INSULIN SYRINGE 31G X 5/16" 1 ML
- LEADER UNIFINE PENTIPS 31G X 5 MM
- LEADER UNIFINE PENTIPS 32G X 4 MM
- LEADER UNIFINE PENTIPS PLUS 31G X 5 MM
- LEADER UNIFINE PENTIPS PLUS 31G X 8 MM
- LEADER UNIFINE PENTIPS PLUS 32G X 4 MM
- LITETOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML
- LITETOUCH INSULIN SYRINGE 28G X 1/2" 1 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.3 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 1 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 1 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 1 ML
- LITETOUCH PEN NEEDLES 29G X 12.7MM
- LITETOUCH PEN NEEDLES 31G X 5 MM
- LITETOUCH PEN NEEDLES 31G X 6 MM
- LITETOUCH PEN NEEDLES 31G X 8 MM

- LITETOUCH PEN NEEDLES 32G X 4 MM
- LONGS INSULIN SYRINGE 31G X 5/16" 0.5 ML
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.3 ML
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 1 ML
- MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 0.3 ML
- MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 0.5 ML
- MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 1 ML
- MARATHON MEDICAL PENTIPS 29G X 12MM
- MARATHON MEDICAL PENTIPS 31G X 5 MM
- MARATHON MEDICAL PENTIPS 31G X 8 MM
- MARATHON MEDICAL PENTIPS 32G X 4 MM
- MAXI-COMFORT INSULIN SYRINGE 28G X 1/2" 0.5 ML
- MAXI-COMFORT INSULIN SYRINGE 28G X 1/2" 1 ML
- MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM
- MAXI-COMFORT SAFETY PEN NEEDLE 29G X 8MM
- MAXICOMFORT II PEN NEEDLE 31G X 6 MM
- MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 0.5 ML
- MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 1 ML
- MEDIC INSULIN SYRINGE 30G X 5/16" 0.3 ML
- MEDIC INSULIN SYRINGE 30G X 5/16" 0.5 ML
- MEDICINE SHOPPE PEN NEEDLES 29G X 12MM
- MEDICINE SHOPPE PEN NEEDLES 31G X 8 MM
- MEDPURA ALCOHOL PADS 70 % EXTERNAL
- MEIJER ALCOHOL SWABS PAD 70 %
- MEIJER PEN NEEDLES 29G X 12MM
- MEIJER PEN NEEDLES 31G X 6 MM
- MEIJER PEN NEEDLES 31G X 8 MM
- MICRODOT PEN NEEDLE 31G X 6 MM
- MICRODOT PEN NEEDLE 32G X 4 MM
- MICRODOT PEN NEEDLE 33G X 4 MM
- MIRASORB SPONGES 2"X2"
- MM INSULIN SYRINGE/NEEDLE 30G X 5/16" 0.3 ML
- MM INSULIN SYRINGE/NEEDLE 30G X 5/16" 0.5 ML
- MM INSULIN SYRINGE/NEEDLE 30G X 5/16" 1 ML
- MM INSULIN SYRINGE/NEEDLE 31G X 5/16" 0.3 ML
- MM INSULIN SYRINGE/NEEDLE 31G X 5/16" 0.5 ML
- MM INSULIN SYRINGE/NEEDLE 31G X 5/16" 1 ML
- MM PEN NEEDLES 31G X 5 MM
- MM PEN NEEDLES 31G X 6 MM
- MM PEN NEEDLES 31G X 8 MM
- MM PEN NEEDLES 32G X 4 MM
- MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML
- MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (OTC)
- MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 0.5 ML (RX)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (RX)

- MONOJECT INSULIN SYRINGE 29G X 1/2" 0.3 ML
- MONOJECT INSULIN SYRINGE 29G X 1/2" 0.5 ML
- MONOJECT INSULIN SYRINGE 29G X 1/2" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 30G X 5/16" 0.3 ML
- MONOJECT INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)
- MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (OTC)
- MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 31G X 5/16" 1 ML
- MONOJECT INSULIN SYRINGE U-100 1 ML
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (RX)
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (RX)
- MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.3 ML
- MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.5 ML
- MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 1 ML
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (RX)
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (RX)
- MONOJECT ULTRA COMFORT SYRINGE 31G X 5/16" 0.3 ML
- MONOJECT ULTRA COMFORT SYRINGE 31G X 5/16" 0.5 ML
- MS INSULIN SYRINGE 31G X 5/16" 0.3 ML
- MS INSULIN SYRINGE 31G X 5/16" 0.5 ML
- MS INSULIN SYRINGE 31G X 5/16" 1 ML
- NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8 MM
- NOVOFINE PEN NEEDLE 32G X 6 MM
- NOVOFINE PLUS PEN NEEDLE 32G X 4 MM
- PC UNIFINE PENTIPS 31G X 5 MM
- PC UNIFINE PENTIPS 31G X 6 MM
- PC UNIFINE PENTIPS 31G X 8 MM
- PEN NEEDLE/5-BEVEL TIP 31G X 8 MM
- PEN NEEDLE/5-BEVEL TIP 32G X 4 MM
- PEN NEEDLES 29G X 12MM
- PEN NEEDLES 30G X 5 MM (OTC)
- PEN NEEDLES 30G X 5 MM (RX)
- PEN NEEDLES 30G X 8 MM
- PEN NEEDLES 31G X 5 MM (OTC)
- PEN NEEDLES 31G X 5 MM (RX)
- PEN NEEDLES 31G X 6 MM
- PEN NEEDLES 31G X 8 MM (OTC)
- PEN NEEDLES 31G X 8 MM (RX)
- PEN NEEDLES 32G X 4 MM (OTC)
- PEN NEEDLES 32G X 4 MM (RX)
- PEN NEEDLES 32G X 5 MM
- PEN NEEDLES 32G X 6 MM
- PEN NEEDLES 33G X 4 MM
- PEN NEEDLES 5/16" 31G X 8 MM
- PENTIPS 29G X 12MM (OTC)
- PENTIPS 29G X 12MM (RX)
- PENTIPS 31G X 5 MM (OTC)
- PENTIPS 31G X 5 MM (RX)
- PENTIPS 31G X 6 MM
- PENTIPS 31G X 8 MM (OTC)
- PENTIPS 31G X 8 MM (RX)
- PENTIPS 32G X 4 MM (OTC)
- PENTIPS 32G X 4 MM (RX)
- PENTIPS 32G X 6 MM

- PENTIPS GENERIC PEN NEEDLES 29G X 12MM
- PENTIPS GENERIC PEN NEEDLES 31G X 5 MM
- PENTIPS GENERIC PEN NEEDLES 31G X 6 MM
- PENTIPS GENERIC PEN NEEDLES 31G X 8 MM
- PENTIPS GENERIC PEN NEEDLES 32G X 4 MM
- PENTIPS GENERIC PEN NEEDLES 32G X 6 MM
- PHARMACIST CHOICE ALCOHOL PAD
- PIP PEN NEEDLES 31G X 5MM 31G X 5 MM
- PIP PEN NEEDLES 32G X 4MM 32G X 4 MM
- PRECISION SURE-DOSE SYRINGE 30G X 5/16" 0.3 ML
- PREFERRED PLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML
- PREFERRED PLUS INSULIN SYRINGE 28G X 1/2" 1 ML
- PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 0.3 ML
- PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML
- PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 1 ML
- PREFERRED PLUS INSULIN SYRINGE 30G X 5/16" 0.3 ML
- PREFERRED PLUS INSULIN SYRINGE 30G X 5/16" 0.5 ML
- PREFERRED PLUS INSULIN SYRINGE 30G X 5/16" 1 ML
- PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM
- PREVENT DROPSAFE PEN NEEDLES 31G X 6 MM
- PREVENT DROPSAFE PEN NEEDLES 31G X 8 MM
- PREVENT SAFETY PEN NEEDLES 31G X 6 MM
- PREVENT SAFETY PEN NEEDLES 31G X 8 MM
- PRO COMFORT ALCOHOL PAD 70 %
- PRO COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML
- PRO COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- PRO COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- PRO COMFORT PEN NEEDLES 32G X 4 MM
- PRO COMFORT PEN NEEDLES 32G X 5 MM
- PRO COMFORT PEN NEEDLES 32G X 6 MM
- PRO COMFORT PEN NEEDLES 32G X 8 MM
- PRODIGY INSULIN SYRINGE 28G X 1/2" 1 ML
- PRODIGY INSULIN SYRINGE 31G X 5/16" 0.3 ML
- PRODIGY INSULIN SYRINGE 31G X 5/16" 0.5 ML
- PURE COMFORT ALCOHOL PREP PAD
- PURE COMFORT PEN NEEDLE 32G X 4 MM
- PURE COMFORT PEN NEEDLE 32G X 5 MM
- PURE COMFORT PEN NEEDLE 32G X 6 MM
- PURE COMFORT PEN NEEDLE 32G X 8 MM
- PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM
- PURE COMFORT SAFETY PEN NEEDLE 31G X 6 MM

- PURE COMFORT SAFETY PEN NEEDLE 32G X 4 MM
- PX EXTRA SHORT PEN NEEDLES 31G X 6 MM
- PX INSULIN SYRINGE 30G X 1/2" 0.5 ML
- PX MINI PEN NEEDLES 31G X 5 MM
- PX PEN NEEDLE 29G X 12MM
- PX PEN NEEDLE 31G X 8 MM
- QC ALCOHOL
- QC ALCOHOL SWABS PAD 70 %
- QC BORDER ISLAND GAUZE PAD 2"X2"
- QC PEN NEEDLES 29G X 12MM
- QC PEN NEEDLES 31G X 6 MM
- QC PEN NEEDLES 31G X 8 MM
- QC UNIFINE PENTIPS 32G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 29G X 12.7MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 5 MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 6 MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 8 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 5 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 6 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 8 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 5 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 6 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 8 MM
- RA ALCOHOL SWABS PAD 70 %
- RA INSULIN SYRINGE 29G X 1/2" 0.5 ML
- RA INSULIN SYRINGE 29G X 1/2" 1 ML
- RA INSULIN SYRINGE 30G X 5/16" 0.5 ML
- RA INSULIN SYRINGE 30G X 5/16" 1 ML
- *ra isopropyl alcohol wipes*
- RA PEN NEEDLES 31G X 5 MM
- RA PEN NEEDLES 31G X 8 MM
- RA STERILE PAD 2"X2"
- RAYA SURE PEN NEEDLE 29G X 12MM
- RAYA SURE PEN NEEDLE 31G X 4 MM
- RAYA SURE PEN NEEDLE 31G X 5 MM
- RAYA SURE PEN NEEDLE 31G X 6 MM
- RAYA SURE PEN NEEDLE 31G X 8 MM
- REALITY INSULIN SYRINGE 28G X 1/2" 0.5 ML
- REALITY INSULIN SYRINGE 28G X 1/2" 1 ML
- REALITY INSULIN SYRINGE 29G X 1/2" 0.5 ML
- REALITY INSULIN SYRINGE 29G X 1/2" 1 ML
- REALITY SWABS PAD
- RELI-ON INSULIN SYRINGE 29G 0.3 ML
- RELION ALCOHOL SWABS PAD
- RELION ALCOHOL SWABS PAD 70 %
- RELION INSULIN SYRINGE 29G X 1/2" 0.5 ML
- RELION INSULIN SYRINGE 31G X 15/64" 0.3 ML
- RELION INSULIN SYRINGE 31G X 15/64" 0.5 ML
- RELION INSULIN SYRINGE 31G X 15/64" 1 ML

- RELION INSULIN SYRINGE 31G X 5/16" 0.3 ML
- RELION INSULIN SYRINGE 31G X 5/16" 0.5 ML
- RELION INSULIN SYRINGE 31G X 5/16" 1 ML
- RELION MINI PEN NEEDLES 31G X 6 MM
- RELION PEN NEEDLES 29G X 12MM
- RELION PEN NEEDLES 31G X 6 MM
- RELION PEN NEEDLES 31G X 8 MM
- RELION PEN NEEDLES 32G X 4 MM
- RELION SHORT PEN NEEDLES 31G X 8 MM
- RESTORE CONTACT LAYER PAD 2"X2"
- SAFETY PEN NEEDLES 30G X 5 MM
- SAFETY PEN NEEDLES 30G X 8 MM
- SAPS CARE ALCOHOL PREP PAD 70 %
- SAPS HEALTH ALCOHOL PREP PAD 70 %
- SAPS HEALTH CARE ALCOHOL PREP PAD 70 %
- SB ALCOHOL PREP PAD 70 %
- SB INSULIN SYRINGE 29G X 1/2" 0.5 ML
- SB INSULIN SYRINGE 29G X 1/2" 1 ML
- SB INSULIN SYRINGE 30G X 5/16" 0.5 ML
- SB INSULIN SYRINGE 30G X 5/16" 1 ML
- SB INSULIN SYRINGE 31G X 5/16" 1 ML
- SECURESAFE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- SECURESAFE INSULIN SYRINGE 29G X 1/2" 1 ML
- SECURESAFE SAFETY PEN NEEDLES 30G X 8 MM
- SECURESAFE SAFETY PEN NEEDLES 31G X 5 MM
- SM STERILE PAD 2"X2"
- STERILE GAUZE PAD 2"X2"
- STERILE PAD 2"X2"
- SURE COMFORT ALCOHOL PREP PAD 70 %
- SURE COMFORT INSULIN SYRINGE 28G X 1/2" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 28G X 1/2" 1 ML
- SURE COMFORT INSULIN SYRINGE 29G X 1/2" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 29G X 1/2" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 29G X 1/2" 1 ML
- SURE COMFORT INSULIN SYRINGE 30G X 1/2" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML
- SURE COMFORT INSULIN SYRINGE 30G X 5/16" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- SURE COMFORT INSULIN SYRINGE 31G X 1/4" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 31G X 1/4" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 31G X 1/4" 1 ML
- SURE COMFORT INSULIN SYRINGE 31G X 5/16" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- SURE COMFORT PEN NEEDLES 29G X 12.7MM
- SURE COMFORT PEN NEEDLES 30G X 8 MM
- SURE COMFORT PEN NEEDLES 31G X 5 MM

- SURE COMFORT PEN NEEDLES 31G X 6 MM
- SURE COMFORT PEN NEEDLES 31G X 8 MM
- SURE COMFORT PEN NEEDLES 32G X 4 MM (OTC)
- SURE COMFORT PEN NEEDLES 32G X 4 MM (RX)
- SURE COMFORT PEN NEEDLES 32G X 6 MM
- SURGICAL GAUZE SPONGE PAD 2"X2"
- TECHLITE INSULIN SYRINGE 30G X 1/2" 1 ML
- TECHLITE INSULIN SYRINGE 31G X 15/64" 0.3 ML
- TECHLITE INSULIN SYRINGE 31G X 15/64" 0.5 ML
- TECHLITE INSULIN SYRINGE 31G X 15/64" 1 ML
- TECHLITE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- TECHLITE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- TECHLITE INSULIN SYRINGE 31G X 5/16" 1 ML
- TECHLITE PEN NEEDLES 29G X 12MM
- TECHLITE PEN NEEDLES 31G X 5 MM
- TECHLITE PEN NEEDLES 31G X 8 MM
- TECHLITE PEN NEEDLES 32G X 4 MM
- TECHLITE PEN NEEDLES 32G X 6 MM
- TECHLITE PLUS PEN NEEDLES 32G X 4 MM
- TEGADERM FOAM PAD 2"X2"
- TODAYS HEALTH PEN NEEDLES 29G X 12MM
- TODAYS HEALTH SHORT PEN NEEDLE 31G X 8 MM
- TOPCARE CLICKFINE PEN NEEDLES 31G X 6 MM
- TOPCARE CLICKFINE PEN NEEDLES 31G X 8 MM
- TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 0.3 ML
- TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 0.5 ML
- TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 1 ML
- TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 0.3 ML
- TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 0.5 ML
- TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 1 ML
- TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 0.3 ML
- TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 0.5 ML
- TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 1 ML
- TOPFINE INSULIN PEN NEEDLE 32G X 4 MM
- TRUE COMFORT ALCOHOL PREP PADS PAD 70 %
- TRUE COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- TRUE COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML
- TRUE COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- TRUE COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- TRUE COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- TRUE COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- TRUE COMFORT INSULIN SYRINGE 32G X 5/16" 1 ML
- TRUE COMFORT PEN NEEDLES 31G X 5 MM
- TRUE COMFORT PEN NEEDLES 31G X 6 MM

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- TRUE COMFORT PEN NEEDLES 32G X 4 MM
- TRUE COMFORT PRO ALCOHOL PREP PAD 70 %
- TRUE COMFORT PRO INSULIN SYR 30G X 1/2" 0.5 ML
- TRUE COMFORT PRO INSULIN SYR 30G X 1/2" 1 ML
- TRUE COMFORT PRO INSULIN SYR 30G X 5/16" 0.5 ML
- TRUE COMFORT PRO INSULIN SYR 30G X 5/16" 1 ML
- TRUE COMFORT PRO INSULIN SYR 31G X 5/16" 0.5 ML
- TRUE COMFORT PRO INSULIN SYR 31G X 5/16" 1 ML
- TRUE COMFORT PRO INSULIN SYR 32G X 5/16" 0.5 ML
- TRUE COMFORT PRO INSULIN SYR 32G X 5/16" 1 ML
- TRUE COMFORT PRO PEN NEEDLES 31G X 5 MM
- TRUE COMFORT PRO PEN NEEDLES 31G X 6 MM
- TRUE COMFORT PRO PEN NEEDLES 31G X 8 MM
- TRUE COMFORT PRO PEN NEEDLES 32G X 4 MM
- TRUE COMFORT PRO PEN NEEDLES 32G X 5 MM
- TRUE COMFORT PRO PEN NEEDLES 32G X 6 MM
- TRUE COMFORT PRO PEN NEEDLES 33G X 4 MM
- TRUE COMFORT PRO PEN NEEDLES 33G X 5 MM
- TRUE COMFORT PRO PEN NEEDLES 33G X 6 MM
- TRUE COMFORT SAFETY PEN NEEDLE 31G X 5 MM
- TRUE COMFORT SAFETY PEN NEEDLE 31G X 6 MM
- TRUE COMFORT SAFETY PEN NEEDLE 32G X 4 MM
- TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM
- TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM
- TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM
- TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM
- TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM
- TRUEPLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 28G X 1/2" 1 ML
- TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 29G X 1/2" 1 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 1 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 1 ML
- TRUEPLUS PEN NEEDLES 29G X 12MM
- TRUEPLUS PEN NEEDLES 31G X 5 MM
- TRUEPLUS PEN NEEDLES 31G X 6 MM
- TRUEPLUS PEN NEEDLES 31G X 8 MM
- TRUEPLUS PEN NEEDLES 32G X 4 MM
- ULTICARE ALCOHOL SWABS PAD

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- ULTICARE ALCOHOL SWABS PAD 70 %
- ULTICARE INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- ULTICARE INSULIN SAFETY SYR 29G X 1/2" 1 ML
- ULTICARE INSULIN SYR 1/2 UNIT 31G X 1/4" 0.3 ML
- ULTICARE INSULIN SYRINGE 28G X 1/2" 0.5 ML
- ULTICARE INSULIN SYRINGE 28G X 1/2" 1 ML
- ULTICARE INSULIN SYRINGE 29G X 1/2" 0.3 ML
- ULTICARE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ULTICARE INSULIN SYRINGE 29G X 1/2" 1 ML
- ULTICARE INSULIN SYRINGE 30G X 1/2" 0.3 ML
- ULTICARE INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML
- ULTICARE INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML (OTC)
- ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)
- ULTICARE INSULIN SYRINGE 30G X 5/16" 1 ML
- ULTICARE INSULIN SYRINGE 31G X 1/4" 0.3 ML
- ULTICARE INSULIN SYRINGE 31G X 1/4" 0.5 ML
- ULTICARE INSULIN SYRINGE 31G X 1/4" 1 ML
- ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML (OTC)
- ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML (RX)
- ULTICARE INSULIN SYRINGE 31G X 5/16" 0.5 ML (OTC)
- ULTICARE INSULIN SYRINGE 31G X 5/16" 0.5 ML (RX)
- ULTICARE INSULIN SYRINGE 31G X 5/16" 1 ML
- ULTICARE MICRO PEN NEEDLES 31G X 6 MM
- ULTICARE MICRO PEN NEEDLES 31G X 8 MM
- ULTICARE MICRO PEN NEEDLES 32G X 4 MM
- ULTICARE MINI PEN NEEDLES 30G X 5 MM
- ULTICARE MINI PEN NEEDLES 31G X 6 MM
- ULTICARE MINI PEN NEEDLES 32G X 6 MM
- ULTICARE PEN NEEDLES 29G X 12.7MM (OTC)
- ULTICARE PEN NEEDLES 29G X 12.7MM (RX)
- ULTICARE PEN NEEDLES 31G X 5 MM
- ULTICARE SHORT PEN NEEDLES 30G X 8 MM
- ULTICARE SHORT PEN NEEDLES 31G X 8 MM (OTC)
- ULTICARE SHORT PEN NEEDLES 31G X 8 MM (RX)
- ULTIGUARD SAFEPACK PEN NEEDLE 29G X 12.7MM
- ULTIGUARD SAFEPACK PEN NEEDLE 31G X 5 MM
- ULTIGUARD SAFEPACK PEN NEEDLE 31G X 6 MM
- ULTIGUARD SAFEPACK PEN NEEDLE 31G X 8 MM
- ULTIGUARD SAFEPACK PEN NEEDLE 32G X 4 MM
- ULTIGUARD SAFEPACK PEN NEEDLE 32G X 6 MM
- ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 0.3 ML
- ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 0.5 ML

- ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 1 ML
- ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 0.3 ML
- ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 0.5 ML
- ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 1 ML
- ULTILET ALCOHOL SWABS PAD
- ULTILET PEN NEEDLE 29G X 12.7MM
- ULTILET PEN NEEDLE 31G X 5 MM
- ULTILET PEN NEEDLE 31G X 8 MM
- ULTILET PEN NEEDLE 32G X 4 MM
- ULTRA COMFORT INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ULTRA FLO INSULIN PEN NEEDLES 29G X 12MM
- ULTRA FLO INSULIN PEN NEEDLES 31G X 5 MM
- ULTRA FLO INSULIN PEN NEEDLES 31G X 8 MM
- ULTRA FLO INSULIN PEN NEEDLES 32G X 4 MM
- ULTRA FLO INSULIN PEN NEEDLES 33G X 4 MM
- ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 1/2" 0.3 ML
- ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 5/16" 0.3 ML
- ULTRA FLO INSULIN SYR 1/2 UNIT 31G X 5/16" 0.3 ML
- ULTRA FLO INSULIN SYRINGE 29G X 1/2" 0.3 ML
- ULTRA FLO INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ULTRA FLO INSULIN SYRINGE 29G X 1/2" 1 ML
- ULTRA FLO INSULIN SYRINGE 30G X 1/2" 0.3 ML
- ULTRA FLO INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ULTRA FLO INSULIN SYRINGE 30G X 1/2" 1 ML
- ULTRA FLO INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ULTRA FLO INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ULTRA FLO INSULIN SYRINGE 30G X 5/16" 1 ML
- ULTRA FLO INSULIN SYRINGE 31G X 5/16" 0.3 ML
- ULTRA FLO INSULIN SYRINGE 31G X 5/16" 0.5 ML
- ULTRA FLO INSULIN SYRINGE 31G X 5/16" 1 ML
- ULTRA THIN PEN NEEDLES 32G X 4 MM
- ULTRA-CARE ALCOHOL PREP PADS PAD 70 %
- ULTRA-THIN II INS SYR SHORT 30G X 5/16" 0.3 ML
- ULTRA-THIN II INS SYR SHORT 30G X 5/16" 0.5 ML
- ULTRA-THIN II INS SYR SHORT 30G X 5/16" 1 ML
- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.3 ML
- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.5 ML
- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 1 ML
- ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 1 ML
- ULTRA-THIN II MINI PEN NEEDLE 31G X 5 MM
- ULTRA-THIN II PEN NEEDLE SHORT 31G X 8 MM
- ULTRA-THIN II PEN NEEDLES 29G X 12.7MM
- ULTRACARE INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ULTRACARE INSULIN SYRINGE 30G X 1/2" 1 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 0.3 ML

- ULTRACARE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 1 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 1 ML
- ULTRACARE PEN NEEDLES 31G X 5 MM
- ULTRACARE PEN NEEDLES 31G X 6 MM
- ULTRACARE PEN NEEDLES 31G X 8 MM
- ULTRACARE PEN NEEDLES 32G X 4 MM
- ULTRACARE PEN NEEDLES 32G X 5 MM
- ULTRACARE PEN NEEDLES 32G X 6 MM
- ULTRACARE PEN NEEDLES 33G X 4 MM
- UNIFINE OTC PEN NEEDLES 31G X 5 MM
- UNIFINE OTC PEN NEEDLES 32G X 4 MM
- UNIFINE PENTIPS 29G X 12MM
- UNIFINE PENTIPS 30G X 5 MM
- UNIFINE PENTIPS 31G X 5 MM
- UNIFINE PENTIPS 31G X 6 MM
- UNIFINE PENTIPS 31G X 8 MM
- UNIFINE PENTIPS 32G X 4 MM
- UNIFINE PENTIPS 32G X 6 MM
- UNIFINE PENTIPS 33G X 4 MM
- UNIFINE PENTIPS PLUS 29G X 12MM
- UNIFINE PENTIPS PLUS 30G X 5 MM
- UNIFINE PENTIPS PLUS 31G X 5 MM
- UNIFINE PENTIPS PLUS 31G X 6 MM
- UNIFINE PENTIPS PLUS 31G X 8 MM
- UNIFINE PENTIPS PLUS 32G X 4 MM
- UNIFINE PENTIPS PLUS 33G X 4 MM
- UNIFINE PROTECT PEN NEEDLE 30G X 5 MM
- UNIFINE PROTECT PEN NEEDLE 30G X 8 MM
- UNIFINE PROTECT PEN NEEDLE 32G X 4 MM
- UNIFINE SAFECONTROL PEN NEEDLE 30G X 5 MM
- UNIFINE SAFECONTROL PEN NEEDLE 30G X 8 MM
- UNIFINE SAFECONTROL PEN NEEDLE 31G X 5 MM
- UNIFINE SAFECONTROL PEN NEEDLE 31G X 6 MM
- UNIFINE SAFECONTROL PEN NEEDLE 31G X 8 MM
- UNIFINE SAFECONTROL PEN NEEDLE 32G X 4 MM
- UNIFINE ULTRA PEN NEEDLE 29G X 12MM
- UNIFINE ULTRA PEN NEEDLE 31G X 5 MM
- UNIFINE ULTRA PEN NEEDLE 31G X 6 MM
- UNIFINE ULTRA PEN NEEDLE 31G X 8 MM
- UNIFINE ULTRA PEN NEEDLE 32G X 4 MM
- UNIFINE ULTRA PEN NEEDLE 32G X 6 MM
- UNIFINE ULTRA PEN NEEDLE 34G X 3.5 MM
- VALUE HEALTH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- VALUE HEALTH INSULIN SYRINGE 29G X 1/2" 1 ML
- VANISHPOINT INSULIN SYRINGE 29G X 1/2" 1 ML
- VANISHPOINT INSULIN SYRINGE 29G X 5/16" 1 ML
- VANISHPOINT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- VANISHPOINT INSULIN SYRINGE 30G X 3/16" 0.5 ML

- VANISHPOINT INSULIN SYRINGE 30G X 3/16" 1 ML
- VANISHPOINT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- VANISHPOINT INSULIN SYRINGE 30G X 5/16" 1 ML
- VERIFINE INSULIN PEN NEEDLE 29G X 12MM
- VERIFINE INSULIN PEN NEEDLE 31G X 5 MM
- VERIFINE INSULIN PEN NEEDLE 31G X 8 MM
- VERIFINE INSULIN PEN NEEDLE 32G X 4 MM
- VERIFINE INSULIN PEN NEEDLE 32G X 6 MM
- VERIFINE INSULIN SYRINGE 28G X 1/2" 1 ML
- VERIFINE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- VERIFINE INSULIN SYRINGE 29G X 1/2" 1 ML
- VERIFINE INSULIN SYRINGE 30G X 1/2" 1 ML
- VERIFINE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- VERIFINE INSULIN SYRINGE 30G X 5/16" 1 ML
- VERIFINE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- VERIFINE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- VERIFINE INSULIN SYRINGE 31G X 5/16" 1 ML
- VERIFINE PLUS PEN NEEDLE 31G X 5 MM
- VERIFINE PLUS PEN NEEDLE 31G X 8 MM
- VERIFINE PLUS PEN NEEDLE 32G X 4 MM
- VERISAFE SAFETY INSULIN SYR 29G X 1/2" 1 ML
- VP INSULIN SYRINGE 29G X 1/2" 0.3 ML
- WEBCOL ALCOHOL PREP LARGE PAD 70 %
- WEBCOL ALCOHOL PREP MEDIUM PAD 70 %
- WEGMANS UNIFINE PENTIPS PLUS 31G X 5 MM
- WEGMANS UNIFINE PENTIPS PLUS 31G X 6 MM
- WEGMANS UNIFINE PENTIPS PLUS 31G X 8 MM
- WEGMANS UNIFINE PENTIPS PLUS 32G X 4 MM
- ZEVRX INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ZEVRX INSULIN SYRINGE 30G X 1/2" 1 ML
- ZEVRX INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ZEVRX INSULIN SYRINGE 30G X 5/16" 1 ML
- ZEVRX PEN NEEDLES 31G X 5 MM
- ZEVRX PEN NEEDLES 31G X 6 MM
- ZEVRX PEN NEEDLES 31G X 8 MM
- ZEVRX PEN NEEDLES 32G X 4 MM
- ZEVRX STERILE ALCOHOL PREP PAD PAD 70 %

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

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

INTERFERON FOR MS-AVONEX

Products Affected

- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT
- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT

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

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INTERFERON FOR MS-BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

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

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INTERFERON FOR MS-PLEGRIDY

Products Affected

- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

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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/RENEWAL: PLAN YEAR.
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

ISAVUCONAZONIUM

Products Affected

- CRESEMBA ORAL

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

IVACAFTOR

Products Affected
- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
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/RENEWAL: PLAN YEAR.
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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IXAZOMIB

Products Affected

- NINLARO

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

LAMOTRIGINE

Products Affected

- SUBVENITE ORAL SUSPENSION

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

LANREOTIDE

Products Affected

- LANREOTIDE ACETATE
- SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 60 MG/0.2ML, 90 MG/0.3ML

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

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LAPATINIB

Products Affected

- *lapatinib ditosylate*

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

LAROTRECTINIB

Products Affected

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

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

LAZERTINIB

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

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

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LECANEMAB-IRMB

Products Affected

- LEQEMBI IQLIK
- LEQEMBI IQLIK (500 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ALZHEIMERS DISEASE: INITIAL: 1) CLINICAL DEMENTIA RATING GLOBAL SCORE OF 0.5 OR 1.0, OR 2) MINI MENTAL STATUS EXAM SCORE OF 22-30.
Age Restrictions	
Prescriber Restrictions	ALZHEIMERS DISEASE: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR PSYCHIATRIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ALZHEIMERS DISEASE: INITIAL: 1) PRESENCE OF AMYLOID-BETA PLAQUES, 2) BASELINE BRAIN MRI WITHIN ONE YEAR PRIOR TO TREATMENT, 3) NO HISTORY OF A CLOTTING DISORDER, AND 4) NO CONCURRENT USE WITH ANY ANTICOAGULANT OR ANTIPLATELET THERAPY EXCEPT FOR ASPIRIN AT 81MG DAILY OR LESS. RENEWAL: 1) COGNITIVE DECLINE HAS SLOWED OR STOPPED, 2) NOT EXPERIENCING ANY SEVERE, UNSTABLE, OR SYMPTOMATIC AMYLOID-RELATED IMAGING ABNORMALITIES, AND 3) NO CONCURRENT USE WITH ANY ANTICOAGULANT OR ANTIPLATELET THERAPY EXCEPT FOR ASPIRIN AT 81MG DAILY OR LESS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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PA Criteria	Criteria Details
Prerequisite Therapy Required	No

LENALIDOMIDE

Products Affected

- *lenalidomide*

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

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LENVATINIB

Products Affected

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)

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

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LETERMOVIR

Products Affected

- PREVYMIS ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYTOMEGALOVIRUS (CMV) PROPHYLAXIS: PRESCRIBED BY OR IN CONSULTATION WITH A TRANSPLANT SPECIALIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	CMV PROPHYLAXIS: 7 MONTHS
Other Criteria	CMV PROPHYLAXIS FOR HSCT: 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 200 DAYS POST TRANSPLANT. CMV PROPHYLAXIS FOR 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 acetate injection*

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

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LEUPROLIDE DEPOT

Products Affected

- LEUPROLIDE ACETATE (3 MONTH)
- LUTRATE DEPOT

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

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LEUPROLIDE MESYLATE

Products Affected

- CAMCEVI

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

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LEUPROLIDE-ELIGARD

Products Affected

- ELIGARD

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

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LEUPROLIDE-LUPRON DEPOT

Products Affected

- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ENDOMETRIOSIS, UTERINE FIBROIDS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	PROSTATE CA: PLAN YEAR. UTERINE FIBROIDS: 3 MOS. ENDOMETRIOSIS: INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: ENDOMETRIOSIS, UTERINE FIBROIDS: NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT. ENDOMETRIOSIS: 1) TRIAL OF OR CONTRAINDICATION TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN NSAID, A PROGESTIN-CONTAINING PREPARATION, AND 2) 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.

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

LEUPROLIDE-LUPRON DEPOT-PED

Products Affected

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

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	No

L-GLUTAMINE

Products Affected

- *l-glutamine oral packet*

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/RENEWAL: PLAN YEAR.
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 external ointment 5 %*

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

LIDOCAINE PATCH

Products Affected

- *lidocaine external patch 5 %*
- *lidocan*

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

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LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine external cream*

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

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LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

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

LOTILANER

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DEMODEX BLEPHARITIS: PRESENCE OF DEMODEX MITES CONFIRMED BY LIGHT MICROSCOPY OR SLIT LAMP EXAMINATION.
Age Restrictions	DEMODEX BLEPHARITIS: 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	DEMODEX BLEPHARITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPHTHALMOLOGIST OR OPTOMETRIST.
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/RENEWAL: PLAN YEAR.
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: PLAN YEAR.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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MARIBAVIR

Products Affected
- LIVTENCITY

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

MECASERMIN

Products Affected

- INCRELEX

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

MECHLORETHAMINE

Products Affected

- VALCHLOR

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

MEPOLIZUMAB

Products Affected

- NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 40 MG/0.4ML
- NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED

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. EOSINOPHILIC CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL AT SCREENING (I.E., WITHIN THE PAST 3 MONTHS) OR AT LEAST 300 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/RENEWAL: PLAN YEAR.
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

PA Criteria	Criteria Details
	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 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 ONE OF THE FOLLOWING: (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	

PA Criteria	Criteria Details
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	PHEOCHROMOCYTOMA: PRE-OP SURGERY: 30 DAYS, TREATMENT: PLAN YEAR.
Other Criteria	PHEOCHROMOCYTOMA: INITIAL: HAS NON-METASTATIC PHEOCHROMOCYTOMA. PREOPERATIVE PREPARATION FOR SURGERY: USE IN COMBINATION WITH AN ALPHA-ADRENERGIC RECEPTOR BLOCKER. RENEWAL: MALIGNANT PHEOCHROMOCYTOMA: STABLE OR CLINICAL IMPROVEMENT WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

MIDAZOLAM

Products Affected

- NAYZILAM

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

MIDOSTAURIN

Products Affected

- RYDAPT

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

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

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

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MILTEFOSINE

Products Affected

- IMPAVIDO

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

MIRDAMETINIB

Products Affected

- GOMEKLI ORAL CAPSULE 1 MG, 2 MG
- GOMEKLI ORAL TABLET SOLUBLE

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

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MODAFINIL

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

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

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MOMELOTINIB

Products Affected

- OJJAARA

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

MORPHINE SOLUTION

Products Affected

- *morphine sulfate (concentrate) oral solution 100 mg/5ml*

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

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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: PLAN YEAR.
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:

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

NILOTINIB - TASIGNA

Products Affected

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

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

NILOTINIB-DANZITEN

Products Affected

- DANZITEN

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

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NINTEDANIB

Products Affected

- *nintedanib esylate*
- OFEV

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/RENEWAL: PLAN YEAR.
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

PA Criteria	Criteria Details
	ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). INITIAL/RENEWAL: IPF, PF-ILD: NO CONCURRENT USE WITH ESBRIET. RENEWAL: IPF, SSC-ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NIRAPARIB

Products Affected

- ZEJULA ORAL TABLET

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

NIRAPARIB-ABIRATERONE

Products Affected

- AKEEGA

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

NIROGACESTAT

Products Affected

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

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

NITISINONE

Products Affected

- *nitisinone*
- ORFADIN ORAL SUSPENSION

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

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NIVOLUMAB

Products Affected

- OPDIVO

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

NIVOLUMAB-HYALURONIDASE-NVHY

Products Affected

- OPDIVO QVANTIG

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

OFATUMUMAB SQ

Products Affected

- KESIMPTA

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

OLAPARIB

Products Affected

- LYNPARZA ORAL TABLET

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

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OLEZARSEN

Products Affected

- TRYNGOLZA

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

OLUTASIDENIB

Products Affected

- REZLIDHIA

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

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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: PLAN YEAR.
Other Criteria	INITIAL: CSU: 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO, FOUR TIMES THE MAXIMALLY LABELED DOSE OF 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 CLINICAL STANDARD OF CARE AGENT: A TOPICAL NASAL CORTICOSTEROID, 2) TRIAL OF OR CONTRAINDICATION TO

PA Criteria	Criteria Details
	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 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	

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PA Criteria	Criteria Details
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: PLAN YEAR.
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)

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

OSILODROSTAT

Products Affected

- ISTURISA ORAL TABLET 1 MG, 5 MG

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

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OSIMERTINIB

Products Affected

- TAGRISSO

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

PACRITINIB

Products Affected

- VONJO

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

PASIREOTIDE DIASPARTATE

Products Affected

- SIGNIFOR

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

PAZOPANIB

Products Affected

- *pazopanib hcl oral tablet 200 mg, 400 mg*

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

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PEGFILGRASTIM - APGF

Products Affected

- NYVEPRIA

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

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PEGFILGRASTIM - CBQV

Products Affected
- UDENYCA ONBODY

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

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PEGINTERFERON ALFA-2A

Products Affected

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

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

PEGVISOMANT

Products Affected

- SOMAVERT

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

PEMBROLIZUMAB

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

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

PEMBROLIZUMAB-BERAHYALURONIDASE ALFA-PMPH

Products Affected
- KEYTRUDA QLEX

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

PEMIGATINIB

Products Affected

- PEMAZYRE

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

PENICILLAMINE TABLET

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WILSONS DISEASE: 1) GENETIC TESTING CONFIRMING AN ATP7B MUTATION, 2) 24-HOUR URINARY COPPER EXCRETION (GREATER THAN 40 MICROGRAMS/24 HOURS), 3) LIVER BIOPSY WITH COPPER DRY WEIGHT GREATER THAN 75 MICROGRAMS/GRAM, OR 4) SERUM CERULOPLASMIN LEVEL OF LESS THAN 20 MG/DL. INITIAL: CYSTINURIA: HAS NEPHROLITHIASIS AND ONE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTINE, 2) PRESENCE OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) FAMILY HISTORY OF CYSTINURIA AND POSITIVE CYANIDE-NITROPRUSSIDE SCREENING.
Age Restrictions	
Prescriber Restrictions	WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. INITIAL: CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. RENEWAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) EXPERIENCED OR MAINTAINED IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT

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PA Criteria	Criteria Details
	COUNT COMPARED TO BASELINE. CYSTINURIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PEXIDARTINIB

Products Affected

- TURALIO ORAL CAPSULE 125 MG

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

PIMAVANSERIN

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

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: PLAN YEAR.
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: PLAN YEAR.
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). INITIAL/RENEWAL: NO CONCURRENT USE WITH OFEV. RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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POMALIDOMIDE

Products Affected

- POMALIDOMIDE
- POMALYST

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

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PONATINIB

Products Affected
- ICLUSIG

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

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POSACONAZOLE TABLET

Products Affected

- *posaconazole oral tablet delayed release*

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

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PRALSETINIB

Products Affected

- GAVRETO

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

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PYRIMETHAMINE

Products Affected

- *pyrimethamine oral*

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

QUININE

Products Affected

- *quinine sulfate oral*

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

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QUIZARTINIB

Products Affected

- VANFLYTA

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

REGORAFENIB

Products Affected

- STIVARGA

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

RELACORILANT

Products Affected

- LIFYORLI (125 MG DOSE)
- LIFYORLI (150 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

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RELUGOLIX

Products Affected

- ORGOVYX

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

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REPOTRECTINIB

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

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

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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 ONE OF THE FOLLOWING: 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: PLAN YEAR.
Other Criteria	NASH: INITIAL: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: WEGOVY. RENEWAL: CONTINUES TO HAVE NONCIRRHOTIC NASH WITH MODERATE TO ADVANCED LIVER FIBROSIS (CONSISTENT WITH STAGES F2 TO F3 FIBROSIS). INITIAL/RENEWAL: NO CONCURRENT USE WITH WEGOVY FOR THE TREATMENT OF NASH.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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REVUMENIB

Products Affected

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

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

RIBOCICLIB

Products Affected

- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)

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

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RIBOCICLIB-LETROZOLE

Products Affected

- KISQALI FEMARA (200 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)

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

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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): PLAN YEAR. IBS-D: 8 WKS.
Other Criteria	HE: TRIAL OF THE CLINICAL STANDARD OF CARE AGENT: LACTULOSE OR CURRENTLY ON LACTULOSE MONOTHERAPY. IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D): TRIAL OF OR CONTRAINDICATION TO THE CLINICAL STANDARD OF CARE AGENT: DICYCLOMINE. TRAVELERS DIARRHEA (TD): TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: GENERIC ORAL CIPROFLOXACIN, AZITHROMYCIN, OFLOXACIN, LEVOFLOXACIN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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RILONACEPT

Products Affected
- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR 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) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) HAS PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, OR 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	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: 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

PA Criteria	Criteria Details
	THE PREFERRED AGENT: KINERET. RP: 1) HAD AN EPISODE OF ACUTE PERICARDITIS, AND 2) SYMPTOM-FREE FOR 4 TO 6 WEEKS. INITIAL/RENEWAL: RP: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR RP. RENEWAL: RP: REDUCTION OF PERICARDITIS RECURRENCE OR IMPROVEMENT IN SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RIMEGEPANT

Products Affected

- NURTEC

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

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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: PLAN YEAR.
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	

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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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI
- SKYRIZI PEN

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

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

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RUCAPARIB

Products Affected

- RUBRACA

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

RUXOLITINIB

Products Affected

- JAKAFI
- JAKAFI XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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*
- *sapropterin dihydrochloride oral tablet*

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

SARGRAMOSTIM

Products Affected

- LEUKINE INJECTION SOLUTION RECONSTITUTED

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

SARILUMAB

Products Affected
- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ IR, RINVOQ. PMR: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PMR. INITIAL/RENEWAL: RA, PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. RENEWAL: RA, PJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

SECUKINUMAB SQ

Products Affected

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

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. AS, NR-AXSPA: TRIAL

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PA Criteria	Criteria Details
	OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. ERA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN NSAID, SULFASALAZINE, 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 100 MCG, 1000 MCG, 1200 MCG, 1400 MCG, 150 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI TITRATION

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: PLAN YEAR.
Other Criteria	PAH: INITIAL: 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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

SELINEXOR

Products Affected

- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 40 MG
- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG, 80 MG
- XPOVIO (80 MG TWICE WEEKLY)

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

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SELPERCATINIB

Products Affected

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

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

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SELUMETINIB

Products Affected

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

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

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SEMAGLUTIDE - WEGOVY

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	TREATMENT OF OBESITY
Required Medical Information	INITIAL: MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE): 1) BODY MASS INDEX (BMI) OF AT LEAST 27 KG/M(2), OR 2) BMI OF AT LEAST 25 KG/M(2) IF ASIAN. NONCIRRHOTIC METABOLIC DYSFUNCTION ASSOCIATED STEATOHEPATITIS (MASH): HAD A BIOPSY OR NON-INVASIVE TEST OBTAINED IN THE PAST 12 MONTHS DEMONSTRATING LIVER FIBROSIS OF STAGE 2 OR 3.
Age Restrictions	
Prescriber Restrictions	INITIAL: MASH: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST, GASTROENTEROLOGIST, OR ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MACE: INITIAL/RENEWAL: 1) NO CONCURRENT USE WITH ANOTHER GLP-1 OR GLP-1/GIP RECEPTOR AGONIST, AND 2) HAS A HISTORY OF AND WILL CONTINUE ON, OR HAS A CONTRAINDICATION TO ALL OF THE FOLLOWING CLINICAL STANDARD OF CARE TREATMENTS: (A) AN ANTIPLATELET MEDICATION (REQUIREMENT DOES NOT APPLY TO PATIENTS WITH A HISTORY OF A HEMORRHAGIC STROKE), (B) A HMG-COA REDUCTASE INHIBITOR, AND (C) A BLOOD PRESSURE MEDICATION. MASH: INITIAL: NO CONCURRENT USE WITH REZDIFFRA, ANOTHER GLP-1 OR GLP-1/GIP RECEPTOR AGONIST. RENEWAL: 1) HAS DISEASE STABILITY OR IMPROVEMENT FROM BASELINE, AND 2) NO CONCURRENT USE WITH REZDIFFRA, ANOTHER GLP-1 OR GLP-1/GIP RECEPTOR AGONIST.

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

SEVABERTINIB

Products Affected

- HYRNUO

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

SILDENAFIL TABLET

Products Affected

- *sildenafil citrate oral tablet 20 mg*

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: PLAN YEAR.
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

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PA Criteria	Criteria Details
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/RENEWAL: PLAN YEAR.
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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

SOFOSBUVIR/VELPATASVIR

Products Affected

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

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

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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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	No

SOMATROPIN - NORDITROPIN

Products Affected

- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR

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: PLAN YEAR.

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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 SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	HIV/WASTING: INITIAL: 1) FOR NON-SUPPRESSED HIV VIREMIA (VIRAL LOAD GREATER THAN 200 COPIES/ML), ONE OF THE FOLLOWING: (A) GREATER THAN 10% LOSS OF BASELINE BODY WEIGHT AND HAS CHRONIC DIARRHEA, CHRONIC WEAKNESS OR A FEVER FOR AT LEAST 30 DAYS, (B) 90% IDEAL BODY WEIGHT OR BODY MASS INDEX (BMI) LESS THAN 18.5 KG/M2 AND A GREATER THAN 10% WEIGHT LOSS FROM PREMORBID MAXIMUM OVER A 12-MONTH PERIOD, OR (C) 90% IDEAL BODY WEIGHT OR BMI LESS THAN 18.5 KG/M2 AND A GREATER THAN 5% WEIGHT LOSS IN THE PREVIOUS 6 MONTHS, OR 2) FOR SUPPRESSED HIV VIREMIA (VIRAL LOAD LESS THAN 200 COPIES/ML), ONE OF THE FOLLOWING: (A) GREATER THAN 5% LOSS OF PREMORBID BODY WEIGHT OVER 6 MONTHS, (B) GREATER THAN 10% LOSS OF PREMORBID BODY WEIGHT OVER 12 MONTHS, (C) LOW BMI (LESS THAN 20 KG/M2) IF OBJECTIVE WEIGHT LOSS IS NOT AVAILABLE.
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: PLAN YEAR.
Other Criteria	HIV/WASTING: INITIAL/RENEWAL: PATIENT IS ON OPTIMIZED HIV ANTI-RETROVIRAL THERAPY. RENEWAL: POSITIVE RESPONSE TO TREATMENT (E.G., IMPROVEMENT IN BMI OR

PA Criteria	Criteria Details
	WEIGHT, PHYSICAL IMPROVEMENTS SUCH AS TIMED WALK OR CHAIR RISE).
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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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SONROTOCLAX

Products Affected

- BEQALZI
- BEQALZI STARTER PACK

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

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SORAFENIB

Products Affected

- *sorafenib tosylate*

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

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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: PLAN YEAR.
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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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SPARSENTAN

Products Affected

- FILSPARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IGAN): INITIAL: 1) DIAGNOSIS CONFIRMED BY BIOPSY, 2) PROTEINURIA OF AT LEAST 0.5G/DAY, AND 3) EGFR OF AT LEAST 30ML/MIN/1.73M2.
Age Restrictions	
Prescriber Restrictions	PRIMARY IGAN: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PRIMARY IGAN: 1) TRIED AND WILL CONTINUE TO USE AN SGLT2 INHIBITOR, OR HAS A CONTRAINDICATION TO AN SGLT2 INHIBITOR, AND 2) NO CONCURRENT USE WITH AN ACE INHIBITOR, ARB, ENDOTHELIN RECEPTOR ANTAGONIST, ALISKIREN, FABHALTA, VANRAFIA, OR VOYXACT. FSGS: 1) TRIAL OF OR CONTRAINDICATION TO AT LEAST 3 MONTHS OF TREATMENT WITH ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ACE INHIBITOR OR AN ARB, AND 2) NO CONCURRENT USE WITH AN ACE INHIBITOR OR AN ARB. RENEWAL: PRIMARY IGAN: 1) NO CONCURRENT USE WITH AN ACE INHIBITOR, ARB, ENDOTHELIN RECEPTOR ANTAGONIST, ALISKIREN, FABHALTA, VANRAFIA, OR VOYXACT, AND 2) REDUCTION IN PROTEINURIA, OR IMPROVED OR STABLE KIDNEY FUNCTION COMPARED TO BASELINE. FSGS: 1) REDUCTION IN PROTEINURIA FROM BASELINE, 2) REDUCTION IN UPCR, AND 3) NO CONCURRENT USE WITH AN ACE INHIBITOR OR AN ARB.
Indications	All FDA-approved Indications.
Off Label Uses	

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

STIRIPENTOL

Products Affected

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

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

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SUNITINIB

Products Affected

- *sunitinib malate*

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

TADALAFIL - ADCIRCA, ALYQ

Products Affected

- *alyq*

PA Criteria	Criteria Details
Exclusion Criteria	
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: PLAN YEAR.
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

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TADALAFIL-CIALIS

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

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

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TAFAMIDIS

Products Affected
- VYNDAMAX

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

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TALAZOPARIB

Products Affected

- TALZENNA

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

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TALETRECTINIB

Products Affected

- IBTROZI

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

TELOTRISTAT

Products Affected

- XERMELO

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

TEPOTINIB

Products Affected

- TEPMETKO

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

TERIPARATIDE

Products Affected

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

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

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TESTOSTERONE

Products Affected

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

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

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TESTOSTERONE CYPIONATE - DEPO

Products Affected

- *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)*

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

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TESTOSTERONE ENANTHATE

Products Affected

- *testosterone enanthate intramuscular solution*

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 HYPOGONADISM/ MALE DELAYED PUBERTY: PLAN YEAR. OTHER INDICATIONS: PLAN YEAR.
Other Criteria	INITIAL/RENEWAL: MALE HYPOGONADISM: 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED WITHIN THE PAST 12 MONTHS, AND 1) PSA LEVEL IS LESS THAN OR EQUAL TO 4 NG/ML, OR 2) PSA LEVEL IS GREATER THAN 4 NG/ML AND THE BENEFITS OF ONGOING THERAPY OUTWEIGH THE RISKS OF ELEVATED PSA. RENEWAL: MALE HYPOGONADISM: 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

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

THALIDOMIDE

Products Affected

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

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

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TIVOZANIB

Products Affected

- FOTIVDA

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

TOCILIZUMAB-AAZG IV

Products Affected
- TYENNE

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: RA, PJIA, SJIA, GCA: PLAN YEAR. CRS: 1 MONTH.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOIDS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ IR, RINVOQ. RENEWAL: RA, PJIA, SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. GCA: NO CONCURRENT USE WITH ANOTHER

PA Criteria	Criteria Details
	SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TOCILIZUMAB-AAZG SQ

Products Affected

- TYENNE

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

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

TOFACITINIB

Products Affected

- *tofacitinib citrate er*
- *tofacitinib citrate oral*

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

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

TOLVAPTAN

Products Affected

- *tolvaptan oral tablet*
- *tolvaptan oral tablet therapy pack*

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

TOPICAL TRETINOIN

Products Affected

- ALTRENO
- *tretinoin external cream*

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

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TOVORAFENIB

Products Affected

- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET

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

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TRAMETINIB SOLUTION

Products Affected

- MEKINIST ORAL SOLUTION RECONSTITUTED

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

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TRAMETINIB TABLET

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

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

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TRASTUZUMAB-DKST

Products Affected

- OGIVRI

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

TRASTUZUMAB-HYALURONIDASE-OYSK

Products Affected

- HERCEPTIN HYLECTA

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

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TRAZODONE

Products Affected
- RALDESY

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

TREPROSTINIL-YUTREPIA

Products Affected

- YUTREPIA

PA Criteria	Criteria Details
Exclusion Criteria	
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: PLAN YEAR.
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	Yes

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TRIENTINE CAPSULE

Products Affected

- *trientine hcl oral capsule 250 mg*

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

TRIFLURIDINE/TIPIRACIL

Products Affected

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

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

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TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

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

UBROGEPANT

Products Affected

- UBRELVY

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

UPADACITINIB

Products Affected

- RINVOQ
- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	
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. ATOPIC DERMATITIS (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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: A TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR

PA Criteria	Criteria Details
	TOPICAL JAK INHIBITOR. AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: 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 IV

Products Affected
- OTULFI

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

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

USTEKINUMAB-AAUZ SQ

Products Affected
- OTULFI

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

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PA Criteria	Criteria Details
Off Label Uses	
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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

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

USTEKINUMAB-AEKN SQ

Products Affected
- SELARSDI

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

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PA Criteria	Criteria Details
Off Label Uses	
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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

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

USTEKINUMAB-KFCE SQ

Products Affected
- YESINTEK

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

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

VALBENAZINE

Products Affected

- INGREZZA ORAL CAPSULE
- INGREZZA ORAL CAPSULE SPRINKLE
- INGREZZA ORAL CAPSULE THERAPY PACK

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

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VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

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

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VEDOLIZUMAB

Products Affected

- ENTYVIO INTRAVENOUS
- ENTYVIO PEN

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

VEMURAFENIB

Products Affected

- ZELBORAF

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

VENETOCLAX

Products Affected

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

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

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VEPDEGESTRANT

Products Affected

- VEPPANU

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

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VERICIGUAT

Products Affected

- VERQUVO

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

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VIGABATRIN

Products Affected

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

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

VIMSELTINIB

Products Affected

- ROMVIMZA

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

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VISMODEGIB

Products Affected

- ERIVEDGE

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

VONOPRAZAN

Products Affected
- VOQUEZNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: H PYLORI: 30 DAYS. EE: 8 WEEKS. NERD: 4 WEEKS. RENEWAL: EE: PLAN YEAR.
Other Criteria	INITIAL: EROSIVE ESOPHAGITIS (EE): TRIAL OF OR CONTRAINDICATION TO THE CLINICAL STANDARD OF CARE AGENTS: 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 THE CLINICAL STANDARD OF CARE AGENT: 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

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VORASIDENIB

Products Affected

- VORANIGO

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

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VORICONAZOLE SUSPENSION

Products Affected

- *voriconazole oral suspension reconstituted*

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

ZANUBRUTINIB

Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

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

ZIDESAMTINIB

Products Affected

- JIDEYTRO

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

ZIFTOMENIB

Products Affected

- KOMZIFTI

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

ZONGERTINIB

Products Affected

- HERNEXEOS

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

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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

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