



## Advantage D-SNP

### 2026 List of Prior Authorization Requirements

Effective: 6/1/2026

This document contains information about requirements for approval of certain drugs covered by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP (HMO). If you have questions about your drug coverage, call 1-888-361-7526 (TTY 711) from 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30.

Health Plan of San Joaquin Advantage/Mountain Valley Health Plan Advantage D-SNP is an HMO with Medicare and Medi-Cal contracts. Enrollment in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP depends on contract renewal.

Este documento proporciona información sobre los requisitos para aprobar ciertos medicamentos cubiertos por Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP (HMO). Si tiene preguntas sobre su cobertura de medicamentos, llame al 1-888-361-7526 (TTY: 711), de 8:00 a. m. a 8:00 p. m., los siete días de la semana, del 1 de octubre al 31 de marzo; y de lunes a viernes, del 1 de abril al 30 de septiembre.

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP es un plan HMO que tiene contrato con Medicare y Medi-Cal. La inscripción en Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP depende de la renovación del contrato.

Tài liệu này chứa thông tin về các yêu cầu phê duyệt một số loại thuốc được Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP (HMO) chi trả. Nếu quý vị có câu hỏi về bảo hiểm thuốc, hãy gọi tới số 1-888-361-7526 (TTY 711), từ 8:00 sáng đến 8:00 tối, bảy ngày một tuần từ ngày 1 tháng 10 đến ngày 31 tháng 3 và Thứ Hai đến Thứ Sáu từ ngày 1 tháng 4 đến ngày 30 tháng 9.

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP là một chương trình thuộc loại Tổ Chức Duy Trì Sức Khỏe (HMO) có hợp đồng với Medicare và Medi-Cal. Việc ghi danh tham gia Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP phụ thuộc vào tình trạng gia hạn hợp đồng.

ឯកសារនេះមានព័ត៌មានអំពីតម្រូវការសម្រាប់ការអនុម័តឱសថមួយចំនួនដែលធានារ៉ាប់រងដោយគម្រោងសុខភាព Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP (HMO)។ ប្រសិនបើអ្នកមានសំណួរអំពីការធានារ៉ាប់រងលើឱសថរបស់អ្នក សូមទូរសព្ទទៅលេខ 1-888-361-7526 (TTY 711) ចាប់ពីម៉ោង 8:00 ព្រឹក ដល់ម៉ោង 8:00 យប់ ប្រាំពីរថ្ងៃក្នុងមួយសប្តាហ៍ ចាប់ពីថ្ងៃទី 1 ខែតុលា ដល់ថ្ងៃទី 31 ខែមីនា និងពីថ្ងៃចន្ទ ដល់ថ្ងៃសុក្រ ចាប់ពីថ្ងៃទី 1 ខែមេសា ដល់ថ្ងៃទី 30 ខែកញ្ញា។

គម្រោងថែទាំសុខភាព Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP គឺជា HMO ដែលមានកិច្ចសន្យាជាមួយ Medicare និង Medi-Cal។ ការចុះឈ្មោះនៅក្នុងគម្រោង Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP អាស្រ័យលើការបន្តកិច្ចសន្យាថ្មី។

# Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

## English

ATTENTION: If you need help in your language call **1-888-361-7526, TTY 711**. Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-888-361-7526, TTY 711**. These services are free of charge.

## العربية (Arabic)

يرجى الانتباه: إذا احتجت المساعدة بلغتك، فاتصل بـ **1-888-361-7526, TTY 711** تتوفر أيضا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل والخط الكبير. اتصل بـ **1-888-361-7526, TTY 711**. هذه الخدمات مجانية

## Հայերեն (Armenian)

Ուժեղ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-888-361-7526, TTY 711**: Կան նաև օժանդակ միջոցներու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1-888-361-7526, TTY 711**: Այս ծառայություններն անվճար են:

## ខ្មែរ (Cambodian)

ចំណាំ: បើអ្នកត្រូវការជំនួយជាភាសាខ្មែរសម្រាប់ជនមានការពិការភ្នែក សូមទូរសព្ទទៅលេខ **1-888-361-7526, TTY 711**។ ជំនួយ ឯសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធំសម្រាប់ជនពិការ និងជាពុម្ពអក្សរធំក៏អាចរកបានផងដែរ។ ទូរសព្ទទៅលេខ **1-888-361-7526, TTY 711**។ សេវាកម្មទាំងនេះមិនគិតថ្លៃទេ ។

## 中文 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 **1-888-361-7526, TTY 711**。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 **1-888-361-7526, TTY 711**。这些服务都是免费的。

## فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1-888-361-7526, TTY 711** تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1-888-361-7526, TTY 711** تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

## हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है, तो **1-888-361-7526, TTY 711** पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1-888-361-7526, TTY 711** पर कॉल करें। ये सेवाएं नि:शुल्क हैं।

## Hmoob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1-888-361-7526, TTY 711**. Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1-888-361-7526, TTY 711**. Cov kev pab cuam no yog pab dawb xwb.

## 日本語 (Japanese)

注意：日本語の対応が必要な場合は、**1-888-361-7526, TTY 711**へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスを用意しています。**1-888-361-7526, TTY 711**へお電話ください。これらのサービスは無料で提供しています。

## 한국어 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1-888-361-7526, TTY 711** 번으로 의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1-888-361-7526, TTY 711** 번으로 의하십시오. 이러한 서비스는 무료로 제공됩니다.

## **ພາສາລາວ (Laotian)**

ປະກາດ:

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານ ໃຫ້ໂທຫາເບີ **1-888-361-7526, TTY 711.**

ຍັງມີຄວາມຊ່ວຍເຫຼືອ ແລະ

ການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນ:

ເອກະສານທີ່ເປັນອັກສອນນູນ ແລະ ມິໂຕຟິມໃຫຍ່, ໃຫ້ໂທຫາເບີ **1-888-361-7526, TTY 711.**

ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ

## **Mien**

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiex longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **1-888-361-7526, TTY 711.** Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hlou mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1-888-361-7526, TTY 711.** Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

## **ਪੰਜਾਬੀ (Punjabi)**

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ **1-888-361-7526, TTY 711** 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਰਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਅੱਖਰਾਂ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। **1-888-361-7526, TTY 711** 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

## **Русский (Russian)**

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-888-361-7526, TTY 711.** Предоставляются также средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-888-361-7526, TTY 711.** Такие услуги предоставляются бесплатно

## **Español (Spanish)**

ATENCIÓN: si necesita ayuda en su idioma, llame al **1-888-361-7526, TTY 711.** También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1-888-361-7526, TTY 711.** Estos servicios son gratuitos.

## **Tagalog (Filipino)**

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-888-361-7526, TTY 711.** Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1-888-361-7526, TTY 711.** Libre ang mga serbisyong ito.

## **ภาษาไทย (Thai)**

โปรดทราบ:

หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1-888-361-7526, TTY 711.** นอกจากนี้ ยังพร้อมให้

ความช่วยเหลือและบริการต่าง ๆ

สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ

ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วย

ตัวอักษรขนาดใหญ่. กรุณาโทรศัพท์ไปที่หมายเลข **1-888-361-7526, TTY 711.** ไม่มีค่าใช้จ่าย

สำหรับบริการเหล่านี้.

## **Українська (Ukrainian)**

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1-888-361-7526, TTY 711.** Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на Номер **1-888-361-7526, TTY 711.** Ці послуги безкоштовні.

## **Tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-888-361-7526, TTY 711.** Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ chữ lớn. Vui lòng gọi số **1-888-361-7526, TTY 711.** Các dịch vụ này đều miễn phí.

# ABALOPARATIDE

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## Products Affected

- TYMLOS

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

# ABATACEPT IV

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## Products Affected

- ORENCIA (WITH MALTOSE)

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

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

# ABATACEPT SQ

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## Products Affected

- ORENCIA
- ORENCIA CLICKJECT

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

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

# ABEMACICLIB

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## Products Affected

- VERZENIO

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

# ABIRATERONE

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## Products Affected

- *abiraterone*
- *abirtega*

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

# ABIRATERONE SUBMICRONIZED

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## Products Affected

- *abiraterone, submicronized*
- YONSA

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

# ACALABRUTINIB

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## Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

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

# ACORAMIDIS

## Products Affected

- ATTRUBY

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

# ADAGRASIB

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## Products Affected

- KRAZATI

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

# ADALIMUMAB

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.

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

# ADALIMUMAB-AATY

## Products Affected

- *adalimumab-aaty*
- *adalimumab-aaty(cf) ai crohns*
- YUFLYMA(CF)
- YUFLYMA(CF) AI CROHN'S-UC-HS
- YUFLYMA(CF) AUTOINJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.

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

# ADALIMUMAB-ADBIM

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.

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

# ADALIMUMAB-BWWD

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.

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

# AFATINIB

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## Products Affected

- GILOTRIF

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

# ALECTINIB

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## Products Affected

- ALECENSA

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

# ALPELISIB-PIQRAY

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## Products Affected

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

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

# AMIKACIN LIPOSOMAL INH

## Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	MAC LUNG DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 6 MONTHS.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# AMIVANTAMAB-HYALURONIDASE-LPUJ

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## Products Affected

- RYBREVANT FASPRO

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

# AMIVANTAMAB-VMJW

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## Products Affected

- RYBREVANT

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

# ANAKINRA

## Products Affected

- KINERET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	RA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. CAPS, DIRA: LIFETIME.

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

# APALUTAMIDE

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## Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

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

# APOMORPHINE - ONAPGO

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## Products Affected

- ONAPGO

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

# APOMORPHINE - SL

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## Products Affected

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

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

# APREMILAST

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

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

# ARIMOCLOMOL

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## Products Affected

- MIPLYFFA

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

# ASCIMINIB

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## Products Affected

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

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

# ASFOTASE ALFA

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## Products Affected

- STRENSIQ

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

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

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

# ATOGEPANT

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## Products Affected

- QULIPTA

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

# AVACOPAN

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## Products Affected

- TAVNEOS

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

# AVAPRITINIB

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## Products Affected

- AYVAKIT

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

# AVUTOMETINIB-DEFACTINIB

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## Products Affected

- AVMAPKI
- AVMAPKI-FAKZYNJA
- FAKZYNJA

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

# AXATILIMAB-CSFR

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## Products Affected

- NIKTIMVO

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

# AXITINIB

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## Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

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

# AZACITIDINE

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## Products Affected

- ONUREG

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

# AZTREONAM INHALED

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## Products Affected

- CAYSTON

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

# BEDAQUILINE

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## Products Affected

- SIRTURO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 WEEKS
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# BELIMUMAB

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## Products Affected

- BENLYSTA SUBCUTANEOUS

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

# BELUMOSUDIL

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## Products Affected

- REZUROCK

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

# BELZUTIFAN

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## Products Affected

- WELIREG

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

# BENDAMUSTINE

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## Products Affected

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

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

# BENRALIZUMAB

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## Products Affected

- FASENRA
- FASENRA PEN

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

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

# BETAINE

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## Products Affected

- *betaine*

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

# BEVACIZUMAB-BVZR

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## Products Affected

- ZIRABEV

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

# BEXAROTENE

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## Products Affected

- *bexarotene*

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

# BINIMETINIB

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## Products Affected

- MEKTOVI

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

# BORTEZOMIB

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## Products Affected

- *bortezomib injection*
- BORUZU

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

# BOSENTAN

## Products Affected

- *bosentan oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	PAH: INITIAL: 1) DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASE IN BILIRUBIN BY 2 OR MORE TIMES ULN, AND 2) NO CONCURRENT USE WITH CYCLOSPORINE A OR GLYBURIDE. RENEWAL: NO CONCURRENT USE WITH CYCLOSPORINE A OR GLYBURIDE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# BOSUTINIB

## Products Affected

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

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

# BRIGATINIB

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## Products Affected

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

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

# C1 ESTERASE INHIBITOR-HAEGARDA

## Products Affected

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

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

# CABOZANTINIB CAPSULE

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## Products Affected

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

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

# CABOZANTINIB TABLET

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## Products Affected

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

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

# CANNABIDIOL

## Products Affected

- EPIDIOLEX

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

# CAPIVASERTIB

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## Products Affected

- TRUQAP

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

# CAPMATINIB

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## Products Affected

- TABRECTA

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

# CARGLUMIC ACID

## Products Affected

- *carglumic acid*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ACUTE HA DUE TO NAGS/PA/MMA: 7 DAYS. CHRONIC HA DUE TO NAGS: INITIAL: 6 MOS, RENEWAL: 12 MOS.
<b>Other Criteria</b>	RENEWAL: CHRONIC HA DUE TO NAGS: PATIENT HAS SHOWN CLINICAL IMPROVEMENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# CERITINIB

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## Products Affected

- ZYKADIA

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

# CERTOLIZUMAB PEGOL

## Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST
- CIMZIA STARTER KIT

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

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

# CETUXIMAB

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## Products Affected

- ERBITUX

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

# CLADRIBINE

## Products Affected

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

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

# CLOBAZAM-SYMPAZAN

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## Products Affected

- SYMPAZAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: LENNOX-GASTAUT SYNDROME (LGS): THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	LGS: INITIAL: CONTRAINDICATION TO OR UNABLE TO SWALLOW CLOBAZAM TABLETS OR SUSPENSION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# COBIMETINIB

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## Products Affected

- COTELLIC

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

# CORTICOTROPIN

## Products Affected

- CORTROPHIN GEL INJECTION

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

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

# CRIZOTINIB CAPSULE

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## Products Affected

- XALKORI ORAL CAPSULE

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

# CRIZOTINIB PELLETS

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## Products Affected

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

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

# DABRAFENIB CAPSULES

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## Products Affected

- TAFINLAR ORAL CAPSULE

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

# DABRAFENIB SUSPENSION

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## Products Affected

- TAFINLAR ORAL TABLET FOR SUSPENSION

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

# DACOMITINIB

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## Products Affected

- VIZIMPRO

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

# DALFAMPRIDINE

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## Products Affected

- *dalfampridine*

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

# DAROLUTAMIDE

## Products Affected

- NUBEQA

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

# DASATINIB

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## Products Affected

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

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

# DATOPOTAMAB DERUXTECAN-DLNK

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## Products Affected

- DATROWAY

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

# DECITABINE/CEDAZURIDINE

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## Products Affected

- INQOVI

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

# DEFERASIROX

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS OR NTDT: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# DENOSUMAB-BMWO - OSENVELT

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## Products Affected

- OSENVELT

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

# DEUTETRABENAZINE

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TARDIVE DYSKINESIA: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# DICLOFENAC TOPICAL SOLUTION

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## Products Affected

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

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

# DICLOFENAC-FLECTOR

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## Products Affected

- *diclofenac epolamine*

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

# DIMETHYL FUMARATE

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## Products Affected

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

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

# DIROXIMEL FUMARATE

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## Products Affected

- VUMERITY

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

# DORDAVIPRONE

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## Products Affected

- MODEYSO

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

# DOSTARLIMAB-GXLY

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## Products Affected

- JEMPERLI

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

# DRONABINOL CAPSULE

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## Products Affected

- *dronabinol*

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

# DROXIDOPA

## Products Affected

- *droxidopa*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NOH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
<b>Coverage Duration</b>	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
<b>Other Criteria</b>	NOH: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# DUPILUMAB

## Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: AD, PN, CSU: PRESCRIBED OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST OR PULMONOLOGIST. CRSWNP: PRESCRIBED OR IN CONSULTATION WITH OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED OR IN CONSULTATION WITH GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST. COPD: PRESCRIBED OR IN CONSULTATION WITH PULMONOLOGIST. RENEWAL: CSU: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
<b>Coverage Duration</b>	BP, AFRS: 12 MO. AD/CRSWNP/EOE/PN/CSU: INITIAL/RENEWAL: 6 MO/12 MO. ASTHMA/COPD: INIT/RENEW: 12 MO.

PA Criteria	Criteria Details
Other Criteria	<p>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-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS, OR ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 3) INADEQUATELY CONTROLLED DISEASE. PRURIGO NODULARIS (PN): CHRONIC PRURITUS (ITCH MORE THAN 6 WEEKS), MULTIPLE PRURIGINOUS LESIONS, AND HISTORY OR SIGN OF A PROLONGED SCRATCHING BEHAVIOR. EOSINOPHILIC COPD: USED IN COMBINATION WITH A LAMA/LABA/ICS. CHRONIC SPONTANEOUS URTICARIA (CSU): 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. INITIAL/RENEWAL : ALL INDICATIONS EXCEPT BULLOUS PEMPHIGOID (BP): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4</p>

PA Criteria	Criteria Details
	<p>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 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.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# DUVELISIB

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## Products Affected

- COPIKTRA

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

# EFLORNITHINE

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## Products Affected

- IWILFIN

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

# ELACESTRANT

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## Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

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

# ELAGOLIX

## Products Affected

- ORLISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 18 YEARS OF AGE OR OLDER.
<b>Prescriber Restrictions</b>	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# ELAPEGADEMASE-LVLR

## Products Affected

- REVC0VI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ADA-SCID: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH IMMUNOLOGIST, HEMATOLOGIST/ONCOLOGIST, OR PHYSICIAN SPECIALIZING IN INHERITED METABOLIC DISORDERS.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	ADA-SCID: RENEWAL: 1) IMPROVEMENT OR MAINTENANCE OF IMMUNE FUNCTION FROM BASELINE, AND 2) HAS NOT RECEIVED SUCCESSFUL HCT OR GENE THERAPY.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ELEXACFTOR-TEZACFTOR-IVACFTOR

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ELRANATAMAB-BCMM

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	RELAPSED OR REFRACTORY MULTIPLE MYELOMA: RENEWAL: 1) HAS RECEIVED AT LEAST 24 WEEKS OF TREATMENT WITH ELREXFIO, AND 2) HAS RESPONDED TO TREATMENT (PARTIAL RESPONSE OR BETTER), AND HAS MAINTAINED THIS RESPONSE FOR AT LEAST 2 MONTHS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ELTROMBOPAG - ALVAIZ

## Products Affected

- ALVAIZ

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

# ELTROMBOPAG - PROMACTA

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: 1) PLATELET COUNT OF LESS THAN $30 \times 10^9/L$ , OR 2) PLATELET COUNT OF LESS THAN $50 \times 10^9/L$ AND A PRIOR BLEEDING EVENT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
<b>Coverage Duration</b>	ITP: INITIAL: 6 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO.
<b>Other Criteria</b>	INITIAL: ITP: 1) TRIAL OF OR CONTRAINDICATION TO ONE CORTICOSTEROID OR IMMUNOGLOBULIN, OR HAD AN INSUFFICIENT RESPONSE TO SPLENECTOMY, AND 2) NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS). ALL INDICATIONS: ELTROMBOPAG ORAL SUSPENSION PACKETS: TRIAL OF A FORMULARY VERSION OF ELTROMBOPAG TABLET OR PATIENT IS UNABLE TO TOLERATE TABLET FORMULATION. RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNTS FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# ENASIDENIB

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## Products Affected

- IDHIFA

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

# ENCORAFENIB

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## Products Affected

- BRAFTOVI

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

# ENSARTINIB

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## Products Affected

- ENSACOVE ORAL CAPSULE 100 MG, 25 MG

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

# ENTRECTINIB CAPSULES

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## Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

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

# ENTRECTINIB PELLETS

## Products Affected

- ROZLYTREK ORAL PELLETS IN PACKET

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

# ENZALUTAMIDE

## Products Affected

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

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

# EPCORITAMAB-BYSP

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## Products Affected

- EPKINLY

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

# EPOETIN ALFA-EPBX

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE, OR CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL IS LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HEMOGLOBIN LEVEL IS 13G/DL OR LESS. RENEWAL: 1) CKD IN ADULTS NOT ON DIALYSIS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 2) CKD IN PEDIATRIC PATIENTS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS APPROACHED OR EXCEEDS 12G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 3) ANEMIA RELATED TO ZIDOVUDINE: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. 4) CANCER CHEMOTHERAPY: (A) HEMOGLOBIN LEVEL IS LESS THAN 10 G/DL, OR (B) HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: 12 MONTHS. SURGERY: 1 MONTH.
<b>Other Criteria</b>	RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES.

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

# ERDAFITINIB

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## Products Affected

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

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

# ERENUMAB-AOOE

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## Products Affected

- AIMOVIG AUTOINJECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ERLOTINIB

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## Products Affected

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

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

# ESKETAMINE

## Products Affected

- SPRAVATO

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

# ETANERCEPT

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## Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

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

# EVEROLIMUS-AFINITOR

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## Products Affected

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

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

# EVEROLIMUS-AFINITOR DISPERZ

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## Products Affected

- *everolimus (antineoplastic) oral tablet for suspension*

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

# FECAL MICROBIOTA CAPSULE

## Products Affected

- VOWST

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

# FEDRATINIB

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## Products Affected

- INREBIC

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

# FENFLURAMINE

## Products Affected

- FINTEPLA

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

# FENTANYL CITRATE

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## Products Affected

- *fentanyl citrate buccal lozenge on a handle*

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

# FEZOLINETANT

## Products Affected

- VEOZAH

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	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).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# FILGRASTIM-AAFI

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## Products Affected

- NIVESTYM

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

# FINERENONE

## Products Affected

- KERENDIA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: HF: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# FINGOLIMOD

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## Products Affected

- *fingolimod*

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

# FOSCARBIDOPA-FOSLEVODOPA

## Products Affected

- VYALEV

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

# FRUQUINTINIB

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## Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

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

# FUTIBATINIB

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## Products Affected

- LYTGOBI

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

# GALCANEZUMAB-GNLM

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: MIGRAINE PREVENTION: 6 MOS. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): 12 MOS.
<b>Other Criteria</b>	MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY. EPISODIC CLUSTER HEADACHE: RENEWAL: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# GANAXOLONE

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## Products Affected

- ZTALMY

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

# GEFITINIB

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## Products Affected

- *gefitinib*

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

# GEPIRONE

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# GILTERITINIB

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## Products Affected

- XOSPATA

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

# GLASDEGIB

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## Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

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

# GLATIRAMER

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## Products Affected

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

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

# GLP1-DULAGLUTIDE

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## Products Affected

- TRULICITY

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

# GLP1-SEMAGLUTIDE

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## Products Affected

- OZEMPIC ORAL
- OZEMPIC SUBCUTANEOUS
- RYBELSUS

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

# GLP1-TIRZEPATIDE

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## Products Affected

- MOUNJARO

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

# GOSERELIN

## Products Affected

- ZOLADEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
<b>Coverage Duration</b>	STAGE B2-C PROSTATIC CARCINOMA: 4 MOS. ENDOMETRIOSIS: 6 MOS PER LIFETIME. ALL OTHERS: 12 MONTHS.
<b>Other Criteria</b>	ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# GUSELKUMAB

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

## Products Affected

- *morphine concentrate oral solution*

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

# HIGH RISK DRUGS IN THE ELDERLY - BUTALBITAL-CONTAINING AGENTS

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# HIGH RISK DRUGS IN THE ELDERLY - DIPYRIDAMOLE

## Products Affected

- *dipyridamole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# HIGH RISK DRUGS IN THE ELDERLY - ESTROGEN-MEDROXYPROGESTERONE

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## Products Affected

- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# HIGH RISK DRUGS IN THE ELDERLY - GLYBURIDE FORMULATIONS

## Products Affected

- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TYPE 2 DIABETES MELLITUS (DM): 1) TRIAL OF OR CONTRAINDICATION TO GLIMEPIRIDE OR 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# HIGH RISK DRUGS IN THE ELDERLY - KETOROLAC

## Products Affected

- *ketorolac oral*

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

# HIGH RISK DRUGS IN THE ELDERLY - PHENOBARBITAL

## Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	EPILEPSY/SEIZURES: PATIENTS WHO ARE NEWLY PRESCRIBED PHENOBARBITAL: 1) HAS NOT RESPONDED TO AT LEAST ONE ANTICONVULSANT, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# HIGH RISK DRUGS IN THE ELDERLY - PROMETHAZINE

## Products Affected

- *promethazine injection solution 25 mg/ml*                      *mg*
- *promethazine oral tablet*
- *promethazine rectal suppository 25 mg*
- *promethegan rectal suppository 12.5 mg, 25*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# HIGH RISK DRUGS IN THE ELDERLY - SCOPOLAMINE

## Products Affected

- *scopolamine base*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# HIGH RISK DRUGS IN THE ELDERLY- DIPHENOXYLATE-ATROPINE

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## Products Affected

- *diphenoxylate-atropine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# HIGH RISK DRUGS IN THE ELDERLY- INDOMETHACIN

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## Products Affected

- *indomethacin oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# HIGH RISK DRUGS IN THE ELDERLY- MEGESTROL

## Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# HIGH RISK DRUGS IN THE ELDERLY- PAROXETINE

## Products Affected

- *paroxetine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

# IBRUTINIB

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## Products Affected

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

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

# ICATIBANT

## Products Affected

- *icatibant*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) TYPE III HAE, OR 2) TYPE I OR II HAE CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	HAE: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR THE TREATMENT OF ACUTE HAE ATTACKS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# IDELALISIB

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## Products Affected

- ZYDELIG

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

# IMATINIB

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## Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

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

# IMATINIB SOLUTION

## Products Affected

- IMKELDI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# IMETELSTAT

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## Products Affected

- RYTELO

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

# IMLUNESTRANT

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## Products Affected

- INLURIYO

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

# INAVOLISIB

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## Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

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

# INFLIXIMAB

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## Products Affected

- *infliximab*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

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

# INSULIN SUPPLIES PAYMENT DETERMINATION

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## Products Affected

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

- CARETOUCH PEN NEEDLE 31GX5/16"
- CARETOUCH PEN NEEDLE 32GX3/16"
- CARETOUCH PEN NEEDLE 32GX5/32"
- CARETOUCH SYR 0.3 ML 31GX5/16"
- CARETOUCH SYR 0.5 ML 30GX5/16"
- CARETOUCH SYR 0.5 ML 31GX5/16"
- CARETOUCH SYR 1 ML 28GX5/16"
- CARETOUCH SYR 1 ML 29GX5/16"
- CARETOUCH SYR 1 ML 30GX5/16"
- CARETOUCH SYR 1 ML 31GX5/16"
- CLICKFINE PEN NEEDLE 32GX5/32"  
32GX4MM, STERILE
- COMFORT EZ 0.3 ML 31G 15/64"
- COMFORT EZ 0.5 ML 31G 15/64"
- COMFORT EZ INS 0.3 ML 30GX1/2"
- COMFORT EZ INS 0.3 ML 30GX5/16"
- COMFORT EZ INS 1 ML 31G 15/64"
- COMFORT EZ INS 1 ML 31GX5/16"
- COMFORT EZ INSULIN SYR 0.3 ML
- COMFORT EZ INSULIN SYR 0.5 ML
- COMFORT EZ PEN NEEDLE 12MM 29G
- COMFORT EZ PEN NEEDLES 4MM 32G  
SINGLE USE, MICRO
- COMFORT EZ PEN NEEDLES 4MM 33G
- COMFORT EZ PEN NEEDLES 5MM 31G  
MINI
- COMFORT EZ PEN NEEDLES 5MM 32G  
SINGLE USE,MINI,HRI
- COMFORT EZ PEN NEEDLES 5MM 33G
- COMFORT EZ PEN NEEDLES 6MM 31G
- COMFORT EZ PEN NEEDLES 6MM 32G
- COMFORT EZ PEN NEEDLES 6MM 33G
- COMFORT EZ PEN NEEDLES 8MM 31G  
SHORT
- COMFORT EZ PEN NEEDLES 8MM 32G
- COMFORT EZ PEN NEEDLES 8MM 33G
- COMFORT EZ PRO PEN ND L 30G 8MM
- COMFORT EZ PRO PEN ND L 31G 4MM
- COMFORT EZ PRO PEN ND L 31G 5MM
- COMFORT EZ SYR 0.3 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 28GX1/2"
- COMFORT EZ SYR 0.5 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 27G 12.7MM
- COMFORT EZ SYR 1 ML 28GX1/2"
- COMFORT EZ SYR 1 ML 29GX1/2"
- COMFORT EZ SYR 1 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 30GX5/16"
- COMFORT POINT PEN ND L 31GX1/3"
- COMFORT POINT PEN ND L 31GX1/6"
- COMFORT TOUCH PEN ND L 31G 4MM
- COMFORT TOUCH PEN ND L 31G 5MM
- COMFORT TOUCH PEN ND L 31G 6MM
- COMFORT TOUCH PEN ND L 31G 8MM
- COMFORT TOUCH PEN ND L 32G 4MM
- COMFORT TOUCH PEN ND L 32G 5MM
- COMFORT TOUCH PEN ND L 32G 6MM
- COMFORT TOUCH PEN ND L 32G 8MM
- COMFORT TOUCH PEN ND L 33G 4MM
- COMFORT TOUCH PEN ND L 33G 6MM
- COMFORT TOUCH PEN ND L 33GX5MM
- CURAD GAUZE PADS 2" X 2"
- CURITY ALCOHOL PREPS 2  
PLY,MEDIUM
- CURITY GAUZE PADS
- CURITY GAUZE SPONGES (12 PLY)-  
200/BAG
- DERMACEA 2"X2" GAUZE 12 PLY, USP  
TYPE VII
- DERMACEA GAUZE 2"X2" SPONGE 8  
PLY
- DERMACEA NON-WOVEN 2"X2"  
SPNGE
- DROPLET 0.3 ML 29G 12.7MM(1/2)  
OUTER
- DROPLET 0.3 ML 30G 12.7MM(1/2)  
OUTER
- DROPLET 0.5 ML 29GX12.5MM(1/2)
- DROPLET 0.5 ML 30GX12.5MM(1/2)
- DROPLET INS 0.3 ML 29GX12.5MM
- DROPLET INS 0.3 ML 30G 8MM(1/2)  
OUTER
- DROPLET INS 0.3 ML 30GX12.5MM
- DROPLET INS 0.3 ML 31G 6MM(1/2)  
OUTER
- DROPLET INS 0.3 ML 31G 8MM(1/2)  
OUTER
- DROPLET INS 0.5 ML 29G 12.7MM  
OUTER
- DROPLET INS 0.5 ML 30G 12.7MM  
OUTER
- DROPLET INS 0.5 ML 30GX6MM(1/2)
- DROPLET INS 0.5 ML 30GX8MM(1/2)
- DROPLET INS 0.5 ML 31GX6MM(1/2)

- DROPLET INS 0.5 ML 31GX8MM(1/2)
- DROPLET INS SYR 0.3 ML 30GX6MM
- DROPLET INS SYR 0.3 ML 30GX8MM
- DROPLET INS SYR 0.3 ML 31GX6MM
- DROPLET INS SYR 0.3 ML 31GX8MM
- DROPLET INS SYR 0.5 ML 30G 8MM OUTER
- DROPLET INS SYR 0.5 ML 31G 6MM OUTER
- DROPLET INS SYR 0.5 ML 31G 8MM OUTER
- DROPLET INS SYR 1 ML 29G 12.7MM OUTER
- DROPLET INS SYR 1 ML 30G 12.5MM
- DROPLET INS SYR 1 ML 30G 6MM
- DROPLET INS SYR 1 ML 30G 8MM OUTER
- DROPLET INS SYR 1 ML 31G 6MM OUTER
- DROPLET INS SYR 1 ML 31G 8MM
- DROPLET MICRON 34G X 9/64"
- DROPLET PEN NEEDLE 29G 10MM
- DROPLET PEN NEEDLE 29G 12MM
- DROPLET PEN NEEDLE 30G 8MM
- DROPLET PEN NEEDLE 31G 5MM
- DROPLET PEN NEEDLE 31G 6MM
- DROPLET PEN NEEDLE 31G 8MM
- DROPLET PEN NEEDLE 32G 4MM
- DROPLET PEN NEEDLE 32G 5MM
- DROPLET PEN NEEDLE 32G 6MM
- DROPLET PEN NEEDLE 32G 8MM
- DROPSAFE ALCOHOL 70% PREP PADS
- DROPSAFE INS SYR 0.3 ML 31G 6MM
- DROPSAFE INS SYR 0.3 ML 31G 8MM
- DROPSAFE INS SYR 0.5 ML 31G 6MM
- DROPSAFE INS SYR 0.5 ML 31G 8MM
- DROPSAFE INSUL SYR 1 ML 31G 6MM
- DROPSAFE INSUL SYR 1 ML 31G 8MM
- DROPSAFE INSULN 1 ML 29G 12.5MM
- DROPSAFE PEN NEEDLE 31G 4MM
- DROPSAFE PEN NEEDLE 31G 5MM
- DROPSAFE PEN NEEDLE 31G 8MM
- DROPSAFE PEN NEEDLE 31GX1/4"
- DRUG MART ULTRA COMFORT SYR
- EASY CMFT SFTY PEN NDL 31G 5MM
- EASY CMFT SFTY PEN NDL 31G 6MM
- EASY CMFT SFTY PEN NDL 32G 4MM
- EASY COMFORT 0.3 ML 31G 1/2"
- EASY COMFORT 0.3 ML 31G 5/16"
- EASY COMFORT 0.3 ML SYRINGE
- EASY COMFORT 0.5 ML 30GX1/2"
- EASY COMFORT 0.5 ML 31GX5/16"
- EASY COMFORT 0.5 ML 32GX5/16"
- EASY COMFORT 0.5 ML SYRINGE
- EASY COMFORT 1 ML 31GX5/16"
- EASY COMFORT 1 ML 32GX5/16"
- EASY COMFORT ALCOHOL 70% PAD
- EASY COMFORT INSULIN 1 ML SYR
- EASY COMFORT PEN NDL 29G 4MM
- EASY COMFORT PEN NDL 29G 5MM
- EASY COMFORT PEN NDL 31GX1/4"
- EASY COMFORT PEN NDL 31GX3/16"
- EASY COMFORT PEN NDL 31GX5/16"
- EASY COMFORT PEN NDL 32GX5/32"
- EASY COMFORT PEN NDL 33G 4MM
- EASY COMFORT PEN NDL 33G 5MM
- EASY COMFORT PEN NDL 33G 6MM
- EASY COMFORT SYR 0.5 ML 29G 8MM
- EASY COMFORT SYR 1 ML 29G 8MM
- EASY COMFORT SYR 1 ML 30GX1/2"
- EASY GLIDE INS 0.3 ML 31GX6MM
- EASY GLIDE INS 0.5 ML 31GX6MM
- EASY GLIDE INS 1 ML 31GX6MM
- EASY GLIDE PEN NEEDLE 4MM 33G
- EASY TOUCH 0.3 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 27GX1/2"
- EASY TOUCH 0.5 ML SYR 29GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX5/16
- EASY TOUCH 1 ML SYR 29GX1/2"
- EASY TOUCH 1 ML SYR 30GX1/2"
- EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED
- EASY TOUCH AUTO 0.5 ML 30G 6MM
- EASY TOUCH AUTO 0.5 ML 30G 8MM
- EASY TOUCH AUTORET 1 ML 30G 6MM
- EASY TOUCH AUTORET 1 ML 30G 8MM
- EASY TOUCH FLIPLOK 1 ML 27GX0.5
- EASY TOUCH INS 0.5 ML 30G 8MM
- EASY TOUCH INS 0.5 ML 31G 8MM
- EASY TOUCH INS 1 ML 27G 1/2"
- EASY TOUCH INS 1 ML 28G 12.7MM
- EASY TOUCH INS 1 ML 29G 12.7MM
- EASY TOUCH INS SYR 1 ML 30G 8MM

- EASY TOUCH INS SYR 1 ML 31G 8MM
- EASY TOUCH INSULIN 1 ML 29GX1/2
- EASY TOUCH INSULIN 1 ML 30GX1/2
- EASY TOUCH INSULIN SYR 0.3 ML
- EASY TOUCH INSULIN SYR 1 ML  
RETRACTABLE
- EASY TOUCH INSULN 1 ML 29GX1/2"
- EASY TOUCH INSULN 1 ML 30GX1/2"
- EASY TOUCH INSULN 1 ML 30GX5/16
- EASY TOUCH INSULN 1 ML 31GX5/16
- EASY TOUCH LUER LOK INSUL 1 ML
- EASY TOUCH PEN NEEDLE 29GX1/2"
- EASY TOUCH PEN NEEDLE 30GX5/16
- EASY TOUCH PEN NEEDLE 31GX1/4"
- EASY TOUCH PEN NEEDLE 31GX3/16
- EASY TOUCH PEN NEEDLE 31GX5/16
- EASY TOUCH PEN NEEDLE 32GX1/4"
- EASY TOUCH PEN NEEDLE 32GX3/16
- EASY TOUCH PEN NEEDLE 32GX5/32
- EASY TOUCH SAF PEN NDL 29G 5MM
- EASY TOUCH SAF PEN NDL 29G 8MM
- EASY TOUCH SAF PEN NDL 30G 5MM
- EASY TOUCH SAF PEN NDL 30G 8MM
- EASY TOUCH SYR 0.5 ML 28G 12.7MM
- EASY TOUCH SYR 0.5 ML 29G 12.7MM
- EASY TOUCH SYR 1 ML 27G 16MM
- EASY TOUCH UNI-SLIP SYR 1 ML
- EASYLIFE ALCOHOL 70% PADS
- EASYLIFE INS PEN NDL 29G 12MM
- EASYLIFE INS PEN NDL 31G 4MM
- EASYLIFE INS PEN NDL 31G 5MM
- EASYLIFE INS PEN NDL 31G 6MM
- EASYLIFE INS PEN NDL 31G 8MM
- EASYLIFE INS PEN NDL 32G 4MM
- EASYLIFE INS PEN NDL 32G 5MM
- EASYLIFE INS PEN NDL 32G 6MM
- EASYLIFE INS PEN NDL 32G 8MM
- EASYLIFE INS PEN NDL 33G 4MM
- EASYLIFE INS PEN NDL 33G 5MM
- EASYLIFE INS PEN NDL 33G 6MM
- EASYLIFE INS PEN NDL 33G 8MM
- EASYLIFE INS SYR 0.5 ML 30G 8MM
- EASYLIFE INS SYR 1 ML 30G 8MM
- EASYLIFE INS SYR 1 ML 31G 8MM
- EASYLIFE SAFTY PEN NDL 31G 4MM
- EASYLIFE SAFTY PEN NDL 31G 5MM
- EASYLIFE SYR 1 ML 30G 12.7MM
- EASYTOUCH SAF PEN NDL 30G 6MM
- EMBRACE PEN NEEDLE 29G 12MM
- EMBRACE PEN NEEDLE 30G 5MM
- EMBRACE PEN NEEDLE 30G 8MM
- EMBRACE PEN NEEDLE 31G 5MM
- EMBRACE PEN NEEDLE 31G 6MM
- EMBRACE PEN NEEDLE 31G 8MM
- EMBRACE PEN NEEDLE 32G 4MM
- EQL INSULIN 1 ML SYRINGE SHORT  
NEEDLE
- EXEL U100 0.3 ML 29GX1/2"
- FP INSULIN 1 ML SYRINGE
- FREESTYLE PREC 0.5 ML 30GX5/16
- FREESTYLE PREC 0.5 ML 31GX5/16
- FREESTYLE PREC 1 ML 30GX5/16"
- FREESTYLE PREC 1 ML 31GX5/16"
- FT STERILE PADS 2" X 2"
- GAUZE PAD TOPICAL BANDAGE 2 X 2  
"
- GAUZE PADS 2"X2" STRL
- GNP ALCOHOL SWAB STERILE, TWO  
PLY
- GNP CLICKFINE 31G X 1/4" NDL 6MM,  
UNIVERSAL
- GNP CLICKFINE 31G X 5/16" NDL 8MM,  
UNIVERSAL
- GNP PEN NEEDLE 31G 5MM
- GNP PEN NEEDLE 32G 4MM
- GNP PEN NEEDLE 32G 6MM
- GNP SIMPLI PEN NEEDLE 32G 4MM
- GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2  
UNIT
- GNP ULT CMFRT 0.5 ML 29GX1/2"
- GNP ULTRA COMFORT 0.5 ML SYR
- GNP ULTRA COMFORT 1 ML SYRINGE
- GNP ULTRA COMFORT 3/10 ML SYR
- HEALTHWISE INS 0.3 ML 30GX5/16"
- HEALTHWISE INS 0.3 ML 31GX5/16"
- HEALTHWISE INS 0.5 ML 30GX5/16"
- HEALTHWISE INS 0.5 ML 31GX5/16"
- HEALTHWISE INS 1 ML 30GX5/16"
- HEALTHWISE INS 1 ML 31GX5/16"
- HEALTHWISE PEN NEEDLE 31G 5MM
- HEALTHWISE PEN NEEDLE 31G 8MM
- HEALTHWISE PEN NEEDLE 32G 4MM
- HEALTHY ACCENTS PENTIP 4MM 32G
- HEALTHY ACCENTS PENTIP 5MM 31G

- HEALTHY ACCENTS PENTIP 6MM 31G
- HEALTHY ACCENTS PENTIP 8MM 31G
- HEALTHY ACCENTS PENTIP 12MM 29G
- HEB INCONTROL ALCOHOL 70% PADS
- INCONTROL PEN NEEDLE 12MM 29G
- INCONTROL PEN NEEDLE 4MM 32G
- INCONTROL PEN NEEDLE 5MM 31G
- INCONTROL PEN NEEDLE 6MM 31G
- INCONTROL PEN NEEDLE 8MM 31G
- INSULIN 1 ML SYRINGE
- INSULIN 1/2 ML SYRINGE
- INSULIN 3/10 ML SYRINGE
- INSULIN SYR 0.3 ML 31GX1/4(1/2)
- INSULIN SYR 0.5 ML 28G 12.7MM (OTC)
- INSULIN SYRIN 0.5 ML 30GX1/2" (RX)
- INSULIN SYRING 0.5 ML 27G 1/2" INNER
- INSULIN SYRINGE 0.3 ML
- INSULIN SYRINGE 0.3 ML 31GX1/4
- INSULIN SYRINGE 0.5 ML
- INSULIN SYRINGE 0.5 ML 31GX1/4
- INSULIN SYRINGE 1 ML
- INSULIN SYRINGE 1 ML 27G 1/2" INNER
- INSULIN SYRINGE 1 ML 27G 16MM
- INSULIN SYRINGE 1 ML 28G 12.7MM (OTC)
- INSULIN SYRINGE 1 ML 30GX1/2" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 31GX1/4"
- INSULIN SYRINGE 1 ML 31GX5/16" SHORT NEEDLE, THIN II (OTC)
- INSULIN SYRINGE NEEDLELESS
- INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE
- INSULIN U-500 SYRINGE-NEEDLE
- INSUPEN PEN NEEDLE 29GX1/2"
- INSUPEN PEN NEEDLE 31G 8MM
- INSUPEN PEN NEEDLE 31GX3/16"
- INSUPEN PEN NEEDLE 32G 4MM
- INSUPEN PEN NEEDLE 32G 6MM (RX)
- IV ANTISEPTIC WIPES
- KENDALL ALCOHOL 70% PREP PAD
- LISCO SPONGES 100/BAG
- LITE TOUCH 31GX1/4" PEN NEEDLE
- LITE TOUCH INSULIN 0.5 ML SYR
- LITE TOUCH INSULIN 1 ML SYR
- LITE TOUCH INSULIN SYR 1 ML
- LITE TOUCH PEN NEEDLE 29G
- LITE TOUCH PEN NEEDLE 31G
- LITETOUCH INS 0.3 ML 29GX1/2"
- LITETOUCH INS 0.3 ML 30GX5/16"
- LITETOUCH INS 0.3 ML 31GX5/16"
- LITETOUCH INS 0.5 ML 31GX5/16"
- LITETOUCH SYR 0.5 ML 28GX1/2"
- LITETOUCH SYR 0.5 ML 29GX1/2"
- LITETOUCH SYR 0.5 ML 30GX5/16"
- LITETOUCH SYRIN 1 ML 28GX1/2"
- LITETOUCH SYRIN 1 ML 29GX1/2"
- LITETOUCH SYRIN 1 ML 30GX5/16"
- MAGELLAN INSUL SYRINGE 0.3 ML
- MAGELLAN INSUL SYRINGE 0.5 ML
- MAGELLAN INSULIN SYR 0.3 ML
- MAGELLAN INSULIN SYR 0.5 ML
- MAGELLAN INSULIN SYRINGE 1 ML
- MAXI-COMFORT INS 0.5 ML 28G
- MAXI-COMFORT INS 1 ML 28GX1/2"
- MAXICOMFORT II PEN NDL 31GX6MM
- MAXICOMFORT INS 0.5 ML 27GX1/2"
- MAXICOMFORT INS 1 ML 27GX1/2"
- MAXICOMFORT PEN NDL 29G X 5MM
- MAXICOMFORT PEN NDL 29G X 8MM
- MICRODOT PEN NEEDLE 31GX6MM
- MICRODOT PEN NEEDLE 32GX4MM
- MICRODOT PEN NEEDLE 33GX4MM
- MICRODOT READYGARD NDL 31G 5MM OUTER
- MINI PEN NEEDLE 32G 5MM
- MINI PEN NEEDLE 32G 8MM
- MINI PEN NEEDLE 33G 4MM
- MINI PEN NEEDLE 33G 5MM
- MINI PEN NEEDLE 33G 6MM
- MINI ULTRA-THIN II PEN NDL 31G STERILE
- MONOJECT 0.5 ML SYRN 28GX1/2"
- MONOJECT 1 ML SYRN 27X1/2"
- MONOJECT 1 ML SYRN 28GX1/2" (OTC)
- MONOJECT INSUL SYR U100 (OTC)
- MONOJECT INSUL SYR U100 .5ML, 29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)
- MONOJECT INSUL SYR U100 1 ML

- MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)
- MONOJECT INSULIN SYR 0.3 ML
- MONOJECT INSULIN SYR 0.3 ML (OTC)
- MONOJECT INSULIN SYR 0.5 ML
- MONOJECT INSULIN SYR 0.5 ML (OTC)
- MONOJECT INSULIN SYR 1 ML 3'S (OTC)
- MONOJECT INSULIN SYR U-100
- MONOJECT SYRINGE 0.3 ML
- MONOJECT SYRINGE 0.5 ML
- MONOJECT SYRINGE 1 ML
- NANO 2 GEN PEN NEEDLE 32G 4MM
- NANO PEN NEEDLE 32G 4MM
- NOVOFINE 30
- NOVOFINE 32G NEEDLES
- NOVOFINE PLUS PEN NDL 32GX1/6"
- NOVOTWIST
- PC UNIFINE PENTIPS 8MM NEEDLE SHORT
- PEN NEEDLE 30G 5MM OUTER
- PEN NEEDLE 30G 8MM INNER
- PEN NEEDLE 30G X 5/16"
- PEN NEEDLE 31G 8MM
- PEN NEEDLE 31G X 1/4" HRI
- PEN NEEDLE 6MM 31G 6MM
- PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLES 12MM 29G 29GX12MM,STRL
- PEN NEEDLES 4MM 32G
- PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC)
- PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC)
- PENTIPS PEN NEEDLE 29G 1/2"
- PENTIPS PEN NEEDLE 31G 1/4"
- PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM
- PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM
- PENTIPS PEN NEEDLE 32G 1/4"
- PENTIPS PEN NEEDLE 32GX5/32" 4MM
- PIP PEN NEEDLE 31G X 5MM
- PIP PEN NEEDLE 32G X 4MM
- PREFPLS INS SYR 1 ML 30GX5/16" (OTC)
- PREVENT PEN NEEDLE 31GX1/4"
- PREVENT PEN NEEDLE 31GX5/16"
- PRO COMFORT 0.5 ML 30GX1/2"
- PRO COMFORT 0.5 ML 30GX5/16"
- PRO COMFORT 0.5 ML 31GX5/16"
- PRO COMFORT 1 ML 30GX1/2"
- PRO COMFORT 1 ML 30GX5/16"
- PRO COMFORT 1 ML 31GX5/16"
- PRO COMFORT ALCOHOL 70% PADS
- PRO COMFORT PEN NDL 32G 8MM
- PRO COMFORT PEN NDL 32G X 1/4"
- PRO COMFORT PEN NDL 4MM 32G
- PRO COMFORT PEN NDL 5MM 32G
- PRO-COMFORT ALCOHOL 70% PADS
- PRODIGY INS SYR 1 ML 28GX1/2"
- PRODIGY SYRNG 0.5 ML 31GX5/16"
- PRODIGY SYRNGE 0.3 ML 31GX5/16"
- PURE CMFT SFTY PEN NDL 31G 5MM
- PURE CMFT SFTY PEN NDL 31G 6MM
- PURE CMFT SFTY PEN NDL 32G 4MM
- PURE COMFORT ALCOHOL 70% PADS
- PURE COMFORT PEN NDL 32G 4MM
- PURE COMFORT PEN NDL 32G 5MM
- PURE COMFORT PEN NDL 32G 6MM
- PURE COMFORT PEN NDL 32G 8MM
- RAYA SURE PEN NEEDLE 29G 12MM
- RAYA SURE PEN NEEDLE 31G 4MM
- RAYA SURE PEN NEEDLE 31G 5MM
- RAYA SURE PEN NEEDLE 31G 6MM
- RELION INS SYR 0.3 ML 31GX6MM
- RELION INS SYR 0.5 ML 31GX6MM
- RELION INS SYR 1 ML 31GX15/64"
- SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10
- SAFETY PEN NEEDLE 31G 4MM
- SAFETY PEN NEEDLE 5MM X 31G
- SAFETY SYRINGE 0.5 ML 30G 1/2"

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

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

- ULTRA-FINE 0.5 ML 30G 12.7MM
- ULTRA-FINE INS SYR 1 ML 31G 6MM
- ULTRA-FINE INS SYR 1 ML 31G 8MM
- ULTRA-FINE PEN NDL 29G 12.7MM
- ULTRA-FINE PEN NEEDLE 31G 5MM
- ULTRA-FINE PEN NEEDLE 31G 8MM
- ULTRA-FINE PEN NEEDLE 32G 6MM
- ULTRA-FINE SYR 0.5 ML 31G 6MM
- ULTRA-FINE SYR 0.5 ML 31G 8MM
- ULTRA-FINE SYR 1 ML 30G 12.7MM
- ULTRA-THIN II 1 ML 31GX5/16"
- ULTRA-THIN II INS 0.3 ML 30G
- ULTRA-THIN II INS 0.3 ML 31G
- ULTRA-THIN II INS 0.5 ML 29G
- ULTRA-THIN II INS 0.5 ML 30G
- ULTRA-THIN II INS 0.5 ML 31G
- ULTRA-THIN II INS SYR 1 ML 29G
- ULTRA-THIN II INS SYR 1 ML 30G
- ULTRA-THIN II PEN NDL 29GX1/2"
- ULTRA-THIN II PEN NDL 31GX5/16
- ULTRACARE INS 0.3 ML 30GX5/16"
- ULTRACARE INS 0.3 ML 31GX5/16"
- ULTRACARE INS 0.5 ML 30GX1/2"
- ULTRACARE INS 0.5 ML 30GX5/16"
- ULTRACARE INS 0.5 ML 31GX5/16"
- ULTRACARE INS 1 ML 30G X 5/16"
- ULTRACARE INS 1 ML 30GX1/2"
- ULTRACARE INS 1 ML 31G X 5/16"
- ULTRACARE PEN NEEDLE 31GX1/4"
- ULTRACARE PEN NEEDLE 31GX3/16"
- ULTRACARE PEN NEEDLE 31GX5/16"
- ULTRACARE PEN NEEDLE 32GX1/4"
- ULTRACARE PEN NEEDLE 32GX3/16"
- ULTRACARE PEN NEEDLE 32GX5/32"
- ULTRACARE PEN NEEDLE 33GX5/32"
- UNIFINE OTC PEN NEEDLE 31G 5MM
- UNIFINE OTC PEN NEEDLE 32G 4MM
- UNIFINE PEN NEEDLE 32G 4MM
- UNIFINE PENTIPS 12MM 29G  
29GX12MM, STRL
- UNIFINE PENTIPS 31GX3/16"  
31GX5MM,STRL,MINI
- UNIFINE PENTIPS 32G 4MM
- UNIFINE PENTIPS 32GX1/4"
- UNIFINE PENTIPS 33GX5/32"
- UNIFINE PENTIPS 6MM 31G
- UNIFINE PENTIPS MAX 30GX3/16"
- UNIFINE PENTIPS NEEDLES 29G
- UNIFINE PENTIPS PLUS 29GX1/2"  
12MM
- UNIFINE PENTIPS PLUS 30GX3/16"
- UNIFINE PENTIPS PLUS 31GX1/4"  
ULTRA SHORT, 6MM
- UNIFINE PENTIPS PLUS 31GX3/16"  
MINI
- UNIFINE PENTIPS PLUS 31GX5/16"  
SHORT
- UNIFINE PENTIPS PLUS 32GX5/32"
- UNIFINE PENTIPS PLUS 33GX5/32"
- UNIFINE PROTECT 30G 5MM
- UNIFINE PROTECT 30G 8MM
- UNIFINE PROTECT 32G 4MM
- UNIFINE SAFECONTROL 30G 5MM
- UNIFINE SAFECONTROL 30G 8MM
- UNIFINE SAFECONTROL 31G 5MM
- UNIFINE SAFECONTROL 31G 6MM
- UNIFINE SAFECONTROL 31G 8MM
- UNIFINE SAFECONTROL 32G 4MM
- UNIFINE ULTRA PEN NDL 31G 5MM
- UNIFINE ULTRA PEN NDL 31G 6MM
- UNIFINE ULTRA PEN NDL 31G 8MM
- UNIFINE ULTRA PEN NDL 32G 4MM
- VANISHPOINT 0.5 ML 30GX1/2" SY  
OUTER
- VANISHPOINT INS 0.5 ML 30G 8MM  
OUTER
- VANISHPOINT INS 1 ML 30GX3/16"
- VANISHPOINT U-100 29X1/2 SYR
- VERIFINE INS SYR 1 ML 29G 1/2"
- VERIFINE PEN NEEDLE 29G 12MM
- VERIFINE PEN NEEDLE 31G 5MM
- VERIFINE PEN NEEDLE 31G X 6MM
- VERIFINE PEN NEEDLE 31G X 8MM
- VERIFINE PEN NEEDLE 32G 6MM
- VERIFINE PEN NEEDLE 32G X 4MM
- VERIFINE PEN NEEDLE 32G X 5MM
- VERIFINE PLUS PEN NDL 31G 5MM
- VERIFINE PLUS PEN NDL 31G 8MM
- VERIFINE PLUS PEN NDL 32G 4MM
- VERIFINE PLUS PEN NDL 32G 4MM-  
SHARPS CONTAINER
- VERIFINE SYRING 0.5 ML 29G 1/2"
- VERIFINE SYRING 1 ML 31G 5/16"
- VERIFINE SYRNG 0.3 ML 31G 5/16"

- VERIFINE SYRNG 0.5 ML 31G 5/16"
- VERSALON ALL PURPOSE SPONGE  
25'S,N-STERILE,3PLY
- WEBCOL ALCOHOL PREPS 20'S,LARGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	LIFETIME
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# INTERFERON FOR MS-AVONEX

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## Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

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

# INTERFERON FOR MS-BETASERON

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## Products Affected

- BETASERON SUBCUTANEOUS KIT

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

# INTERFERON FOR MS-PLEGRIDY

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## Products Affected

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

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

# INTERFERON GAMMA-1B

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## Products Affected

- ACTIMMUNE

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

# IPILIMUMAB

## Products Affected

- YERVOY

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

# ISAVUCONAZONIUM

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## Products Affected

- CRESEMBA ORAL

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

# IVACAFTOR

## Products Affected

- KALYDECO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
<b>Coverage Duration</b>	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# IVOSIDENIB

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## Products Affected

- TIBSOVO

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

# IXAZOMIB

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## Products Affected

- NINLARO

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

# LAMOTRIGINE

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## Products Affected

- SUBVENITE ORAL SUSPENSION

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

# LANREOTIDE

## Products Affected

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

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

# LAPATINIB

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## Products Affected

- *lapatinib*

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

# LAROTRECTINIB

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## Products Affected

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

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

# LAZERTINIB

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## Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

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

# LEDIPASVIR-SOFOSBUVIR

## Products Affected

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

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

# LENALIDOMIDE

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## Products Affected

- *lenalidomide*

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

# LENVATINIB

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## Products Affected

- LENVIMA

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

# LETERMOVIR

## Products Affected

- PREVYMIS ORAL TABLET

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

# LEUPROLIDE

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## Products Affected

- *leuprolide subcutaneous kit*

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

# LEUPROLIDE DEPOT

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## Products Affected

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

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

# LEUPROLIDE MESYLATE

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## Products Affected

- CAMCEVI (6 MONTH)

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

# LEUPROLIDE-ELIGARD

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## Products Affected

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

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

# LEUPROLIDE-LUPRON DEPOT

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
<b>Coverage Duration</b>	PROSTATE CA: 12 MOS. UTERINE FIBROIDS: 3 MOS. ENDOMETRIOSIS: INITIAL/RENEWAL: 6 MOS.
<b>Other Criteria</b>	INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. RENEWAL: ENDOMETRIOSIS: 1) IMPROVEMENT OF PAIN RELATED TO ENDOMETRIOSIS WHILE ON THERAPY, 2) RECEIVING CONCOMITANT ADD-BACK THERAPY (I.E., COMBINATION ESTROGEN-PROGESTIN OR PROGESTIN-ONLY CONTRACEPTIVE PREPARATION), 3) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 4) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# LEUPROLIDE-LUPRON DEPOT-PED

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CPP: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# L-GLUTAMINE

## Products Affected

- *glutamine (sickle cell)*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	SICKLE CELL DISEASE(SCD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
<b>Coverage Duration</b>	INITIAL: 12 MONTHS. RENEWAL: LIFETIME.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# LIDOCAINE OINTMENT

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## Products Affected

- *lidocaine topical ointment*

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

# LIDOCAINE PATCH

## Products Affected

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

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

# LIDOCAINE PRILOCAINE

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## Products Affected

- *lidocaine-prilocaine topical cream*

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

# LINVOSELTAMAB-GCPT

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## Products Affected

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

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

# LONCASTUXIMAB TESIRINE-LPYL

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## Products Affected

- ZYNLONTA

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

# LORLATINIB

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## Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

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

# LOTILANER

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## Products Affected

- XDEMZY

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

# LUMACAFITOR-IVACAFITOR

## Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# MACITENTAN

## Products Affected

- OPSUMIT

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

# MARGETUXIMAB-CMKB

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## Products Affected

- MARGENZA

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

# MARIBAVIR

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## Products Affected

- LIVTENCITY

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

# MAVACAMTEN

## Products Affected

- CAMZYOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	OBSTRUCTIVE HYPERTROPHIC CARDIOMYOPATHY(HCM): INITIAL: LEFT VENTRICULAR OUTFLOW TRACK (LVOT) GRADIENT OF 50 MMHG OR HIGHER
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	OBSTRUCTIVE HCM: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	OBSTRUCTIVE HCM: INITIAL: TRIAL OF, CONTRAINDICATION, OR INTOLERANCE TO A BETA-BLOCKER OR A NON-DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKER. RENEWAL: CONTINUED CLINICAL BENEFIT (E.G., REDUCTION OF SYMPTOMS, NYHA CLASSIFICATION IMPROVEMENT).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# MECASERMIN

## Products Affected

- INCRELEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	GROWTH FAILURE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR NEPHROLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	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).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# MECHLORETHAMINE

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## Products Affected

- VALCHLOR

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

# MEPOLIZUMAB

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: CRSWNP: 6 MO. OTHERS: 12 MO. RENEWAL: CRSWNP, ASTHMA, COPD, EGPA, HES: 12 MO.

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

PA Criteria	Criteria Details
	<p>SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): 1) REDUCTION IN EGPA SYMPTOMS COMPARED TO BASELINE OR ABILITY TO REDUCE/ELIMINATE CORTICOSTEROID USE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS, OR (C) INCREASE IN FEV1 OF AT LEAST 5 PERCENT FROM PRETREATMENT BASELINE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# METYROSINE

## Products Affected

- *metirosine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PHEOCHROMOCYTOMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, ENDOCRINE SURGEON, OR HEMATOLOGIST-ONCOLOGIST.
<b>Coverage Duration</b>	PREOPERATIVE PREPARATION FOR SURGERY: 30 DAYS. MALIGNANT PHEOCHROMOCYTOMA: INITIAL/RENEWAL:12 MOS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# MIDOSTAURIN

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## Products Affected

- RYDAPT

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

# MIFEPRISTONE

## Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	CS: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICIDS. 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# MILTEFOSINE

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## Products Affected

- IMPAVIDO

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

# MIRDAMETINIB

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## Products Affected

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

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

# MIRVETUXIMAB SORAVTANSINE-GYNX

## Products Affected

- ELAHERE

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

# MOMELOTINIB

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## Products Affected

- OJAARA

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

# MOSUNETUZUMAB-AXGB

## Products Affected

- LUNSUMIO
- LUNSUMIO VELO

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

# NARCOLEPSY AGENTS

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## Products Affected

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

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

# NAXITAMAB-GQGK

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## Products Affected

- DANYELZA

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

# NERANDOMILAST

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## Products Affected

- JASCAYD

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. PPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	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 WORSENERD/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: OFEV (NINTEDANIB). RENEWAL: IPF, PPF: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# NERATINIB

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## Products Affected

- NERLYNX

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

# NILOTINIB - TASIGNA

## Products Affected

- *nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg*
- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

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

# NILOTINIB-DANZITEN

## Products Affected

- DANZITEN

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

# NINTEDANIB

## Products Affected

- *nintedanib*
- OFEV

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: SSC-ILD: 6 MOS. IPF, PF-ILD: 12 MOS. RENEWAL (ALL INDICATIONS): 12 MOS.

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

# NIRAPARIB

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## Products Affected

- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET

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

# NIRAPARIB-ABIRATERONE

## Products Affected

- AKEEGA

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

# NIROGACESTAT

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## Products Affected

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

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

# NITISINONE

## Products Affected

- *nitisinone*
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HT-1: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	HT-1: INITIAL: ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED NITISINONE TABLETS OR CAPSULES.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# NIVOLUMAB

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## Products Affected

- OPDIVO

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

# NIVOLUMAB-HYALURONIDASE-NVHY

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## Products Affected

- OPDIVO QVANTIG

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

# NIVOLUMAB-RELATLIMAB-RMBW

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## Products Affected

- OPDUALAG

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

# NOGAPENDEKIN ALFA

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## Products Affected

- ANKTIVA

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

# OFATUMUMAB SQ

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## Products Affected

- KESIMPTA PEN

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

# OLAPARIB

## Products Affected

- LYNPARZA

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

# OLUTASIDENIB

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## Products Affected

- REZLIDHIA

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

# OMACETAXINE

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## Products Affected

- SYNRIBO

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

# OMALIZUMAB

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL/RENEWAL: ASTHMA 12 MO/12 MO, CSU 6 MO/12 MO, CRSWNP 6 MO/12 MO, FOOD ALLERGY 12 MO/24 MO

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: CSU: 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE, 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA ON MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS, AND 3) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: DUPIXENT. CRSWNP: 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: NUCALA, DUPIXENT, 3) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 4) INADEQUATELY CONTROLLED DISEASE. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA. FOOD ALLERGY: CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION .</p> <p>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</p>

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

# OSIMERTINIB

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## Products Affected

- TAGRISSO

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

# OXANDROLONE

## Products Affected

- *oxandrolone*

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

# PACRITINIB

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## Products Affected

- VONJO

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

# PALBOCICLIB

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## Products Affected

- IBRANCE

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

# PARATHYROID HORMONE

## Products Affected

- NATPARA

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

# PASIREOTIDE DIASPARTATE

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## Products Affected

- SIGNIFOR

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

# PAZOPANIB

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## Products Affected

- *pazopanib oral tablet 200 mg, 400 mg*

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

# PEGFILGRASTIM - APGF

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## Products Affected

- NYVEPRIA

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

# PEGFILGRASTIM - CBQV

## Products Affected

- UDENYCA ONBODY

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

# PEGINTERFERON ALFA-2A

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## Products Affected

- PEGASYS

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

# PEGVISOMANT

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## Products Affected

- SOMAVERT

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

# PEMBROLIZUMAB

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## Products Affected

- KEYTRUDA

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

# PEMBROLIZUMAB-BERAHYALURONIDASE ALFA-PMPH

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## Products Affected

- KEYTRUDA QLEX

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

# PEMIGATINIB

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## Products Affected

- PEMAZYRE

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

# PENICILLAMINE TABLET

## Products Affected

- *penicillamine oral tablet*

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

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

# PEXIDARTINIB

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## Products Affected

- TURALIO

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

# PIMAVANSERIN

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## Products Affected

- NUPLAZID

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

# PIRFENIDONE

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	IPF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	IPF: INITIAL: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, OR CANCER). RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# PIRTOBRUTINIB

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## Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

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

# POMALIDOMIDE

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## Products Affected

- *pomalidomide*
- POMALYST

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

# PONATINIB

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## Products Affected

- ICLUSIG

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

# POSACONAZOLE TABLET

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## Products Affected

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

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

# PRALSETINIB

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## Products Affected

- GAVRETO

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

# PYRIMETHAMINE

## Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	TOXOPLASMOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
<b>Coverage Duration</b>	TOXOPLASMOSIS: INITIAL: 8 WEEKS, RENEWAL: 6 MOS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# QUININE

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## Products Affected

- *quinine sulfate*

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

# QUIZARTINIB

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## Products Affected

- VANFLYTA

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

# REGORAFENIB

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## Products Affected

- STIVARGA

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

# RELUGOLIX

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## Products Affected

- ORGOVYX

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

# REPOTRECTINIB

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## Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

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

# RESMETIROM

## Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	NONALCOHOLIC STEATOHEPATITIS (NASH): INITIAL: DIAGNOSIS CONFIRMED BY BIOPSY OR NONINVASIVE TESTING, OBTAINED IN THE PAST 12 MONTHS, DEMONSTRATING: 1) LIVER FIBROSIS STAGE 2 OR 3, OR 2) NONALCOHOLIC FATTY LIVER DISEASE (NAFLD) ACTIVITY SCORE OF 4 OR MORE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NASH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST, GASTROENTEROLOGIST, OR ENDOCRINOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	NASH: RENEWAL: CONTINUES TO HAVE NONCIRRHOTIC NASH WITH MODERATE TO ADVANCED LIVER FIBROSIS (CONSISTENT WITH STAGES F2 TO F3 FIBROSIS).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# RETIFANLIMAB-DLWR

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## Products Affected

- ZYNYZ

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

# REVUMENIB

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## Products Affected

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

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

# RIBOCICLIB

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## Products Affected

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

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

# RIBOCICLIB-LETROZOLE

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## Products Affected

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

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

# RIFAXIMIN

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## Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

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

# RILONACEPT

## Products Affected

- ARCALYST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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.</p> <p>DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) ONE OF THE FOLLOWING: PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, ONYCHOMADESIS. RECURRENT PERICARDITIS (RP): TWO OF THE FOLLOWING: CHEST PAIN CONSISTENT WITH PERICARDITIS, PERICARDIAL FRICTION RUB, ECG SHOWING DIFFUSE ST-SEGMENT ELEVATION OR PR-SEGMENT DEPRESSION, NEW OR WORSENING PERICARDIAL EFFUSION.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	CAPS, DIRA: LIFETIME. RP: 12 MONTHS.

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

# RIMEGEPANT

## Products Affected

- NURTEC ODT

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

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

# RIOCIQUAT

## Products Affected

- ADEMPAS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PAH, CTEPH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# RIPRETINIB

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## Products Affected

- QINLOCK

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

# RISANKIZUMAB-RZAA

## Products Affected

- SKYRIZI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# RITUXIMAB AND HYALURONIDASE HUMAN-SQ

## Products Affected

- RITUXAN HYCELA

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

# RITUXIMAB-ABBS

## Products Affected

- TRUXIMA

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

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

# ROPEGINTERFERON ALFA-2B-NJFT

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## Products Affected

- BESREMI

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

# RUCAPARIB

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## Products Affected

- RUBRACA

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

# RUXOLITINIB

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## Products Affected

- JAKAFI

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

# SAPROPTERIN

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## Products Affected

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

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

# SECUKINUMAB SQ

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: HS: 12 MONTHS, ALL OTHER INDICATIONS: 6 MONTHS. RENEWAL: 12 MONTHS.

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

# SELEXIPAG

## Products Affected

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

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

# SELINEXOR

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## Products Affected

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

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

# SELPERCATINIB

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## Products Affected

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

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

# SELUMETINIB

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## Products Affected

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

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

# SEVABERTINIB

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## Products Affected

- HYRNUO

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

# SILDENAFIL TABLET

## Products Affected

- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# SIPONIMOD

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## Products Affected

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

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

# SIROLIMUS PROTEIN-BOUND

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## Products Affected

- FYARRO

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

# SODIUM OXYBATE-XYREM

## Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: CATAPLEXY IN NARCOLEPSY, EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# SOFOSBUVIR/VELPATASVIR

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	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, TIPRANA VIR/RITONAVIR, TOPOTECAN, SOVALDI (AS A SINGLE AGENT), HARVONI, ZEPATIER, MAVYRET, OR VOSEVI, AND 3) PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

## Products Affected

- VOSEVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	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).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# SOMATROPIN - NORDITROPIN

## Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	SGA: 2 YEARS OF AGE OR OLDER.
<b>Prescriber Restrictions</b>	INITIAL/RENEWAL: ALL INDICATIONS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# SOMATROPIN - SEROSTIM

## Products Affected

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

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

# SONIDEGIB

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## Products Affected

- ODOMZO

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

# SORAFENIB

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## Products Affected

- *sorafenib*

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

# SOTATERCEPT-CSRK

## Products Affected

- WINREVAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

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

# SOTORASIB

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## Products Affected

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

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

# STIRIPENTOL

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## Products Affected

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

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

# SUNITINIB

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## Products Affected

- *sunitinib malate*

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

# TADALAFIL - ADCIRCA, ALYQ

## Products Affected

- *alyq*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TADALAFIL-CIALIS

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## Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA (BPH).
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# TAFAMIDIS

## Products Affected

- VYNDAMAX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ATTR-CM: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	ATTR-CM: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER ATTR-CM TTR STABILIZERS (E.G., ACORAMIDIS)
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TALAZOPARIB

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## Products Affected

- TALZENNA

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

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

# TALETRECTINIB

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## Products Affected

- IBTROZI

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

# TALQUETAMAB-TGVS

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## Products Affected

- TALVEY

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

# TARLATAMAB-DLLE

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## Products Affected

- IMDELLTRA

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

# TAZEMETOSTAT

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## Products Affected

- TAZVERIK

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

# TEBENTAFUSP-TEBN

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## Products Affected

- KIMMTRAK

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

# TECLISTAMAB-CQYV

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## Products Affected

- TECVAYLI

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

# TELISOTUZUMAB VEDOTIN-TLLV

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## Products Affected

- EMRELIS

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

# TELOTRISTAT

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## Products Affected

- XERMELO

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

# TEPOTINIB

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## Products Affected

- TEPMETKO

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

# TERIPARATIDE

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## Products Affected

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

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

# TESTOSTERONE

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	MALE HYPOGONADISM: INITIAL: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TESTOSTERONE CYPIONATE - DEPO

## Products Affected

- *testosterone cypionate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	MALE HYPOGONADISM: INITIAL: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TESTOSTERONE ENANTHATE

## Products Affected

- *testosterone enanthate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL/RENEWAL: MALE DELAYED PUBERTY: 6MO, MALE HYPOGONADISM: 12 MO. OTHER INDICATIONS: 12 MO.
<b>Other Criteria</b>	INITIAL: MALE HYPOGONADISM: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: MALE HYPOGONADISM: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT. MALE DELAYED PUBERTY: HAS NOT RECEIVED MORE THAN TWO 6-MONTH COURSES OF TESTOSTERONE REPLACEMENT THERAPY
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TETRABENAZINE

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## Products Affected

- *tetrabenazine*

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

# THALIDOMIDE

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## Products Affected

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

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

# TISLELIZUMAB-JSGR

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## Products Affected

- TEVIMBRA

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

# TISOTUMAB VEDOTIN-TFTV

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## Products Affected

- TIVDAK

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

# TIVOZANIB

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## Products Affected

- FOTIVDA

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

# TOCILIZUMAB-AAZG IV

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## Products Affected

- TYENNE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: RA, PJIA, SJIA, GCA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: RA, PJIA, SJIA, GCA: 12 MONTHS.

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

# TOCILIZUMAB-AAZG SQ

## Products Affected

- TYENNE
- TYENNE AUTOINJECTOR

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

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

# TOFACITINIB

## Products Affected

- XELJANZ
- XELJANZ XR

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

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

# TOLVAPTAN

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD): INITIAL: CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI, OR ULTRASOUND.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ADPKD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	ADPKD: INITIAL: DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS). RENEWAL: HAS NOT PROGRESSED TO ESRD/DIALYSIS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TOPICAL TRETINOIN

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## Products Affected

- ALTRENO
- *tretinoin topical cream*

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

# TORIPALIMAB-TPZI

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## Products Affected

- LOQTORZI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	NASOPHARYNGEAL CARCINOMA (NPC): FIRST LINE TREATMENT: 24 MOS, PREVIOUSLY TREATED: LIFETIME.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TOVORAFENIB

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## Products Affected

- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION
- OJEMDA ORAL TABLET

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

# TRAMETINIB SOLUTION

## Products Affected

- MEKINIST ORAL RECON SOLN

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

# TRAMETINIB TABLET

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## Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

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

# TRASTUZUMAB-DKST

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## Products Affected

- OGIVRI

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

# TRASTUZUMAB-HYALURONIDASE-OYSK

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## Products Affected

- HERCEPTIN HYLECTA

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

# TRAZODONE

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## Products Affected

- RALDESY

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

# TREMELIMUMAB-ACTL

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## Products Affected

- IMJUDO

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

# TREPROSTINIL-YUTREPIA

## Products Affected

- YUTREPIA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PAH, PH-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TRIENTINE CAPSULE

## Products Affected

- *trientine oral capsule 250 mg*

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

# TRIFLURIDINE/TIPIRACIL

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## Products Affected

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

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

# TRIPTORELIN-TRELSTAR

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## Products Affected

- TRELSTAR INTRAMUSCULAR  
SUSPENSION FOR RECONSTITUTION

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

# TUCATINIB

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## Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

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

# UBROGEPANT

## Products Affected

- UBRELVY

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

# UPADACITINIB

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## Products Affected

- RINVOQ
- RINVOQ LQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. AD: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO A TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR. AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). GIANT CELL ARTERITIS (GCA): HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICIDS.</p> <p>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.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# USTEKINUMAB-AAUZ SQ

## Products Affected

- *ustekinumab-aauz*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# USTEKINUMAB-AEKN IV

## Products Affected

- SELARSDI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# USTEKINUMAB-AEKN SQ

## Products Affected

- SELARSDI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# USTEKINUMAB-KFCE IV

## Products Affected

- YESINTEK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# USTEKINUMAB-KFCE SQ

## Products Affected

- YESINTEK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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

# VALBENAZINE

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## Products Affected

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

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

# VANDETANIB

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## Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

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

# VANZACAFTOR-TEZACAFTOR- DEUTIVACAFTOR

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## Products Affected

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

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

# VEMURAFENIB

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## Products Affected

- ZELBORAF

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

# VENETOCLAX

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## Products Affected

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

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

# VERICIGUAT

## Products Affected

- VERQUVO

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

# VIGABATRIN

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## Products Affected

- *vigabatin*
- *vigadrone*
- *vigpoder*

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

# VIMSELTINIB

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## Products Affected

- ROMVIMZA

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

# VISMODEGIB

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## Products Affected

- ERIVEDGE

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

# VONOPRAZAN

## Products Affected

- VOQUEZNA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: H PYLORI: 30 DAYS. EE: 8 WEEKS. NERD: 4 WEEKS. RENEWAL: EE: 24 WEEKS.
<b>Other Criteria</b>	INITIAL: EROSION ESOPHAGITIS (EE): TRIAL OF OR CONTRAINDICATION TO TWO PROTON PUMP INHIBITORS AT MAXIMUM DOSE FOR 8 WEEKS EACH. NON-EROSIVE GASTROESOPHAGEAL REFLUX DISEASE (NERD): 1) NO PREVIOUS TREATMENT FAILURE WITH VOQUEZNA IN THE LAST 12 MONTHS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE PROTON PUMP INHIBITOR AT MAXIMUM DOSE FOR 8 WEEKS. RENEWAL: EE: MAINTAINED A CLINICAL RESPONSE ON VOQUEZNA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# VORASIDENIB

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## Products Affected

- VORANIGO

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

# VORICONAZOLE SUSPENSION

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## Products Affected

- *voriconazole oral suspension for reconstitution*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	CANDIDA INFECTIONS: 3 MOS. CONTINUATION OF THERAPY, ALL OTHER INDICATIONS: 6 MOS.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ZANIDATAMAB-HR11

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## Products Affected

- ZIIHERA

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

# ZANUBRUTINIB

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## Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

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

# ZENOCUTUZUMAB-ZBCO

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## Products Affected

- BIZENGRI

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

# ZIFTOMENIB

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## Products Affected

- KOMZIFTI

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

# ZOLBETUXIMAB-CLZB

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## Products Affected

- VYLOY

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

# ZONGERTINIB

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## Products Affected

- HERNEXEOS

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

# ZURANOLONE

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## Products Affected

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

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

## INDEX

1ST TIER UNIFINE PENTP 5MM 31G... 181	ANKTIVA.....259
1ST TIER UNIFINE PNTIP 4MM 32G.....181	AQINJECT PEN NEEDLE 31G 5MM..... 181
1ST TIER UNIFINE PNTIP 6MM 31G.....181	AQINJECT PEN NEEDLE 32G 4MM..... 181
1ST TIER UNIFINE PNTIP 8MM 31G	ARCALYST.....304
STRL,SINGLE-USE,SHRT..... 181	ARIKAYCE.....23
1ST TIER UNIFINE PNTIP 29GX1/2"..... 181	<i>armodafinil</i> ..... 243
1ST TIER UNIFINE PNTIP 31GX3/16..... 181	ASSURE ID DUO PRO NDL 31G 5MM.. 181
1ST TIER UNIFINE PNTIP 32GX5/32..... 181	ASSURE ID DUO-SHIELD 30GX3/16" ... 181
<i>abigale</i> ..... 159	ASSURE ID DUO-SHIELD 30GX5/16" ... 181
<i>abiraterone</i> ..... 7	ASSURE ID INSULIN SAFETY
<i>abiraterone, submicronized</i> ..... 8	SYRINGE 1 ML 29 GAUGE X 1/2" ..... 181
<i>abirtega</i> .....7	ASSURE ID PEN NEEDLE 30GX3/16" ... 181
ACTIMMUNE.....194	ASSURE ID PEN NEEDLE 30GX5/16" ... 181
<i>adalimumab-aaty</i> ..... 14	ASSURE ID PEN NEEDLE 31GX3/16" ... 181
<i>adalimumab-aaty(cf) ai crohns</i> ..... 14	ASSURE ID PRO PEN NDL 30G 5MM... 181
ADEMPAS.....308	ASSURE ID SYR 0.5 ML 31GX15/64" .... 181
ADVOCATE INS 0.3 ML 30GX5/16"..... 181	ASSURE ID SYR 1 ML 31GX15/64"..... 181
ADVOCATE INS 0.3 ML 31GX5/16"..... 181	ATTRUBY..... 10
ADVOCATE INS 0.5 ML 30GX5/16"..... 181	AUGTYRO ORAL CAPSULE 160 MG,
ADVOCATE INS 0.5 ML 31GX5/16"..... 181	40 MG.....297
ADVOCATE INS 1 ML 31GX5/16"..... 181	AUSTEDO ORAL TABLET 12 MG, 6
ADVOCATE INS SYR 0.3 ML 29GX1/2. 181	MG, 9 MG..... 90
ADVOCATE INS SYR 0.5 ML 29GX1/2. 181	AUSTEDO XR ORAL TABLET
ADVOCATE INS SYR 1 ML 29GX1/2" .. 181	EXTENDED RELEASE 24 HR 12 MG, 18
ADVOCATE INS SYR 1 ML 30GX5/16.. 181	MG, 24 MG, 30 MG, 36 MG, 42 MG, 48
ADVOCATE PEN NDL 12.7MM 29G.... 181	MG, 6 MG..... 90
ADVOCATE PEN NEEDLE 32G 4MM... 181	AUSTEDO XR TITRATION KT(WK1-4)..90
ADVOCATE PEN NEEDLE 4MM 33G... 181	AUTOSHIELD DUO PEN NDL 30G
ADVOCATE PEN NEEDLES 5MM 31G. 181	5MM..... 181
ADVOCATE PEN NEEDLES 8MM 31G. 181	AVMAPKI.....41
AIMOVIG AUTOINJECTOR..... 123	AVMAPKI-FAKZYNJA.....41
AKEEGA.....253	AVONEX INTRAMUSCULAR PEN
ALCOHOL PADS.....181	INJECTOR KIT.....191
ALCOHOL PREP SWABS.....181	AVONEX INTRAMUSCULAR
ALCOHOL WIPES..... 181	SYRINGE KIT..... 191
ALECENSA..... 21	AYVAKIT.....40
ALTRENO.....377	BALVERSA ORAL TABLET 3 MG, 4
ALUNBRIG ORAL TABLET 180 MG, 30	MG, 5 MG..... 122
MG, 90 MG..... 60	BD AUTOSHIELD DUO NDL
ALUNBRIG ORAL TABLETS,DOSE	5MMX30G..... 181
PACK..... 60	BD ECLIPSE 30GX1/2" SYRINGE..... 181
ALVAIZ..... 110	BD ECLIPSE NEEDLE 30GX1/2" (OTC) 181
ALYFTREK ORAL TABLET 10-50-125	BD INS SYR 0.3 ML 8MMX31G(1/2)..... 181
MG, 4-20-50 MG.....406	BD INS SYR UF 0.3 ML 12.7MMX30G.. 181
<i>alyq</i> ..... 347	

BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE.....	181	BRAFTOVI.....	114
BD INSULIN SYR 1 ML 27GX12.7MM..	181	BRUKINSA ORAL CAPSULE.....	417
BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE.....	181	BRUKINSA ORAL TABLET.....	417
BD LO-DOSE ULTRA-FINE.....	181	<i>butalbital-acetaminop-caf-cod oral capsule</i> <i>50-325-40-30 mg.....</i>	157
BD NANO 2 GEN PEN NDL 32G 4MM..	181	<i>butalbital-acetaminophen-caff oral capsule</i> .....	157
BD SAFETGLD INS 0.3 ML 29G 13MM.	181	<i>butalbital-acetaminophen-caff oral tablet..</i>	157
BD SAFETYGLD INS 0.3 ML 31G 8MM	181	CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG.....	63
BD SAFETYGLD INS 0.5 ML 30G 8MM	181	CALQUENCE.....	9
BD SAFETYGLD INS 1 ML 29G 13MM.	181	CALQUENCE (ACALABRUTINIB MAL).....	9
BD SAFETYGLID INS 1 ML 6MMX31G	181	CAMCEVI (6 MONTH).....	211
BD SAFETYGLIDE SYRINGE 27GX5/8	181	CAMZYOS.....	229
BD SAFTYGLD INS 0.3 ML 6MMX31G	181	CAPRELSA ORAL TABLET 100 MG, 300 MG.....	405
BD SAFTYGLD INS 0.5 ML 29G 13MM	181	CAREFINE PEN NEEDLE 12.7MM 29G.	181
BD SAFTYGLD INS 0.5 ML 6MMX31G	181	CAREFINE PEN NEEDLE 4MM 32G.....	181
BD SINGLE USE SWAB.....	181	CAREFINE PEN NEEDLE 5MM 32G.....	181
BD UF MICRO PEN NEEDLE 6MMX32G.....	181	CAREFINE PEN NEEDLE 6MM 31G.....	181
BD UF MINI PEN NEEDLE 5MMX31G.	181	CAREFINE PEN NEEDLE 8MM 30G.....	181
BD UF NANO PEN NEEDLE 4MMX32G .....	181	CAREFINE PEN NEEDLES 6MM 32G...	181
BD UF ORIG PEN NDL 12.7MMX29G...	181	CAREFINE PEN NEEDLES 8MM 31G...	181
BD UF SHORT PEN NEEDLE 8MMX31G.....	181	CARETOUCH ALCOHOL 70% PREP PAD.....	181
BD VEO INS 0.3 ML 6MMX31G (1/2)....	181	CARETOUCH PEN NEEDLE 29G 12MM .....	181
BD VEO INS SYRING 1 ML 6MMX31G	181	CARETOUCH PEN NEEDLE 31GX1/4" .	181
BD VEO INS SYRN 0.3 ML 6MMX31G.	181	CARETOUCH PEN NEEDLE 31GX3/16" .....	181
BD VEO INS SYRN 0.5 ML 6MMX31G.	181	CARETOUCH PEN NEEDLE 31GX5/16" .....	181
<i>bendamustine intravenous recon soln.....</i>	50	CARETOUCH PEN NEEDLE 32GX3/16" .....	181
BENDAMUSTINE INTRAVENOUS SOLUTION.....	50	CARETOUCH PEN NEEDLE 32GX5/32" .....	181
BENDEKA.....	50	CARETOUCH SYR 0.3 ML 31GX5/16"..	181
BENLYSTA SUBCUTANEOUS.....	47	CARETOUCH SYR 0.5 ML 30GX5/16"..	181
BESREMI.....	316	CARETOUCH SYR 0.5 ML 31GX5/16"..	181
<i>betaine.....</i>	53	CARETOUCH SYR 1 ML 28GX5/16".....	181
BETASERON SUBCUTANEOUS KIT ....	192	CARETOUCH SYR 1 ML 29GX5/16".....	181
<i>bexarotene.....</i>	55	CARETOUCH SYR 1 ML 30GX5/16".....	181
BIZENGRI.....	418	CARETOUCH SYR 1 ML 31GX5/16".....	181
BORDERED GAUZE 2"X2".....	181	<i>carglumic acid.....</i>	67
<i>bortezomib injection.....</i>	57	CAYSTON.....	45
BORUZU.....	57	CIMZIA.....	69
<i>bosentan oral tablet.....</i>	58		
BOSULIF ORAL CAPSULE 100 MG, 50 MG.....	59		
BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG.....	59		

CIMZIA POWDER FOR RECONST.....	69	COMFORT EZ SYR 0.5 ML 28GX1/2" ....	181
CIMZIA STARTER KIT.....	69	COMFORT EZ SYR 0.5 ML 29GX1/2" ....	181
CLICKFINE PEN NEEDLE 32GX5/32"		COMFORT EZ SYR 0.5 ML 30GX1/2" ....	181
32GX4MM, STERILE.....	181	COMFORT EZ SYR 1 ML 27G 12.7MM.	181
COMETRIQ ORAL CAPSULE 100		COMFORT EZ SYR 1 ML 28GX1/2" .....	181
MG/DAY(80 MG X1-20 MG X1), 140		COMFORT EZ SYR 1 ML 29GX1/2" .....	181
MG/DAY(80 MG X1-20 MG X3), 60		COMFORT EZ SYR 1 ML 30GX1/2" .....	181
MG/DAY (20 MG X 3/DAY).....	62	COMFORT EZ SYR 1 ML 30GX5/16" .....	181
COMFORT EZ 0.3 ML 31G 15/64" .....	181	COMFORT POINT PEN NDL 31GX1/3".	181
COMFORT EZ 0.5 ML 31G 15/64" .....	181	COMFORT POINT PEN NDL 31GX1/6".	181
COMFORT EZ INS 0.3 ML 30GX1/2" .....	181	COMFORT TOUCH PEN NDL 31G 4MM	
COMFORT EZ INS 0.3 ML 30GX5/16" ...	181	.....	181
COMFORT EZ INS 1 ML 31G 15/64" .....	181	COMFORT TOUCH PEN NDL 31G 5MM	
COMFORT EZ INS 1 ML 31GX5/16" .....	181	.....	181
COMFORT EZ INSULIN SYR 0.3 ML....	181	COMFORT TOUCH PEN NDL 31G 6MM	
COMFORT EZ INSULIN SYR 0.5 ML....	181	.....	181
COMFORT EZ PEN NEEDLE 12MM		COMFORT TOUCH PEN NDL 31G 8MM	
29G.....	181	.....	181
COMFORT EZ PEN NEEDLES 4MM		COMFORT TOUCH PEN NDL 32G 4MM	
32G SINGLE USE, MICRO.....	181	.....	181
COMFORT EZ PEN NEEDLES 4MM		COMFORT TOUCH PEN NDL 32G 5MM	
33G.....	181	.....	181
COMFORT EZ PEN NEEDLES 5MM		COMFORT TOUCH PEN NDL 32G 6MM	
31G MINI.....	181	.....	181
COMFORT EZ PEN NEEDLES 5MM		COMFORT TOUCH PEN NDL 32G 8MM	
32G SINGLE USE,MINI,HRI.....	181	.....	181
COMFORT EZ PEN NEEDLES 5MM		COMFORT TOUCH PEN NDL 33G 4MM	
33G.....	181	.....	181
COMFORT EZ PEN NEEDLES 6MM		COMFORT TOUCH PEN NDL 33G 6MM	
31G.....	181	.....	181
COMFORT EZ PEN NEEDLES 6MM		COMFORT TOUCH PEN NDL	
32G.....	181	33GX5MM.....	181
COMFORT EZ PEN NEEDLES 6MM		COPIKTRA.....	102
33G.....	181	CORTROPHIN GEL INJECTION.....	75
COMFORT EZ PEN NEEDLES 8MM		COSENTYX (2 SYRINGES).....	320
31G SHORT.....	181	COSENTYX PEN (2 PENS).....	320
COMFORT EZ PEN NEEDLES 8MM		COSENTYX SUBCUTANEOUS	
32G.....	181	SYRINGE 75 MG/0.5 ML.....	320
COMFORT EZ PEN NEEDLES 8MM		COSENTYX UNOREADY PEN.....	320
33G.....	181	COTELIC.....	74
COMFORT EZ PRO PEN NDL 30G 8MM		CRESEMBA ORAL.....	196
.....	181	CURAD GAUZE PADS 2" X 2".....	181
COMFORT EZ PRO PEN NDL 31G 4MM		CURITY ALCOHOL PREPS 2	
.....	181	PLY,MEDIUM.....	181
COMFORT EZ PRO PEN NDL 31G 5MM		CURITY GAUZE PADS.....	181
.....	181	CURITY GAUZE SPONGES (12 PLY)-	
COMFORT EZ SYR 0.3 ML 29GX1/2" ....	181	200/BAG.....	181

CYLTEZO(CF).....	16	DROPLET INS 0.3 ML 31G 8MM(1/2)	
CYLTEZO(CF) PEN.....	16	OUTER.....	181
CYLTEZO(CF) PEN CROHN'S-UC-HS.....	16	DROPLET INS 0.5 ML 29G 12.7MM	
CYLTEZO(CF) PEN PSORIASIS-UV.....	16	OUTER.....	181
<i>dalfampridine</i> .....	82	DROPLET INS 0.5 ML 30G 12.7MM	
DANYELZA.....	244	OUTER.....	181
DANZITEN.....	249	DROPLET INS 0.5 ML 30GX6MM(1/2)..	181
<i>dasatinib oral tablet 100 mg, 140 mg, 20</i>		DROPLET INS 0.5 ML 30GX8MM(1/2)..	181
<i>mg, 50 mg, 70 mg, 80 mg</i> .....	84	DROPLET INS 0.5 ML 31GX6MM(1/2)..	181
DATROWAY.....	85	DROPLET INS 0.5 ML 31GX8MM(1/2)..	181
DAURISMO ORAL TABLET 100 MG, 25		DROPLET INS SYR 0.3 ML 30GX6MM.	181
MG.....	148	DROPLET INS SYR 0.3 ML 30GX8MM.	181
<i>deferasirox oral granules in packet</i> .....	87	DROPLET INS SYR 0.3 ML 31GX6MM.	181
<i>deferasirox oral tablet</i> .....	87	DROPLET INS SYR 0.3 ML 31GX8MM.	181
DERMACEA 2"X2" GAUZE 12 PLY,		DROPLET INS SYR 0.5 ML 30G 8MM	
USP TYPE VII.....	181	OUTER.....	181
DERMACEA GAUZE 2"X2" SPONGE 8		DROPLET INS SYR 0.5 ML 31G 6MM	
PLY.....	181	OUTER.....	181
DERMACEA NON-WOVEN 2"X2"		DROPLET INS SYR 0.5 ML 31G 8MM	
SPNGE.....	181	OUTER.....	181
<i>dermacinrx lidocan 5% patch outer</i> .....	219	DROPLET INS SYR 1 ML 29G 12.7MM	
DIACOMIT ORAL CAPSULE 250 MG,		OUTER.....	181
500 MG.....	345	DROPLET INS SYR 1 ML 30G 12.5MM.	181
DIACOMIT ORAL POWDER IN		DROPLET INS SYR 1 ML 30G 6MM.....	181
PACKET 250 MG, 500 MG.....	345	DROPLET INS SYR 1 ML 30G 8MM	
<i>diclofenac epolamine</i> .....	92	OUTER.....	181
<i>diclofenac sodium topical solution in</i>		DROPLET INS SYR 1 ML 31G 6MM	
<i>metered-dose pump</i> .....	91	OUTER.....	181
<i>dimethyl fumarate oral capsule, delayed</i>		DROPLET INS SYR 1 ML 31G 8MM.....	181
<i>release(dr/ec) 120 mg, 120 mg (14)- 240</i>		DROPLET MICRON 34G X 9/64".....	181
<i>mg (46), 240 mg</i> .....	93	DROPLET PEN NEEDLE 29G 10MM.....	181
<i>diphenoxylate-atropine oral tablet</i> .....	167	DROPLET PEN NEEDLE 29G 12MM.....	181
<i>dipyridamole oral</i> .....	158	DROPLET PEN NEEDLE 30G 8MM.....	181
<i>dronabinol</i> .....	97	DROPLET PEN NEEDLE 31G 5MM.....	181
DROPLET 0.3 ML 29G 12.7MM(1/2)		DROPLET PEN NEEDLE 31G 6MM.....	181
OUTER.....	181	DROPLET PEN NEEDLE 31G 8MM.....	181
DROPLET 0.3 ML 30G 12.7MM(1/2)		DROPLET PEN NEEDLE 32G 4MM.....	181
OUTER.....	181	DROPLET PEN NEEDLE 32G 5MM.....	181
DROPLET 0.5 ML 29GX12.5MM(1/2).....	181	DROPLET PEN NEEDLE 32G 6MM.....	181
DROPLET 0.5 ML 30GX12.5MM(1/2).....	181	DROPLET PEN NEEDLE 32G 8MM.....	181
DROPLET INS 0.3 ML 29GX12.5MM.....	181	DROPSAFE ALCOHOL 70% PREP	
DROPLET INS 0.3 ML 30G 8MM(1/2)		PADS.....	181
OUTER.....	181	DROPSAFE INS SYR 0.3 ML 31G 6MM	181
DROPLET INS 0.3 ML 30GX12.5MM.....	181	DROPSAFE INS SYR 0.3 ML 31G 8MM	181
DROPLET INS 0.3 ML 31G 6MM(1/2)		DROPSAFE INS SYR 0.5 ML 31G 6MM	181
OUTER.....	181	DROPSAFE INS SYR 0.5 ML 31G 8MM	181

DROPSAFE INSUL SYR 1 ML 31G 6MM.....	181	EASY TOUCH 0.5 ML SYR 29GX1/2" ....	181
DROPSAFE INSUL SYR 1 ML 31G 8MM.....	181	EASY TOUCH 0.5 ML SYR 30GX1/2" ....	181
DROPSAFE INSULN 1 ML 29G 12.5MM .....	181	EASY TOUCH 0.5 ML SYR 30GX5/16...	181
DROPSAFE PEN NEEDLE 31G 4MM.....	181	EASY TOUCH 1 ML SYR 29GX1/2" .....	181
DROPSAFE PEN NEEDLE 31G 5MM.....	181	EASY TOUCH 1 ML SYR 30GX1/2" .....	181
DROPSAFE PEN NEEDLE 31G 8MM.....	181	EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED.....	181
DROPSAFE PEN NEEDLE 31GX1/4" .....	181	EASY TOUCH AUTO 0.5 ML 30G 6MM	181
<i>droxidopa</i> .....	98	EASY TOUCH AUTO 0.5 ML 30G 8MM	181
DRUG MART ULTRA COMFORT SYR.	181	EASY TOUCH AUTORET 1 ML 30G 6MM.....	181
DUPIXENT PEN .....	99	EASY TOUCH AUTORET 1 ML 30G 8MM.....	181
DUPIXENT SYRINGE.....	99	EASY TOUCH FLIPLOK 1 ML 27GX0.5	181
EASY CMFT SFTY PEN NDL 31G 5MM	181	EASY TOUCH INS 0.5 ML 30G 8MM.....	181
EASY CMFT SFTY PEN NDL 31G 6MM	181	EASY TOUCH INS 0.5 ML 31G 8MM.....	181
EASY CMFT SFTY PEN NDL 32G 4MM	181	EASY TOUCH INS 1 ML 27G 1/2" .....	181
EASY COMFORT 0.3 ML 31G 1/2" .....	181	EASY TOUCH INS 1 ML 28G 12.7MM...	181
EASY COMFORT 0.3 ML 31G 5/16" .....	181	EASY TOUCH INS 1 ML 29G 12.7MM...	181
EASY COMFORT 0.3 ML SYRINGE.....	181	EASY TOUCH INS SYR 1 ML 30G 8MM .....	181
EASY COMFORT 0.5 ML 30GX1/2" .....	181	EASY TOUCH INS SYR 1 ML 31G 8MM .....	181
EASY COMFORT 0.5 ML 31GX5/16" .....	181	EASY TOUCH INSULIN 1 ML 29GX1/2	181
EASY COMFORT 0.5 ML 32GX5/16" .....	181	EASY TOUCH INSULIN 1 ML 30GX1/2	181
EASY COMFORT 0.5 ML SYRINGE.....	181	EASY TOUCH INSULIN SYR 0.3 ML....	181
EASY COMFORT 1 ML 31GX5/16" .....	181	EASY TOUCH INSULIN SYR 1 ML RETRACTABLE.....	181
EASY COMFORT 1 ML 32GX5/16" .....	181	EASY TOUCH INSULN 1 ML 29GX1/2"	181
EASY COMFORT ALCOHOL 70% PAD	181	EASY TOUCH INSULN 1 ML 30GX1/2"	181
EASY COMFORT INSULIN 1 ML SYR..	181	EASY TOUCH INSULN 1 ML 30GX5/16	181
EASY COMFORT PEN NDL 29G 4MM..	181	EASY TOUCH INSULN 1 ML 31GX5/16	181
EASY COMFORT PEN NDL 29G 5MM..	181	EASY TOUCH LUER LOK INSUL 1 ML	181
EASY COMFORT PEN NDL 31GX1/4" ..	181	EASY TOUCH PEN NEEDLE 29GX1/2"	181
EASY COMFORT PEN NDL 31GX3/16"	181	EASY TOUCH PEN NEEDLE 30GX5/16	181
EASY COMFORT PEN NDL 31GX5/16"	181	EASY TOUCH PEN NEEDLE 31GX1/4"	181
EASY COMFORT PEN NDL 32GX5/32"	181	EASY TOUCH PEN NEEDLE 31GX3/16	181
EASY COMFORT PEN NDL 33G 4MM..	181	EASY TOUCH PEN NEEDLE 31GX5/16	181
EASY COMFORT PEN NDL 33G 5MM..	181	EASY TOUCH PEN NEEDLE 32GX1/4"	181
EASY COMFORT PEN NDL 33G 6MM..	181	EASY TOUCH PEN NEEDLE 32GX3/16	181
EASY COMFORT SYR 0.5 ML 29G 8MM.....	181	EASY TOUCH PEN NEEDLE 32GX5/32	181
EASY COMFORT SYR 1 ML 29G 8MM.	181	EASY TOUCH SAF PEN NDL 29G 5MM .....	181
EASY COMFORT SYR 1 ML 30GX1/2".	181	EASY TOUCH SAF PEN NDL 29G 8MM .....	181
EASY GLIDE INS 0.3 ML 31GX6MM....	181		
EASY GLIDE INS 0.5 ML 31GX6MM....	181		
EASY GLIDE INS 1 ML 31GX6MM.....	181		
EASY GLIDE PEN NEEDLE 4MM 33G..	181		
EASY TOUCH 0.3 ML SYR 30GX1/2" ....	181		
EASY TOUCH 0.5 ML SYR 27GX1/2" ....	181		

EASY TOUCH SAF PEN NDL 30G 5MM	EMBRACE PEN NEEDLE 31G 5MM.....	181
.....	EMBRACE PEN NEEDLE 31G 6MM.....	181
EASY TOUCH SAF PEN NDL 30G 8MM	EMBRACE PEN NEEDLE 31G 8MM.....	181
.....	EMBRACE PEN NEEDLE 32G 4MM.....	181
EASY TOUCH SYR 0.5 ML 28G	EMGALITY PEN.....	143
12.7MM.....	EMGALITY SYRINGE	
EASY TOUCH SYR 0.5 ML 29G	SUBCUTANEOUS SYRINGE 120	
12.7MM.....	MG/ML, 300 MG/3 ML (100 MG/ML X	
EASY TOUCH SYR 1 ML 27G 16MM....	3).....	143
EASY TOUCH UNI-SLIP SYR 1 ML.....	EMRELIS.....	358
181	ENBREL.....	126
EASYLIFE ALCOHOL 70% PADS.....	ENBREL MINI.....	126
181	ENBREL SURECLICK.....	126
EASYLIFE INS PEN NDL 29G 12MM....	ENSACOVE ORAL CAPSULE 100 MG,	
181	25 MG.....	115
EASYLIFE INS PEN NDL 31G 4MM.....	EPCLUSA ORAL PELLETS IN PACKET	
181	150-37.5 MG, 200-50 MG.....	333
EASYLIFE INS PEN NDL 31G 5MM.....	EPCLUSA ORAL TABLET.....	333
181	EPIDIOLEX.....	64
EASYLIFE INS PEN NDL 31G 6MM.....	EPKINLY.....	119
181	EQL INSULIN 1 ML SYRINGE SHORT	
EASYLIFE INS PEN NDL 31G 8MM.....	NEEDLE.....	181
181	ERBITUX.....	71
EASYLIFE INS PEN NDL 32G 4MM.....	ERIVEDGE.....	412
181	ERLEADA ORAL TABLET 240 MG, 60	
EASYLIFE INS PEN NDL 32G 5MM.....	MG.....	28
181	<i>erlotinib oral tablet 100 mg, 150 mg, 25</i>	
EASYLIFE INS PEN NDL 32G 6MM.....	<i>mg.....</i>	124
181	<i>estradiol-norethindrone acet.....</i>	159
EASYLIFE INS PEN NDL 32G 8MM.....	<i>everolimus (antineoplastic) oral tablet 10</i>	
181	<i>mg, 2.5 mg, 5 mg, 7.5 mg.....</i>	128
EASYLIFE INS SYR 0.5 ML 30G 8MM..	<i>everolimus (antineoplastic) oral tablet for</i>	
181	<i>suspension.....</i>	129
EASYLIFE INS SYR 1 ML 30G 8MM....	EXEL U100 0.3 ML 29GX1/2".....	181
181	EXXUA ORAL TABLET EXTENDED	
EASYLIFE SAFTY PEN NDL 31G 4MM	RELEASE 24 HR.....	146
181	EXXUA ORAL TABLET, EXT REL	
EASYLIFE SAFTY PEN NDL 31G 5MM	24HR DOSE PACK.....	146
181	FAKZYNJA.....	41
EASYLIFE SYR 1 ML 30G 12.7MM.....	FASENRA.....	51
181	FASENRA PEN.....	51
EASYTOUCH SAF PEN NDL 30G 6MM	<i>fentanyl citrate buccal lozenge on a handle</i>	
181	.....	133
ELAHERE.....	<i> fingolimod.....</i>	139
240	FINTEPLA.....	132
ELIGARD.....	FOTIVDA.....	369
212	FP INSULIN 1 ML SYRINGE.....	181
ELIGARD (3 MONTH).....		
212		
ELIGARD (4 MONTH).....		
212		
ELIGARD (6 MONTH).....		
212		
ELREXFIO 44 MG/1.1 ML VIAL INNER,		
SUV, P/F.....		109
109		
ELREXFIO SUBCUTANEOUS		
SOLUTION 40 MG/ML.....		109
109		
<i>eltrombopag olamine oral powder in</i>		
<i>packet 12.5 mg, 25 mg.....</i>		111
111		
<i>eltrombopag olamine oral tablet 12.5 mg,</i>		
<i>25 mg, 50 mg, 75 mg.....</i>		111
111		
EMBRACE PEN NEEDLE 29G 12MM....		181
181		
EMBRACE PEN NEEDLE 30G 5MM.....		181
181		
EMBRACE PEN NEEDLE 30G 8MM.....		181

FREESTYLE PREC 0.5 ML 30GX5/16....	181	HAEGARDA SUBCUTANEOUS RECON	
FREESTYLE PREC 0.5 ML 31GX5/16....	181	SOLN 2,000 UNIT, 3,000 UNIT.....	61
FREESTYLE PREC 1 ML 30GX5/16".....	181	HARVONI ORAL PELLETS IN PACKET	
FREESTYLE PREC 1 ML 31GX5/16".....	181	33.75-150 MG, 45-200 MG.....	205
FRUZAQLA ORAL CAPSULE 1 MG, 5		HARVONI ORAL TABLET.....	205
MG.....	141	HEALTHWISE INS 0.3 ML 30GX5/16" ..	181
FT STERILE PADS 2" X 2".....	181	HEALTHWISE INS 0.3 ML 31GX5/16" ..	181
FYARRO.....	330	HEALTHWISE INS 0.5 ML 30GX5/16" ..	181
GAUZE PAD TOPICAL BANDAGE 2 X		HEALTHWISE INS 0.5 ML 31GX5/16" ..	181
2 ".....	181	HEALTHWISE INS 1 ML 30GX5/16".....	181
GAUZE PADS 2"X2" STRL.....	181	HEALTHWISE INS 1 ML 31GX5/16".....	181
GAVRETO.....	291	HEALTHWISE PEN NEEDLE 31G 5MM	181
<i>gefitinib</i> .....	145	HEALTHWISE PEN NEEDLE 31G 8MM	181
GILOTRIF.....	20	HEALTHWISE PEN NEEDLE 32G 4MM	181
<i>glatiramer subcutaneous syringe 20 mg/ml,</i>		HEALTHY ACCENTS PENTIP 4MM	
<i>40 mg/ml</i> .....	149	32G.....	181
<i>glatopa subcutaneous syringe 20 mg/ml, 40</i>		HEALTHY ACCENTS PENTIP 5MM	
<i>mg/ml</i> .....	149	31G.....	181
<i>glutamine (sickle cell)</i> .....	217	HEALTHY ACCENTS PENTIP 6MM	
<i>glyburide</i> .....	161	31G.....	181
<i>glyburide micronized</i> .....	161	HEALTHY ACCENTS PENTIP 8MM	
<i>glyburide-metformin</i> .....	161	31G.....	181
GNP ALCOHOL SWAB STERILE, TWO		HEALTHY ACCENTS PENTIP 12MM	
PLY.....	181	29G.....	181
GNP CLICKFINE 31G X 1/4" NDL 6MM,		HEB INCONTROL ALCOHOL 70%	
UNIVERSAL.....	181	PADS.....	181
GNP CLICKFINE 31G X 5/16" NDL		HERCEPTIN HYLECTA.....	383
8MM, UNIVERSAL.....	181	HERNEXEOS.....	421
GNP PEN NEEDLE 31G 5MM.....	181	HUMIRA PEN.....	12
GNP PEN NEEDLE 32G 4MM.....	181	HUMIRA PEN CROHNS-UC-HS START.	12
GNP PEN NEEDLE 32G 6MM.....	181	HUMIRA PEN PSOR-UVEITS-ADOL HS	12
GNP SIMPLI PEN NEEDLE 32G 4MM...	181	HUMIRA SUBCUTANEOUS SYRINGE	
GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2		KIT 40 MG/0.8 ML.....	12
UNIT.....	181	HUMIRA(CF).....	12
GNP ULT CMFRT 0.5 ML 29GX1/2".....	181	HUMIRA(CF) PEDI CROHNS STARTER	12
GNP ULTRA COMFORT 0.5 ML SYR....	181	HUMIRA(CF) PEN.....	12
GNP ULTRA COMFORT 1 ML		HUMIRA(CF) PEN CROHNS-UC-HS.....	12
SYRINGE.....	181	HUMIRA(CF) PEN PEDIATRIC UC.....	12
GNP ULTRA COMFORT 3/10 ML SYR..	181	HUMIRA(CF) PEN PSOR-UV-ADOL HS.	12
GOMEKLI ORAL CAPSULE 1 MG, 2		HYRNUO.....	326
MG.....	239	IBRANCE.....	270
GOMEKLI ORAL TABLET FOR		IBTROZI.....	352
SUSPENSION.....	239	<i>icatibant</i> .....	172
HADLIMA.....	18	ICLUSIG.....	289
HADLIMA PUSHTOUCH.....	18	IDHIFA.....	113
HADLIMA(CF).....	18	<i>imatinib oral tablet 100 mg, 400 mg</i> .....	174
HADLIMA(CF) PUSHTOUCH.....	18		

IMBRUVICA ORAL CAPSULE 140 MG, 70 MG.....	171	INSULIN SYRINGE NEEDLELESS.....	181
IMBRUVICA ORAL SUSPENSION.....	171	INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE.....	181
IMBRUVICA ORAL TABLET.....	171	INSULIN U-500 SYRINGE-NEEDLE.....	181
IMDELLTRA.....	354	INSUPEN PEN NEEDLE 29GX1/2".....	181
IMJUDO.....	385	INSUPEN PEN NEEDLE 31G 8MM.....	181
IMKELDI.....	175	INSUPEN PEN NEEDLE 31GX3/16".....	181
IMPAVIDO.....	238	INSUPEN PEN NEEDLE 32G 4MM.....	181
INCONTROL PEN NEEDLE 12MM 29G	181	INSUPEN PEN NEEDLE 32G 6MM (RX) .....	181
INCONTROL PEN NEEDLE 4MM 32G..	181	ITOVEBI ORAL TABLET 3 MG, 9 MG..	178
INCONTROL PEN NEEDLE 5MM 31G..	181	IV ANTISEPTIC WIPES.....	181
INCONTROL PEN NEEDLE 6MM 31G..	181	IWILFIN.....	103
INCONTROL PEN NEEDLE 8MM 31G..	181	JAKAFI.....	318
INCRELEX.....	230	JASCAYD.....	245
<i>indomethacin oral capsule</i> .....	168	<i>javygtor oral tablet,soluble</i> .....	319
<i>infliximab</i> .....	179	JAYPIRCA ORAL TABLET 100 MG, 50 MG.....	287
INGREZZA.....	404	JEMPERLI.....	96
INGREZZA INITIATION PK(TARDIV)..	404	JYNARQUE ORAL TABLET.....	376
INGREZZA SPRINKLE.....	404	KALYDECO.....	197
INLURIYO.....	177	KENDALL ALCOHOL 70% PREP PAD.	181
INLYTA ORAL TABLET 1 MG, 5 MG....	43	KERENDIA.....	137
INQOVI.....	86	KESIMPTA PEN.....	260
INREBIC.....	131	<i>ketorolac oral</i> .....	162
INSULIN 1 ML SYRINGE.....	181	KEYTRUDA.....	278
INSULIN 1/2 ML SYRINGE.....	181	KEYTRUDA QLEX.....	279
INSULIN 3/10 ML SYRINGE.....	181	KIMMTRAK.....	356
INSULIN SYR 0.3 ML 31GX1/4(1/2).....	181	KINERET.....	26
INSULIN SYR 0.5 ML 28G 12.7MM (OTC).....	181	KISQALI 200 MG DAILY DOSE.....	301
INSULIN SYRIN 0.5 ML 30GX1/2" (RX)	181	KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG.....	302
INSULIN SYRING 0.5 ML 27G 1/2"	181	KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3).....	301
INNER.....	181	KOMZIFTI.....	419
INSULIN SYRINGE 0.3 ML.....	181	KOSELUGO ORAL CAPSULE 10 MG, 25 MG.....	325
INSULIN SYRINGE 0.3 ML 31GX1/4.....	181	KOSELUGO ORAL CAPSULE, SPRINKLE 5 MG, 7.5 MG.....	325
INSULIN SYRINGE 0.5 ML.....	181	KRAZATI.....	11
INSULIN SYRINGE 0.5 ML 31GX1/4.....	181	KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG.....	30
INSULIN SYRINGE 1 ML.....	181		
INSULIN SYRINGE 1 ML 27G 1/2"	181		
INNER.....	181		
INSULIN SYRINGE 1 ML 27G 16MM....	181		
INSULIN SYRINGE 1 ML 28G 12.7MM (OTC).....	181		
INSULIN SYRINGE 1 ML 30GX1/2"	181		
SHORT NEEDLE (OTC).....	181		
INSULIN SYRINGE 1 ML 31GX1/4".....	181		
INSULIN SYRINGE 1 ML 31GX5/16"	181		
SHORT NEEDLE, THIN II (OTC).....	181		

<i>lanreotide subcutaneous syringe 120 mg/0.5 ml</i> .....	201	LUPRON DEPOT-PED	
<i>lapatinib</i> .....	202	INTRAMUSCULAR SYRINGE KIT.....	215
LAZCLUZE ORAL TABLET 240 MG, 80 MG.....	204	LUTRATE DEPOT (3 MONTH).....	210
<i>lenalidomide</i> .....	206	LYNOZYFIC INTRAVENOUS SOLUTION 2 MG/ML, 20 MG/ML.....	221
LENVIMA.....	207	LYNPARZA.....	261
<i>leuprolide acetate (3 month)</i> .....	210	LYTGOBI.....	142
<i>leuprolide subcutaneous kit</i> .....	209	MAGELLAN INSUL SYRINGE 0.3 ML..	181
<i>lidocaine topical adhesive patch, medicated 5 %</i> .....	219	MAGELLAN INSUL SYRINGE 0.5 ML..	181
<i>lidocaine topical ointment</i> .....	218	MAGELLAN INSULIN SYR 0.3 ML.....	181
<i>lidocaine-prilocaine topical cream</i> .....	220	MAGELLAN INSULIN SYR 0.5 ML.....	181
<i>lidocan iii</i> .....	219	MAGELLAN INSULIN SYRINGE 1 ML	181
LISCO SPONGES 100/BAG.....	181	MARGENZA.....	227
LITE TOUCH 31GX1/4" PEN NEEDLE..	181	MAVENCLAD (10 TABLET PACK).....	72
LITE TOUCH INSULIN 0.5 ML SYR.....	181	MAVENCLAD (4 TABLET PACK).....	72
LITE TOUCH INSULIN 1 ML SYR.....	181	MAVENCLAD (5 TABLET PACK).....	72
LITE TOUCH INSULIN SYR 1 ML.....	181	MAVENCLAD (6 TABLET PACK).....	72
LITE TOUCH PEN NEEDLE 29G.....	181	MAVENCLAD (7 TABLET PACK).....	72
LITE TOUCH PEN NEEDLE 31G.....	181	MAVENCLAD (8 TABLET PACK).....	72
LITETOUCH INS 0.3 ML 29GX1/2".....	181	MAVENCLAD (9 TABLET PACK).....	72
LITETOUCH INS 0.3 ML 30GX5/16".....	181	MAXICOMFORT II PEN NDL 31GX6MM.....	181
LITETOUCH INS 0.3 ML 31GX5/16".....	181	MAXICOMFORT INS 0.5 ML 27GX1/2".....	181
LITETOUCH INS 0.5 ML 31GX5/16".....	181	MAXI-COMFORT INS 0.5 ML 28G.....	181
LITETOUCH SYR 0.5 ML 28GX1/2".....	181	MAXICOMFORT INS 1 ML 27GX1/2"...	181
LITETOUCH SYR 0.5 ML 29GX1/2".....	181	MAXI-COMFORT INS 1 ML 28GX1/2" ..	181
LITETOUCH SYR 0.5 ML 30GX5/16"....	181	MAXICOMFORT PEN NDL 29G X 5MM.....	181
LITETOUCH SYRIN 1 ML 28GX1/2".....	181	MAXICOMFORT PEN NDL 29G X 8MM.....	181
LITETOUCH SYRIN 1 ML 29GX1/2".....	181	MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG.....	329
LITETOUCH SYRIN 1 ML 30GX5/16" ..	181	MAYZENT STARTER(FOR 1MG MAINT).....	329
LIVTENCITY.....	228	MAYZENT STARTER(FOR 2MG MAINT).....	329
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG.....	388	<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)</i> .....	169
LOQTORZI.....	378	<i>megestrol oral tablet</i> .....	169
LORBRENA ORAL TABLET 100 MG, 25 MG.....	223	MEKINIST ORAL RECON SOLN.....	380
LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG.....	344	MEKINIST ORAL TABLET 0.5 MG, 2 MG.....	381
LUNSUMIO.....	242	MEKTOVI.....	56
LUNSUMIO VELO.....	242	<i>metyrosine</i> .....	235
LUPRON DEPOT.....	213	MICRODOT PEN NEEDLE 31GX6MM..	181
LUPRON DEPOT (3 MONTH).....	213	MICRODOT PEN NEEDLE 32GX4MM..	181
LUPRON DEPOT (4 MONTH).....	213	MICRODOT PEN NEEDLE 33GX4MM..	181
LUPRON DEPOT (6 MONTH).....	213		
LUPRON DEPOT-PED (3 MONTH).....	215		

MICRODOT READYGARD NDL 31G 5MM OUTER.....	181	<i>nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg.....</i>	248
<i>mifepristone oral tablet 300 mg.....</i>	237	NINLARO.....	199
<i>mimvey.....</i>	159	<i>nintedanib.....</i>	250
MINI PEN NEEDLE 32G 5MM.....	181	<i>nitisinone.....</i>	255
MINI PEN NEEDLE 32G 8MM.....	181	NIVESTYM.....	136
MINI PEN NEEDLE 33G 4MM.....	181	NORDITROPIN FLEXPRO.....	337
MINI PEN NEEDLE 33G 5MM.....	181	NOVOFINE 30.....	181
MINI PEN NEEDLE 33G 6MM.....	181	NOVOFINE 32G NEEDLES.....	181
MINI ULTRA-THIN II PEN NDL 31G STERILE.....	181	NOVOFINE PLUS PEN NDL 32GX1/6" ..	181
MIPLYFFA.....	33	NOVOTWIST.....	181
<i>modafinil oral tablet 100 mg, 200 mg.....</i>	243	NUBEQA.....	83
MODEYSO.....	95	NUCALA SUBCUTANEOUS AUTO- INJECTOR.....	232
MONOJECT 0.5 ML SYRN 28GX1/2" .....	181	NUCALA SUBCUTANEOUS RECON SOLN.....	232
MONOJECT 1 ML SYRN 27X1/2" .....	181	NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML.....	232
MONOJECT 1 ML SYRN 28GX1/2" (OTC).....	181	NUPLAZID.....	284
MONOJECT INSUL SYR U100 (OTC)....	181	NURTEC ODT .....	306
MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC).....	181	NYVEPRIA.....	274
MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC).....	181	ODOMZO.....	340
MONOJECT INSUL SYR U100 1 ML.....	181	OFEV.....	250
MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC).....	181	OGIVRI.....	382
MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC).....	181	OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG.....	254
MONOJECT INSULIN SYR 0.3 ML.....	181	OJEMDA ORAL SUSPENSION FOR RECONSTITUTION.....	379
MONOJECT INSULIN SYR 0.3 ML (OTC).....	181	OJEMDA ORAL TABLET.....	379
MONOJECT INSULIN SYR 0.5 ML.....	181	OJJAARA.....	241
MONOJECT INSULIN SYR 0.5 ML (OTC).....	181	ONAPGO.....	29
MONOJECT INSULIN SYR 1 ML 3'S (OTC).....	181	ONUREG.....	44
MONOJECT INSULIN SYR U-100.....	181	OPDIVO.....	256
MONOJECT SYRINGE 0.3 ML.....	181	OPDIVO QVANTIG.....	257
MONOJECT SYRINGE 0.5 ML.....	181	OPDUALAG.....	258
MONOJECT SYRINGE 1 ML.....	181	OPSUMIT.....	226
<i>morphine concentrate oral solution.....</i>	156	ORENCIA.....	4
MOUNJARO.....	152	ORENCIA (WITH MALTOSE).....	2
NANO 2 GEN PEN NEEDLE 32G 4MM.	181	ORENCIA CLICKJECT.....	4
NANO PEN NEEDLE 32G 4MM.....	181	ORFADIN ORAL SUSPENSION.....	255
NATPARA.....	271	ORGOVYX.....	296
NERLYNX.....	247	ORILISSA ORAL TABLET 150 MG, 200 MG.....	105
NIKTIMVO.....	42	ORKAMBI ORAL TABLET.....	225
		ORSERDU ORAL TABLET 345 MG, 86 MG.....	104
		OSENVELT.....	89

OTEZLA.....	31	<i>pirfenidone oral tablet 267 mg, 534 mg,</i>	
OTEZLA STARTER.....	31	<i>801 mg.....</i>	285
OTEZLA XR.....	31	PLEGRIDY SUBCUTANEOUS PEN	
OTEZLA XR INITIATION.....	31	INJECTOR 125 MCG/0.5 ML, 63	
<i>oxandrolone.....</i>	268	MCG/0.5 ML- 94 MCG/0.5 ML.....	193
OZEMPIC ORAL.....	151	PLEGRIDY SUBCUTANEOUS	
OZEMPIC SUBCUTANEOUS.....	151	SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5	
<i>paroxetine hcl.....</i>	170	ML- 94 MCG/0.5 ML.....	193
<i>pazopanib oral tablet 200 mg, 400 mg.....</i>	273	<i>pomalidomide.....</i>	288
PC UNIFINE PENTIPS 8MM NEEDLE		POMALYST.....	288
SHORT.....	181	<i>posaconazole oral tablet, delayed release</i>	
PEGASYS.....	276	<i>(dr/ec).....</i>	290
PEMAZYRE.....	280	PREFPLS INS SYR 1 ML 30GX5/16"	
PEN NEEDLE 30G 5MM OUTER.....	181	(OTC).....	181
PEN NEEDLE 30G 8MM INNER.....	181	PREMPHASE.....	160
PEN NEEDLE 30G X 5/16".....	181	PREMPRO.....	160
PEN NEEDLE 31G 8MM.....	181	PREVENT PEN NEEDLE 31GX1/4".....	181
PEN NEEDLE 31G X 1/4" HRI.....	181	PREVENT PEN NEEDLE 31GX5/16".....	181
PEN NEEDLE 6MM 31G 6MM.....	181	PREVYMIS ORAL TABLET.....	208
PEN NEEDLE, DIABETIC NEEDLE 29		PRO COMFORT 0.5 ML 30GX1/2".....	181
GAUGE X 1/2".....	181	PRO COMFORT 0.5 ML 30GX5/16".....	181
PEN NEEDLES 12MM 29G		PRO COMFORT 0.5 ML 31GX5/16".....	181
29GX12MM,STRL.....	181	PRO COMFORT 1 ML 30GX1/2".....	181
PEN NEEDLES 4MM 32G.....	181	PRO COMFORT 1 ML 30GX5/16".....	181
PEN NEEDLES 5MM 31G		PRO COMFORT 1 ML 31GX5/16".....	181
31GX5MM,STRL,MINI (OTC).....	181	PRO COMFORT ALCOHOL 70% PADS	181
PEN NEEDLES 8MM 31G		PRO COMFORT PEN NDL 32G 8MM....	181
31GX8MM,STRL,SHORT (OTC).....	181	PRO COMFORT PEN NDL 32G X 1/4" ...	181
<i>penicillamine oral tablet.....</i>	281	PRO COMFORT PEN NDL 4MM 32G....	181
PENTIPS PEN NEEDLE 29G 1/2".....	181	PRO COMFORT PEN NDL 5MM 32G....	181
PENTIPS PEN NEEDLE 31G 1/4".....	181	PRO-COMFORT ALCOHOL 70% PADS	181
PENTIPS PEN NEEDLE 31GX3/16"		PRODIGY INS SYR 1 ML 28GX1/2".....	181
MINI, 5MM.....	181	PRODIGY SYRNG 0.5 ML 31GX5/16" ...	181
PENTIPS PEN NEEDLE 31GX5/16"		PRODIGY SYRNGE 0.3 ML 31GX5/16".....	181
SHORT, 8MM.....	181	<i>promethazine injection solution 25 mg/ml.</i>	164
PENTIPS PEN NEEDLE 32G 1/4".....	181	<i>promethazine oral tablet.....</i>	164
PENTIPS PEN NEEDLE 32GX5/32"		<i>promethazine rectal suppository 25 mg.....</i>	164
4MM.....	181	<i>promethagan rectal suppository 12.5 mg,</i>	
<i>phenobarbital.....</i>	163	<i>25 mg.....</i>	164
PIP PEN NEEDLE 31G X 5MM.....	181	PURE CMFT SFTY PEN NDL 31G 5MM	181
PIP PEN NEEDLE 32G X 4MM.....	181	PURE CMFT SFTY PEN NDL 31G 6MM	181
PIQRAY ORAL TABLET 200 MG/DAY		PURE CMFT SFTY PEN NDL 32G 4MM	181
(200 MG X 1), 250 MG/DAY (200 MG		PURE COMFORT ALCOHOL 70%	
X1-50 MG X1), 300 MG/DAY (150 MG X		PADS.....	181
2).....	22	PURE COMFORT PEN NDL 32G 4MM..	181
<i>pirfenidone oral capsule.....</i>	285	PURE COMFORT PEN NDL 32G 5MM..	181
		PURE COMFORT PEN NDL 32G 6MM..	181

PURE COMFORT PEN NDL 32G 8MM..	181	SAFESNAP INS SYR UNITS-100 0.5 ML	
<i>pyrimethamine</i> .....	292	30GX5/16",10X10.....	181
QINLOCK.....	310	SAFESNAP INS SYR UNITS-100 1 ML	
<i>quinine sulfate</i> .....	293	28GX1/2",10X10.....	181
QULIPTA.....	38	SAFESNAP INS SYR UNITS-100 1 ML	
RALDESY.....	384	29GX1/2",10X10.....	181
RAYA SURE PEN NEEDLE 29G 12MM.	181	SAFETY PEN NEEDLE 31G 4MM.....	181
RAYA SURE PEN NEEDLE 31G 4MM...	181	SAFETY PEN NEEDLE 5MM X 31G.....	181
RAYA SURE PEN NEEDLE 31G 5MM...	181	SAFETY SYRINGE 0.5 ML 30G 1/2".....	181
RAYA SURE PEN NEEDLE 31G 6MM...	181	<i>sapropterin oral tablet,soluble</i> .....	319
RELION INS SYR 0.3 ML 31GX6MM....	181	SCEMBLIX ORAL TABLET 100 MG, 20	
RELION INS SYR 0.5 ML 31GX6MM....	181	MG, 40 MG.....	34
RELION INS SYR 1 ML 31GX15/64".....	181	<i>scopolamine base</i> .....	166
RETACRIT INJECTION SOLUTION		SECURESAFE PEN NDL 30GX5/16"	
10,000 UNIT/ML, 2,000 UNIT/ML,		OUTER.....	181
20,000 UNIT/2 ML, 20,000 UNIT/ML,		SECURESAFE SYR 0.5 ML 29G 1/2"	
3,000 UNIT/ML, 4,000 UNIT/ML, 40,000		OUTER.....	181
UNIT/ML.....	120	SECURESAFE SYRNG 1 ML 29G 1/2"	
RETEVMO ORAL CAPSULE 40 MG, 80		OUTER.....	181
MG.....	324	SELARSDI.....	396, 398
RETEVMO ORAL TABLET 120 MG, 160		SEROSTIM SUBCUTANEOUS RECON	
MG, 40 MG, 80 MG.....	324	SOLN 4 MG, 5 MG, 6 MG.....	339
REVCIVI.....	107	SIGNIFOR.....	272
REVUFORJ ORAL TABLET 110 MG,		<i>sildenafil (pulm.hypertension) oral tablet..</i>	327
160 MG, 25 MG.....	300	SIRTURO.....	46
REZDIFFRA.....	298	SKY SAFETY PEN NEEDLE 30G 5MM.	181
REZLIDHIA.....	262	SKY SAFETY PEN NEEDLE 30G 8MM.	181
REZUROCK.....	48	SKYRIZI.....	311
RINVOQ.....	392	SM ULT CFT 0.3 ML 31GX5/16(1/2).....	181
RINVOQ LQ.....	392	<i>sodium oxybate</i> .....	331
RITUXAN HYCELA.....	313	SOMATULINE DEPOT	
ROMVIMZA.....	411	SUBCUTANEOUS SYRINGE 60 MG/0.2	
ROZLYTREK ORAL CAPSULE 100 MG,		ML, 90 MG/0.3 ML.....	201
200 MG.....	116	SOMAVERT.....	277
ROZLYTREK ORAL PELLETS IN		<i>sorafenib</i> .....	341
PACKET.....	117	SPRAVATO.....	125
RUBRACA.....	317	STIVARGA.....	295
RYBELSUS.....	151	STRENSIQ.....	35
RYBREVANT.....	25	SUBVENITE ORAL SUSPENSION.....	200
RYBREVANT FASPRO.....	24	<i>sunitinib malate</i> .....	346
RYDAPT.....	236	SURE CMFT SFTY PEN NDL 31G 6MM	181
RYTELO.....	176	SURE CMFT SFTY PEN NDL 32G 4MM	181
SAFESNAP INS SYR UNITS-100 0.3 ML		SURE COMFORT 0.5 ML SYRINGE.....	181
30GX5/16",10X10.....	181	SURE COMFORT 1 ML SYRINGE.....	181
SAFESNAP INS SYR UNITS-100 0.5 ML		SURE COMFORT 3/10 ML SYRINGE....	181
29GX1/2",10X10.....	181	SURE COMFORT 3/10 ML SYRINGE	
		INSULIN SYRINGE.....	181

SURE COMFORT 30G PEN NEEDLE.....	181	TECHLITE PEN NEEDLE 29GX1/2".....	181
SURE COMFORT ALCOHOL PREP		TECHLITE PEN NEEDLE 29GX3/8".....	181
PADS.....	181	TECHLITE PEN NEEDLE 31GX1/4".....	181
SURE COMFORT INS 0.3 ML 31GX1/4.	181	TECHLITE PEN NEEDLE 31GX3/16"....	181
SURE COMFORT INS 0.5 ML 31GX1/4.	181	TECHLITE PEN NEEDLE 31GX5/16"....	181
SURE COMFORT INS 1 ML 31GX1/4"...	181	TECHLITE PEN NEEDLE 32GX1/4".....	181
SURE COMFORT PEN NDL 29GX1/2"		TECHLITE PEN NEEDLE 32GX5/16"....	181
12.7MM.....	181	TECHLITE PEN NEEDLE 32GX5/32"....	181
SURE COMFORT PEN NDL 31G 5MM..	181	TECHLITE PLUS PEN NDL 32G 4MM..	181
SURE COMFORT PEN NDL 31G 8MM..	181	TECVAYLI.....	357
SURE COMFORT PEN NDL 32G 4MM..	181	TEPMETKO.....	360
SURE COMFORT PEN NDL 32G 6MM..	181	<i>teriparatide subcutaneous pen injector 20</i>	
SURE-FINE PEN NEEDLES 12.7MM.....	181	<i>mcg/dose (560mcg/2.24ml).....</i>	361
SURE-FINE PEN NEEDLES 5MM.....	181	TERUMO INS SYRINGE U100-1 ML.....	181
SURE-FINE PEN NEEDLES 8MM.....	181	TERUMO INS SYRINGE U100-1/2 ML..	181
SURE-JECT INSU SYR U100 0.3 ML.....	181	TERUMO INS SYRINGE U100-1/3 ML..	181
SURE-JECT INSU SYR U100 0.5 ML.....	181	TERUMO INS SYRNG U100-1/2 ML.....	181
SURE-JECT INSU SYR U100 1 ML.....	181	<i>testosterone cypionate.....</i>	363
SURE-JECT INSUL SYR U100 1 ML.....	181	<i>testosterone enanthate.....</i>	364
SURE-JECT INSULIN SYRINGE 1 ML..	181	<i>testosterone transdermal gel in metered-</i>	
SURE-PREP ALCOHOL PREP PADS.....	181	<i>dose pump 12.5 mg/ 1.25 gram (1 %),</i>	
SYMPAZAN.....	73	<i>20.25 mg/1.25 gram (1.62 %).....</i>	362
SYNRIBO.....	263	<i>testosterone transdermal gel in packet 1 %</i>	
TABRECTA.....	66	<i>(25 mg/2.5gram), 1 % (50 mg/5 gram).....</i>	362
<i>tadalafil oral tablet 2.5 mg, 5 mg.....</i>	348	<i>tetrabenazine.....</i>	365
TAFINLAR ORAL CAPSULE.....	79	TEVIMBRA.....	367
TAFINLAR ORAL TABLET FOR		THALOMID ORAL CAPSULE 100 MG,	
SUSPENSION.....	80	150 MG, 200 MG, 50 MG.....	366
TAGRISO.....	267	THINPRO INS SYRIN U100-0.3 ML.....	181
TALVEY.....	353	THINPRO INS SYRIN U100-0.5 ML.....	181
TALZENNA.....	350	THINPRO INS SYRIN U100-1 ML.....	181
TASIGNA ORAL CAPSULE 150 MG,		TIBSOVO.....	198
200 MG, 50 MG.....	248	TIVDAK.....	368
TAVNEOS.....	39	<i>tolvaptan (polycys kidney dis) oral tablets,</i>	
TAZVERIK.....	355	<i>sequential.....</i>	376
TECHLITE 0.3 ML 29GX12MM (1/2).....	181	TOPCARE CLICKFINE.....	181
TECHLITE 0.3 ML 30GX8MM (1/2).....	181	TOPCARE ULTRA COMFORT.....	181
TECHLITE 0.3 ML 31GX6MM (1/2).....	181	<i>torpenz oral tablet 10 mg, 2.5 mg, 5 mg,</i>	
TECHLITE 0.3 ML 31GX8MM (1/2).....	181	<i>7.5 mg.....</i>	128
TECHLITE 0.5 ML 30GX12MM (1/2).....	181	TRELSTAR INTRAMUSCULAR	
TECHLITE 0.5 ML 30GX8MM (1/2).....	181	SUSPENSION FOR RECONSTITUTION	389
TECHLITE 0.5 ML 31GX6MM (1/2).....	181	TREMFYA INTRAVENOUS.....	154
TECHLITE 0.5 ML 31GX8MM (1/2).....	181	TREMFYA ONE-PRESS.....	154
TECHLITE INS SYR 1 ML 29GX12MM.	181	TREMFYA PEN INDUCTION PK(2PEN)	
TECHLITE INS SYR 1 ML 30GX12MM.	181	.....	154
TECHLITE INS SYR 1 ML 31GX6MM...	181	TREMFYA PEN SUBCUTANEOUS PEN	
TECHLITE INS SYR 1 ML 31GX8MM...	181	INJECTOR 200 MG/2 ML.....	154

TREMFYA SUBCUTANEOUS	TRUE-CMFRT PRO PEN NDL 31G 8MM
SYRINGE.....	154
<i>tretinoin topical cream</i> .....	377
<i>tridacaine ii</i> .....	219
<i>trientine oral capsule 250 mg</i> .....	387
TRIKAFTA ORAL GRANULES IN	TRUE-CMFRT PRO PEN NDL 32G 4MM
PACKET, SEQUENTIAL.....	108
TRIKAFTA ORAL TABLETS,	TRUEPLUS PEN NEEDLE 29GX1/2".....
SEQUENTIAL.....	108
TRUE CMFRT PRO 0.5 ML 30G 5/16".....	181
TRUE CMFRT PRO 0.5 ML 31G 5/16".....	181
TRUE CMFRT PRO 0.5 ML 32G 5/16".....	181
TRUE CMFT SFTY PEN NDL 31G 5MM	181
TRUE CMFT SFTY PEN NDL 31G 6MM	181
TRUE CMFT SFTY PEN NDL 32G 4MM	181
TRUE COMFORT 0.5 ML 30G 1/2".....	181
TRUE COMFORT 0.5 ML 30G 5/16".....	181
TRUE COMFORT 0.5 ML 31G 5/16".....	181
TRUE COMFORT 0.5 ML 31GX5/16".....	181
TRUE COMFORT 1 ML 31GX5/16".....	181
TRUE COMFORT ALCOHOL 70%	TRUEPLUS SYR 0.3 ML 29GX1/2".....
PADS.....	181
TRUE COMFORT PEN NDL 31G 8MM..	181
TRUE COMFORT PEN NDL 31GX5MM	181
TRUE COMFORT PEN NDL 31GX6MM	181
TRUE COMFORT PEN NDL 32G 5MM..	181
TRUE COMFORT PEN NDL 32G 6MM..	181
TRUE COMFORT PEN NDL 32GX4MM	181
TRUE COMFORT PEN NDL 33G 4MM..	181
TRUE COMFORT PEN NDL 33G 5MM..	181
TRUE COMFORT PEN NDL 33G 6MM..	181
TRUE COMFORT PRO 1 ML 30G 1/2"...	181
TRUE COMFORT PRO 1 ML 30G 5/16".....	181
TRUE COMFORT PRO 1 ML 31G 5/16".....	181
TRUE COMFORT PRO 1 ML 32G 5/16".....	181
TRUE COMFORT PRO ALCOHOL	TRUEPLUS SYR 0.3 ML 31GX5/16".....
PADS.....	181
TRUE COMFORT SFTY 1 ML 30G 1/2".....	181
TRUE COMFRT PRO 0.5 ML 30G 1/2".....	181
TRUE COMFRT SFTY 1 ML 30G 5/16".....	181
TRUE COMFRT SFTY 1 ML 31G 5/16".....	181
TRUE COMFRT SFTY 1 ML 32G 5/16".....	181
TRUE-CMFRT PRO PEN NDL 31G 5MM	TRUEPLUS SYR 0.5 ML 28GX1/2".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	TRUEPLUS SYR 0.5 ML 29GX1/2".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	TRUEPLUS SYR 0.5 ML 30GX5/16".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	TRUEPLUS SYR 0.5 ML 31GX5/16".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	TRUEPLUS SYR 1 ML 28GX1/2".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	TRUEPLUS SYR 1 ML 29GX1/2".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	TRUEPLUS SYR 1 ML 30GX5/16".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	TRUEPLUS SYR 1 ML 31GX5/16".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	TRULICITY.....
.....	150
TRUE-CMFRT PRO PEN NDL 31G 6MM	TRUQAP.....
.....	65
TRUE-CMFRT PRO PEN NDL 31G 6MM	TRUXIMA.....
.....	314
TRUE-CMFRT PRO PEN NDL 31G 6MM	TUKYSA ORAL TABLET 150 MG, 50
.....	390
TRUE-CMFRT PRO PEN NDL 31G 6MM	MG.....
.....	390
TRUE-CMFRT PRO PEN NDL 31G 6MM	TURALIO.....
.....	283
TRUE-CMFRT PRO PEN NDL 31G 6MM	TYENNE.....
.....	370, 372
TRUE-CMFRT PRO PEN NDL 31G 6MM	TYENNE AUTOINJECTOR.....
.....	372
TRUE-CMFRT PRO PEN NDL 31G 6MM	TYMLOS.....
.....	1
TRUE-CMFRT PRO PEN NDL 31G 6MM	UBRELVY.....
.....	391
TRUE-CMFRT PRO PEN NDL 31G 6MM	UDENYCA ONBODY.....
.....	275
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICAR INS 0.3 ML 31GX1/4(1/2).....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE INS 1 ML 31GX1/4".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE INS SYR 0.3 ML 30G 8MM.....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE INS SYR 0.3 ML 31G 6MM.....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE INS SYR 0.3 ML 31G 8MM.....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE INS SYR 0.5 ML 30G 8MM
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	(OTC).....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE INS SYR 0.5 ML 31G 6MM.....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE INS SYR 0.5 ML 31G 8MM
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	(OTC).....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE INS SYR 1 ML 30GX1/2".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE PEN NEEDLE 31GX3/16".....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE PEN NEEDLE 6MM 31G.....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE PEN NEEDLE 8MM 31G.....
.....	181
TRUE-CMFRT PRO PEN NDL 31G 6MM	ULTICARE PEN NEEDLES 12MM 29G.....
.....	181

ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM.....	181	ULTRA FLO 0.3 ML 31G 5/16"(1/2).....	181
ULTICARE PEN NEEDLES 6MM 32G...	181	ULTRA FLO PEN NEEDLE 31G 5MM...	181
ULTICARE SAFE PEN NDL 30G 8MM..	181	ULTRA FLO PEN NEEDLE 31G 8MM...	181
ULTICARE SAFE PEN NDL 5MM 30G..	181	ULTRA FLO PEN NEEDLE 32G 4MM...	181
ULTICARE SAFETY 0.5 ML 29GX1/2 (RX).....	181	ULTRA FLO PEN NEEDLE 33G 4MM...	181
ULTICARE SYR 0.3 ML 29G 12.7MM....	181	ULTRA FLO PEN NEEDLES 12MM 29G .....	181
ULTICARE SYR 0.3 ML 30GX1/2" .....	181	ULTRA FLO SYR 0.3 ML 29GX1/2" .....	181
ULTICARE SYR 0.3 ML 31GX5/16"		ULTRA FLO SYR 0.3 ML 30G 5/16" .....	181
SHORT NDL.....	181	ULTRA FLO SYR 0.3 ML 31G 5/16" .....	181
ULTICARE SYR 0.5 ML 30GX1/2" .....	181	ULTRA FLO SYR 0.5 ML 29G 1/2" .....	181
ULTICARE SYR 0.5 ML 31GX5/16"		ULTRA THIN PEN NDL 32G X 4MM.....	181
SHORT NDL.....	181	ULTRACARE INS 0.3 ML 30GX5/16" ....	181
ULTICARE SYR 1 ML 31GX5/16".....	181	ULTRACARE INS 0.3 ML 31GX5/16" ....	181
ULTIGUARD SAFE 1 ML 30G 12.7MM.	181	ULTRACARE INS 0.5 ML 30GX1/2" .....	181
ULTIGUARD SAFE0.3 ML 30G 12.7MM .....	181	ULTRACARE INS 0.5 ML 30GX5/16" ....	181
ULTIGUARD SAFE0.5 ML 30G 12.7MM .....	181	ULTRACARE INS 0.5 ML 31GX5/16" ....	181
ULTIGUARD SAFEPACK 1 ML 31G 8MM.....	181	ULTRACARE INS 1 ML 30G X 5/16" .....	181
ULTIGUARD SAFEPACK 29G 12.7MM	181	ULTRACARE INS 1 ML 30GX1/2" .....	181
ULTIGUARD SAFEPACK 31G 5MM.....	181	ULTRACARE INS 1 ML 31G X 5/16" .....	181
ULTIGUARD SAFEPACK 31G 6MM.....	181	ULTRACARE PEN NEEDLE 31GX1/4" ..181	
ULTIGUARD SAFEPACK 31G 8MM.....	181	ULTRACARE PEN NEEDLE 31GX3/16" 181	
ULTIGUARD SAFEPACK 32G 4MM.....	181	ULTRACARE PEN NEEDLE 31GX5/16" 181	
ULTIGUARD SAFEPACK 32G 6MM.....	181	ULTRACARE PEN NEEDLE 32GX1/4" ..181	
ULTIGUARD SAFEPK 0.3 ML 31G 8MM.....	181	ULTRACARE PEN NEEDLE 32GX3/16" 181	
ULTIGUARD SAFEPK 0.5 ML 31G 8MM.....	181	ULTRACARE PEN NEEDLE 32GX5/32" 181	
ULTILET ALCOHOL STERL SWAB.....	181	ULTRACARE PEN NEEDLE 33GX5/32" 181	
ULTILET INSULIN SYRINGE 0.3 ML...	181	ULTRA-FINE 0.3 ML 30G 12.7MM.....	181
ULTILET INSULIN SYRINGE 0.5 ML...	181	ULTRA-FINE 0.3 ML 31G 6MM (1/2).....	181
ULTILET INSULIN SYRINGE 1 ML.....	181	ULTRA-FINE 0.3 ML 31G 8MM (1/2).....	181
ULTILET PEN NEEDLE .....	181	ULTRA-FINE 0.5 ML 30G 12.7MM.....	181
ULTILET PEN NEEDLE 4MM 32G.....	181	ULTRA-FINE INS SYR 1 ML 31G 6MM	181
ULTRA COMFORT 0.3 ML SYRINGE...	181	ULTRA-FINE INS SYR 1 ML 31G 8MM	181
ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G.....	181	ULTRA-FINE PEN NDL 29G 12.7MM....	181
ULTRA COMFORT 0.5 ML 29GX1/2"....	181	ULTRA-FINE PEN NEEDLE 31G 5MM..181	
ULTRA COMFORT 0.5 ML SYRINGE...	181	ULTRA-FINE PEN NEEDLE 31G 8MM..181	
ULTRA COMFORT 1 ML 31GX5/16" .....	181	ULTRA-FINE PEN NEEDLE 32G 6MM..181	
ULTRA COMFORT 1 ML SYRINGE.....	181	ULTRA-FINE SYR 0.5 ML 31G 6MM.....	181
ULTRA FLO 0.3 ML 30G 1/2" (1/2).....	181	ULTRA-FINE SYR 0.5 ML 31G 8MM.....	181
ULTRA FLO 0.3 ML 30G 5/16"(1/2).....	181	ULTRA-FINE SYR 1 ML 30G 12.7MM...	181
		ULTRA-THIN II 1 ML 31GX5/16" .....	181
		ULTRA-THIN II INS 0.3 ML 30G.....	181
		ULTRA-THIN II INS 0.3 ML 31G.....	181
		ULTRA-THIN II INS 0.5 ML 29G.....	181
		ULTRA-THIN II INS 0.5 ML 30G.....	181
		ULTRA-THIN II INS 0.5 ML 31G.....	181
		ULTRA-THIN II INS SYR 1 ML 29G.....	181

ULTRA-THIN II INS SYR 1 ML 30G.....	181	VANFLYTA.....	294
ULTRA-THIN II PEN NDL 29GX1/2" .....	181	VANISHPOINT 0.5 ML 30GX1/2" SY	
ULTRA-THIN II PEN NDL 31GX5/16.....	181	OUTER.....	181
UNIFINE OTC PEN NEEDLE 31G 5MM	181	VANISHPOINT INS 0.5 ML 30G 8MM	
UNIFINE OTC PEN NEEDLE 32G 4MM	181	OUTER.....	181
UNIFINE PEN NEEDLE 32G 4MM.....	181	VANISHPOINT INS 1 ML 30GX3/16" ....	181
UNIFINE PENTIPS 12MM 29G		VANISHPOINT U-100 29X1/2 SYR.....	181
29GX12MM, STRL.....	181	VENCLEXTA ORAL TABLET 10 MG,	
UNIFINE PENTIPS 31GX3/16"		100 MG, 50 MG.....	408
31GX5MM,STRL,MINI.....	181	VENCLEXTA STARTING PACK.....	408
UNIFINE PENTIPS 32G 4MM.....	181	VEOZAH.....	134
UNIFINE PENTIPS 32GX1/4" .....	181	VERIFINE INS SYR 1 ML 29G 1/2" .....	181
UNIFINE PENTIPS 33GX5/32" .....	181	VERIFINE PEN NEEDLE 29G 12MM.....	181
UNIFINE PENTIPS 6MM 31G.....	181	VERIFINE PEN NEEDLE 31G 5MM.....	181
UNIFINE PENTIPS MAX 30GX3/16" .....	181	VERIFINE PEN NEEDLE 31G X 6MM...	181
UNIFINE PENTIPS NEEDLES 29G.....	181	VERIFINE PEN NEEDLE 31G X 8MM...	181
UNIFINE PENTIPS PLUS 29GX1/2"		VERIFINE PEN NEEDLE 32G 6MM.....	181
12MM.....	181	VERIFINE PEN NEEDLE 32G X 4MM...	181
UNIFINE PENTIPS PLUS 30GX3/16" .....	181	VERIFINE PEN NEEDLE 32G X 5MM...	181
UNIFINE PENTIPS PLUS 31GX1/4"		VERIFINE PLUS PEN NDL 31G 5MM...	181
ULTRA SHORT, 6MM.....	181	VERIFINE PLUS PEN NDL 31G 8MM...	181
UNIFINE PENTIPS PLUS 31GX3/16"		VERIFINE PLUS PEN NDL 32G 4MM...	181
MINI.....	181	VERIFINE PLUS PEN NDL 32G 4MM-	
UNIFINE PENTIPS PLUS 31GX5/16"		SHARPS CONTAINER.....	181
SHORT.....	181	VERIFINE SYRING 0.5 ML 29G 1/2" .....	181
UNIFINE PENTIPS PLUS 32GX5/32" .....	181	VERIFINE SYRING 1 ML 31G 5/16" .....	181
UNIFINE PENTIPS PLUS 33GX5/32" .....	181	VERIFINE SYRNG 0.3 ML 31G 5/16" .....	181
UNIFINE PROTECT 30G 5MM.....	181	VERIFINE SYRNG 0.5 ML 31G 5/16" .....	181
UNIFINE PROTECT 30G 8MM.....	181	VERQUVO.....	409
UNIFINE PROTECT 32G 4MM.....	181	VERSALON ALL PURPOSE SPONGE	
UNIFINE SAFECONTROL 30G 5MM.....	181	25'S,N-STERILE,3PLY .....	181
UNIFINE SAFECONTROL 30G 8MM.....	181	VERZENIO.....	6
UNIFINE SAFECONTROL 31G 5MM.....	181	<i>vigabatrin</i> .....	410
UNIFINE SAFECONTROL 31G 6MM.....	181	<i>vigadrone</i> .....	410
UNIFINE SAFECONTROL 31G 8MM.....	181	<i>vigpoder</i> .....	410
UNIFINE SAFECONTROL 32G 4MM.....	181	VITRAKVI ORAL CAPSULE 100 MG,	
UNIFINE ULTRA PEN NDL 31G 5MM..	181	25 MG.....	203
UNIFINE ULTRA PEN NDL 31G 6MM..	181	VITRAKVI ORAL SOLUTION.....	203
UNIFINE ULTRA PEN NDL 31G 8MM..	181	VIVIMUSTA.....	50
UNIFINE ULTRA PEN NDL 32G 4MM..	181	VIZIMPRO.....	81
UPTRAVI ORAL TABLET 1,000 MCG,		VONJO.....	269
1,200 MCG, 1,400 MCG, 1,600 MCG, 200		VOQUEZNA.....	413
MCG, 400 MCG, 600 MCG, 800 MCG.....	322	VORANIGO.....	414
UPTRAVI ORAL TABLETS,DOSE		<i>voriconazole oral suspension for</i>	
PACK.....	322	<i>reconstitution</i> .....	415
<i>ustekinumab-aauz</i> .....	394	VOSEVI.....	335
VALCHLOR.....	231	VOWST.....	130

VUMERITY .....	94	ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG.....	422
VYALEV .....	140	ZYDELIG .....	173
VYLOY .....	420	ZYKADIA .....	68
VYNDAMAX.....	349	ZYNLONTA.....	222
WEBCOL ALCOHOL PREPS		ZYNYZ.....	299
20'S,LARGE.....	181		
WELIREG.....	49		
WINREVAIR.....	342		
XALKORI ORAL CAPSULE.....	77		
XALKORI ORAL PELLETT 150 MG, 20 MG, 50 MG.....	78		
XDEMVY .....	224		
XELJANZ.....	374		
XELJANZ XR.....	374		
XERMELO.....	359		
XIFAXAN ORAL TABLET 200 MG, 550 MG.....	303		
XOLAIR.....	264		
XOSPATA.....	147		
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK).....	323		
XTANDI ORAL CAPSULE.....	118		
XTANDI ORAL TABLET 40 MG, 80 MG .....	118		
YERVOY .....	195		
YESINTEK.....	400, 402		
YONSA.....	8		
YUFLYMA(CF).....	14		
YUFLYMA(CF) AI CROHN'S-UC-HS.....	14		
YUFLYMA(CF) AUTOINJECTOR.....	14		
YUTREPIA.....	386		
ZEJULA ORAL CAPSULE.....	252		
ZEJULA ORAL TABLET .....	252		
ZELBORAF .....	407		
ZIIHERA.....	416		
ZIRABEV .....	54		
ZOLADEX.....	153		
ZTALMY .....	144		
ZTLIDO .....	219		